TOP END ABORIGINAL HEALTH PLANNING STUDY

April 2000

REPORT TO THE TOP END REGIONAL INDIGENOUS HEALTH PLANNING COMMITTEE OF THE NORTHERN TERRITORY ABORIGINAL HEALTH FORUM

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PREFACE

This is the Final Report of the Top End Aboriginal Health Planning Study. It builds on the work done for the Central Australian Health Planning Study that was completed in July, '97.

This report covers:

- a summary of policy directions of Commonwealth and Northern Territory Governments;
- an overview of the demographics of the Region;
- an analysis of current Primary Health Care (PHC) service provision;
- a review of current health status by Zone;
- a discussion on the aetiology of persisting poor Aboriginal health status, and how a better understanding of this can lead to the implementation of more effective strategies;
- a proposed model of PHC service delivery for the Top End of the Northern Territory (NT) based on Health Service Zones (HSZ), and the delivery of agreed Core Functions of PHC under a collaborative planning structure, and singular Indigenous Health Authority;
- an analysis of gaps in services;
- recommended priorities in PHC service development.

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

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

We have applied a critical analysis in discussing the issues involved with the perpetration of continued poor Aboriginal health. This includes a discussion of what we have described as *institutionalised conflict* in PHC services to Aboriginal people in the NT. We are aware that others may have different perceptions of these issues, and we do not intend that our discussion inflame tensions between current providers or funding bodies. 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. Currently there is little doubt that the development of health services to Aboriginal people is complicated by continuing conflict and competition between funding bodies, professional groups, and other agencies. The health services thus provided are tediously complex reflecting the negotiations of stakeholders external to the Aboriginal politic concerned with the maintenance of their influence. This makes the achievement of greater community control more difficult.

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. We have listed these people in Appendix 4 (apologies to anyone we have missed).

We are particularly grateful to the many health service workers who spared us their valuable time in giving us information about their service, despite the heavy demands on them.

Thanks to our field staff who collected detailed information under the guidance of Pip Duncan. These are Irene Fisher, Sebastian Lee, Nellie Kamfoo, Robyn Williams, Michael Walshe, and David Alexander.

Our researchers also contributed significantly to various parts of this report. Thanks to Chris Elenor for his work on population projections, Ursula Raymond and Kyrn Stevens for their work on the Aboriginal & Torres Strait Islander Commission (ATSIC) Regional Profiles, and Jill Hardwick for her analysis of hospital data and advice about health financing issues.

We are particularly grateful to Ramakrishna Chondur of the Department of Health & Aged Care (DHAC) who worked with us creating the Zonal Maps.

We also thank Lonely Planet Publications for permission to reproduce their Top End Language Maps from their publication *Australian Phrase Book* Edition 2, Lonely Planet, 1988..

Finally we thank the Steering Committee and especially the Committee's secretary, Jamie Gallacher, for their guidance and support throughout this plan.

The plan was funded by the Office of Aboriginal & Torres Strait Islander Health (OATSIH) and administered by Territory Health Services (THS). It was conducted under the direction of the Top End Regional Indigenous Health Planning Committee (TERIHPC) which was made up of:

- Pat Anderson, Wes Miller - the Aboriginal Medical Services Alliance – Northern Territory (AMSANT);
- David Ashbridge (replaced by Jenny Cleary), Rose Rhodes (replaced by Cheryl Rae) - THS;
- Marion Kroon, Roger Brailsford - OATSIH;
- John Kelly (replaced by Jerry Thomas) - ATSIC.

Jamie Gallacher performed the functions of secretariat to the committee.

The Top End Aboriginal Health Planning Study is the work of PlanHealth Pty Ltd and does not necessarily reflect the views of the Northern Territory Aboriginal Health Forum Partners.

GLOSSARY

A&IAAFR	Aboriginal and Islander Alcohol Awareness and Family Recovery
A&OD	Alcohol & Other Drugs
AA	Alcoholics Anonymous
AAAC	Australian Aboriginal Affairs Council
ABS	Australian Bureau of Statistics
ABTA	Aboriginal Benefits Trust Account
ACAP	Aboriginal Cultural Awareness Program
ACAT	Aged Care Assessment Team
AHL	Aboriginal Hostels Limited
AHMAC	Australian Health Ministers Advisory Council
AHW	Aboriginal Health Worker
AIDS	Auto Immune Deficiency Syndrome
AIMSS	Aboriginal & Islander Medical Support Service Incorporated
ALOS	Average length of stay
ALPA	Arnhem Land Progress Association
ALRA	Aboriginal Land Rights (Northern Territory) Act, 1976
ALT	Aboriginal Land Trust
ALWAT	Aboriginal Living with Alcohol Team
AMSANT	Aboriginal Medical Services Alliance – Northern Territory
ARDS	Aboriginal Resource Development Services
ATSIC	Aboriginal and Torres Strait Islander Commission
CAAMA	Central Australian Aboriginal Media Association
CAAPS	Council for Aboriginal Alcohol Program Services
CACP	Commonwealth Aged Care Program
CADCCC	Central Australian Disease Control Coordinating Committee
CARHTU	Central Australian Remote Health Training Unit
CARIHPC	Central Australian Regional Indigenous Health Planning Committee
CARPA	Central Australian Rural Practitioners Association
CCBFPT	CAAPS Community Based Field Program Team
CCT	Coordinated Care Trial
CCTIS	Coordinated Care Trial Information System
CDEP	Community Development Employment Program
CDH	Commonwealth Department of Health
CHASP	Community Health Accreditation and Standards Program
CIAS	Community Information Access System
CINCRM	Centre for Indigenous Natural and Cultural Resource Management
CLA	Community Living Area
CLC	Central Land Council
CME	Continuing Medical Education
CMS	Church Missionary Society
COAG	Council of Australian Governments
Congress	Central Australian Aboriginal Congress
CRCATH	Cooperative Research Centre for Aboriginal and Tropical Health
CRS	Commonwealth Rehabilitation Service
DAA	Department of Aboriginal Affairs
Danila Dilba	Danila Dilba Biluru Butji Binnilutlum Medical Service
DCS&H	Department of Community Services and Health
DEETYA	Department of Employment, Education, Training, and Youth Affairs

DHAC	Department of Health & Aged Care
DMO	District Medical Officer
DRG	Diagnostic Related Group
EKAMS	East Kimberly Aboriginal Medical Service
ELDO	European Launcher Development Organisation
FACS	Family & Children's Services
FORWAARD	Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties
GPs	General Practitioners
GSAT	Guidelines Standards and Audit Team
HACC	Home & Community Care
HIC	Health Insurance Commission
HINS	Housing Infrastructure Needs Survey
HIV	Human Immune-deficiency Virus
HLG	Department of Housing & Local Government
HSZ	Health Service Zone
IHANT	Indigenous Housing Authority of the NT
IHS	Indian Health Service
IT	Information technology
JHPC	Joint Health Planning Committee
JPA	Jabiluka Project Area
KAAG	Katherine Aboriginal Action Group
KADA	Katherine Alcohol and Drug Association
KCAO	Katherine Combined Aboriginal Organisations
KRSIS	Kakadu Regional Social Impact Study
KWHB	Katherine West Health Board
LHHS	Laynhapuy Homelands Health Service
LWAP	Living with Alcohol Program
MBS	Medical Benefits Scheme
MHB	Maningrida Health Board
MOU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NLC	Northern Land Council
NT	Northern Territory
NTAHF	NT Aboriginal Health Forum
NTAMS	NT Aerial Medical Service
NTG	NT Government
NTRHWFA	NT Remote Health Work Force Agency
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OATSIHS	Office of Aboriginal and Torres Strait Islander Health Services
OPN	Operations North (THS)
PATS	Patient Assisted Travel Scheme
PBS	Pharmaceutical Benefits Scheme
PHC	Primary Health Care
PHHS	Pintupi Homelands Health Service
PIP	Practice Incentive Payments
RAAF	Royal Australian Air Force
RAG	Remote Area Grant
RCI	Remote Community Initiative
RDH	Royal Darwin Hospital
RHSET	Rural Health Support, Education and Training.
RN	Registered Nurse
SA	Service Agreement

SAC	State Advisory Committee
Sep.	Separation
STD	Sexually Transmitted Disease
SWPE	Standard Weighted Patient Equivalents.
TEABBA	Top End Aboriginal Bush Broadcasting Association
TERIHPC	Top End Regional Indigenous Health Planning Committee
THB	Tiwi Health Board
THS	Territory Health Services
TPF	Tripartite Forum
UHS	Urapuntja Health Service

EXECUTIVE SUMMARY

Our work has involved identifying the details of the location, size and mobility of the Aboriginal population of the Top End of the NT. This has involved an examination of population data from a range of sources (ABS[1], ATSIC, HLG[2], THS and HINS[3]), and have also utilised the knowledge of local informants. We have also documented the current level of PHC services in the Top End.

We have also considered the available evidence about the causes of ill health and how these relate to the Aboriginal community. From this we have developed a strategy which involves the development of an Aboriginal health system capable of addressing these underlying causes as well as delivering comprehensive PHC services through community control mechanisms in communities, This strategy is premised on an understanding about the importance of reconstruction of Aboriginal society which has been wounded by the histories of the past 100 years, and is based on the existing strengths of the community and its current health leadership.

In developing this strategy we have particularly considered the local NT experience of community control through various models and overseas experience (and particularly the comparative studies of North America, New Zealand and Australia). In the NT there are two models of PHC delivery under community control which have been successful. One are those services generally known as community controlled health services, and the other are the more recent Coordinated Care Trials (CCT). Both of these types of services are represented in AMSANT and funded by both THS and OATSIH. We have considered many suggestions about how these models of community control could be improved, and have included many of these in this report. However, we did not find any other options for community controlled models in the course of this consultancy.

In regard to the population data, the enormous mobility of people stands out. Many small family groups are living in out-stations or homelands with population of less than 100. Whilst these groups are small (often numbering less than 30 people), their total number is large, numbering in the vicinity of 7,155[4] people. Providing health services to these populations is the key challenge for the PHC system. It is a credit to those PHC providers involved, that around half of these people do receive some level of service. However, the remainder have no organised access to PHC services.

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

We have analysed the demographics of the Top End Region and have presented that information in detail. This has included detailed analyses of population groups, and the development of HSZs based on language, cultural and relationship factors as well as logistic considerations.

Analyses of current health care services have identified barriers to effective delivery and include institutionalised conflict between the different organisations involved in health care, and unnecessary complexity in health service delivery and funding arrangements. However, there is broad agreement on the policy direction needed to address Aboriginal health disadvantage, but there are still implementation problems reflecting, we believe, a gap between bureaucratic frames for developing health services and community realities. This is most apparent in the inability of OATSIH to implement a single Top End health service facility, or function in any of the RCI Sites nominated in 1997.

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1 Australian Bureau of Statistics.

2 Department of Housing and Local Government.

3 Housing Infrastructure Needs Survey.

4 This figure is an estimate of the total number of people living in populations less than 100 people throughout the Top End. Some of these do get some level of health care service; others do not.

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 residents of out-stations/ homelands, many of whom are missing out.

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

A. **Health Service Zones** within which services will be organised with PHC staff to live in the Zone wherever possible;
B. 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:
        a) **Resident** health care services in the community;
        b) **Visiting** professional services;
        c) Provision of **medicine kits** to designated holders;
        d) Access to **medical advice** via phone or radio.
    ii. **Regional support**s for PHC – staff education, management, program development & evaluation 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 requiring community action.
C. Maintaining and expanding the work of the **NT Aboriginal Health Forum** (NTAHF) to facilitate the development of regional collaborative planning of health services and other programs to address Aboriginal health issues.
D. Pursue opportunities to increase **community control** of Comprehensive PHC Services, including the strengthening of the Aboriginal health leadership in the NT.

We have developed the Core Functions of PHC from the Central Australian Health Planning Study. We have included the list of essential components of PHC listed in the Freeman/ Rotem Report in this (See Chapter 8).

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. This can be achieved through the resourcing of the larger community controlled AMSs to act as Hub Centres in a *Hub-Spoke* model.

In the course of this consultancy no other options for models of community control were put to us. It was clear that AMSANT was the only body with a clear vision of how community control would work involving a balance between local community autonomy and the bigger picture of a health care system which itself is under community control. The tendency for many health service staff and bureaucrats to focus only on *local* community control leaves the issue of developing a system for the better delivery of services unaddressed, the decision making status quo in tact, and risks continuing the conflict and incessant debates/ arguments which are a significant barrier to improving service delivery. Note that Kunitz and others (see Chapter 6) have put very persuasive analyses explaining international differences in Indigenous health status that relate specifically to this jurisdictional contest.

We have considered opportunities for community control in two ways:

1. We have outlined a recommended model of PHC services involving the development of a NT wide system largely directed by the Aboriginal community health leadership; and
2. We have considered both zonal and local community control opportunities in the detail of the report under each Zone.

Funding Issues

Recommendation 1

We propose that THS and OATSIH adopt guideline, (acceptable to NTAHF) for funding which strengthen comprehensive PHC service delivery to Aboriginal communities, and reflect the framework of core functions of PHC.

These guidelines are aimed at ensuring adequate levels of resourcing for the effective implementation of:

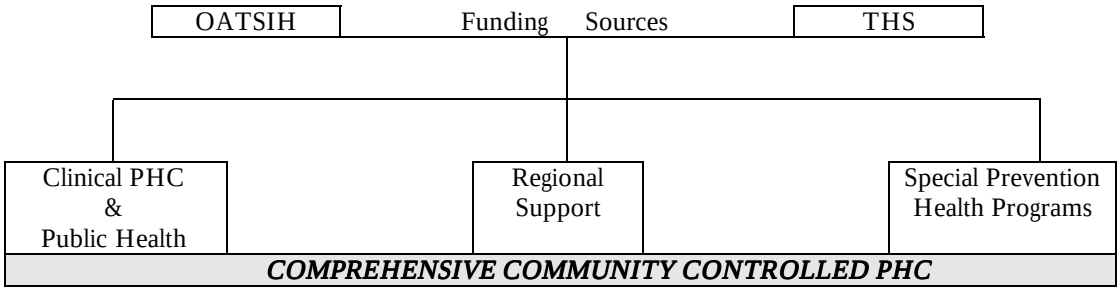
- clinical services, including preventive programs that have a clinical dimension;
- appropriate regional support to PHC services; and
- support for communities to get financial and logistic assistance to develop programs to address the health issues that are not amenable to clinical interventions.

It also ensures a balance between clinical and non-clinical aspects of comprehensive PHC delivery.

It is clear that in order to improve PHC services in terms of 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. We have included a discussion of health financing in Chapter 10, and a brief overview of NT funding compared to other States in Appendix 9.

Figure 1 illustrates diagrammatically these guidelines for funding lines to support the development of comprehensive PHC services in the community.

Figure 1: Funding Lines For Comprehensive Community-Based PHC.



Recommendation 2

We propose that the NTAHF continue to investigate the level of funding required to provide adequate PHC services to people in Top End, and where such funding might come from.

A. Health Service Zones

Recommendation 3

We propose that the Top End (incorporating the 4 ATSIC Regions of Yilli-Rreung, Jabiru, Miwatj and Garrak-Jarru and the THS Districts of Darwin Urban, Darwin Rural, East Arnhem, and Katherine) be divided into 10 HSZs for the purpose of PHC service development.

These Zones can assist the following development of PHC:

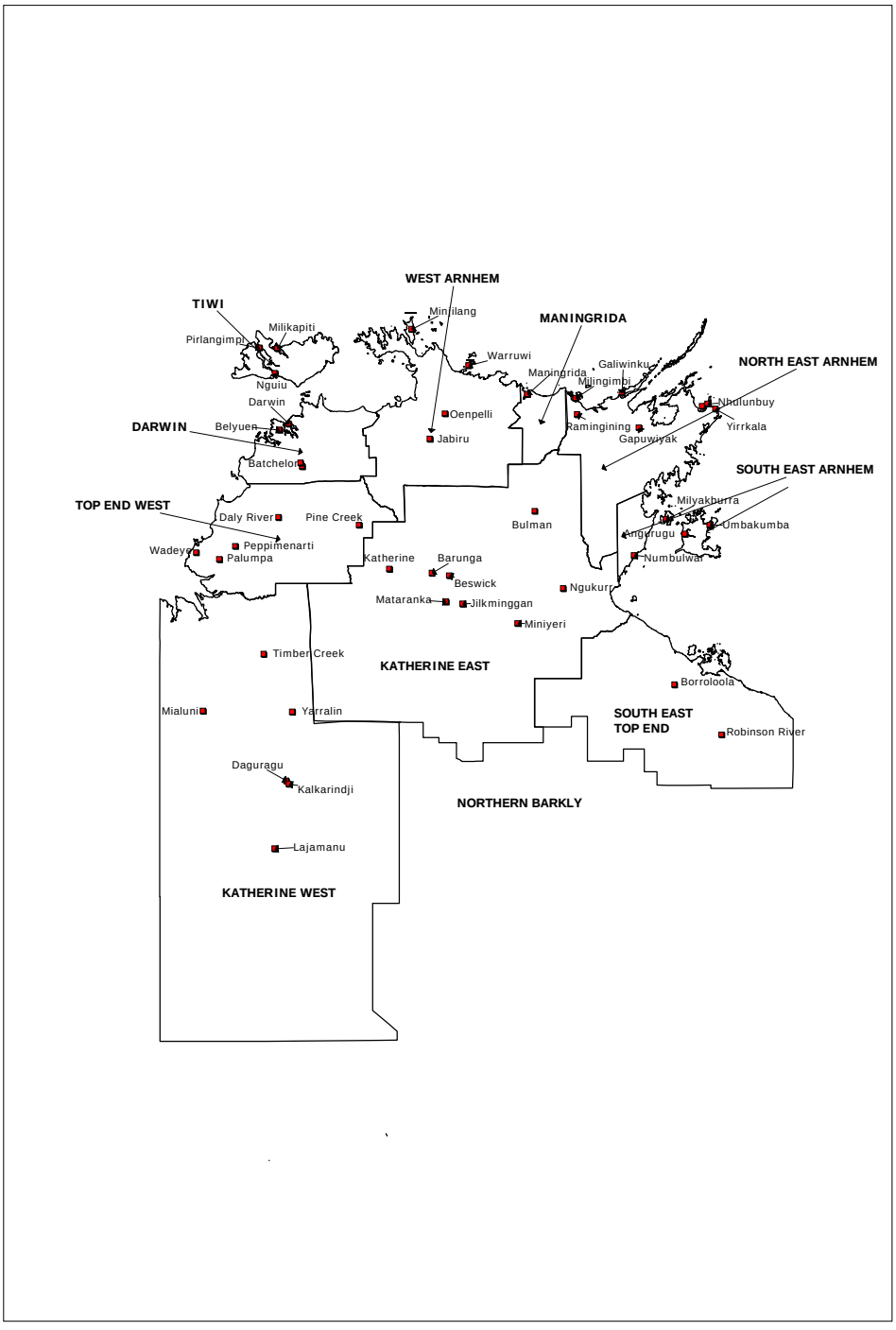
- The identification of resource needs;
- The efficient utilisation of resources within those Zones;
- The delivery of regional support services to those Zones;
- The on-going involvement of community organisations in the processes of PHC service delivery.

Recommendation 4

We recommend that the concept of Zones be used flexibly, and not as a model across the Top End. Specifically, whilst some Zones will lend themselves to the management of health services on a Zone-wide basis (eg Tiwi), this will not be the case in all Zones.

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. Mobility is a hallmark of people in the Top End. A hallmark of PHC is its ability to be responsive. A major issue for PHC is its ability to respond to population mobility.

Figure 2: Map of Top End of the NT Showing Proposed HSZs.



B. Primary Health Care

The Core Functions of PHC (see Chapter 8) is a way of bench marking the development of services to Aboriginal communities.

Recommendation 5

That the NTAHF adopt the expanded Core Functions of PHC as the basis for implementation of PHC services in Aboriginal communities.

Regional Supports for PHC

Hub Centres

Regional support for PHC can be organised in a number of ways, but the most potent way for many functions is to strengthen the role of the community controlled health services in the larger centres. This concept has been vaguely discussed in recent years as a Hub and Spoke Model. It needs to be emphasised that this model is not a means of zone or local community PHC service governance. It is rather a way of organising supports which are beyond the capacity of local communities. This is part of the responsibility of an effective health care system. This concept does not mean that a variety of providers cannot be contracted to deliver specified supports. However, the Hub Centres will be responsible for ensuring such support is delivered. In order for this to work effectively, there are resource implications, including the need to identify the functions of a PHC Hub Centre more precisely.

Recommendation 6
That funding bodies develop appropriate mechanisms for reviewing the funding base of existing Aboriginal community controlled health services to ensure that they are adequately funded to provide PHC services to their local population as well as provide regional support to PHC services in their region.

Recommendation 7
That the Hub-Spoke Model for the provision of regional support to PHC services be pursued by developing some shared understandings of the roles to be undertaken and that funding arrangements be developed for both AMSANT and the Hub Centres to facilitate this development.

Workforce Facility

All PHC services, 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 through a Top End and Central Australian regional approach. Remote services, particularly those not serviced by THS have serious difficulty in this area, and it is a significant barrier to such staff accessing in-service training. The NT Remote Health Work Force Agency (NTRHWFA) is providing this support for doctors, and this should continue. It would be most efficient to change the constitution of the NTRHWFA for them to take on this role for nurses, AHWs, administrators, etc as well as for doctors, or for another agency to take over both roles.

Recommendation 8

We propose that a PHC service workforce unit be established with Top End and Central Australian arms to provide support for recruitment of staff including relief staff. Consideration should be given to utilising the infrastructure of the NTRHWFA to provide this function.

Education and Training Support

Staff education and training support is a fundamental aspect of support to PHC. This support needs to be organised at a regional level and coordinated with the staff relief agency. This could be developed as part of the Hub Centre role, or through an in-service facility for the Top End based at Danila Dilba. It is important that wherever this facility is actually located, that it be firmly located within the PHC sector. This is to ensure that the *felt needs* of the PHC service providers are the drivers of the programs delivered. Currently too much of the in-service training tends to be driven by education provider agendas, and assumptions remote from the PHC service culture. This does not preclude this coordinating facility from purchasing training from other agencies.

Recommendation 9

We propose that an in-service educational unit be established to be responsible for the provision of orientation and in-service programs to all PHC service staff including AHWs, nurses, doctors, and administrators.

The role of Health Boards/ Committees is crucial to the prospects of expanding community control of health services. AMSANT and some of its member Board members have a unique role to offer training programs for new and developing Health Boards. Generic providers of governance training are unable to deliver the specific training needs of Health Boards. These should be run through the Aboriginal community health sector as part of the strategy of reconstructing Aboriginal society. This does not preclude other providers offering their training programs to Health Boards/ Committees.

Recommendation 10

We propose that a program for the training of members of Health Boards/ Committees be established and run through the community-controlled sector, specifically AMSANT and that long standing Board Members of established services be utilised in this training.

Aboriginal Health Workers

The Central Australian Health Planning Study[5] made the following observations:

[5] Bartlett, B, Duncan, P, Alexander, D and Hardwick, J *Central Australian Health Planning Study: Final Report,* PlanHealth/ OATSIHS, Canberra, 1997.

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 AHW practice in the community. However, educational values and standards have been dominant since the transfer of responsibility for AHW education from THS to Batchelor College. The needs of PHC services in the community have become less of a driving force. In many communities it was the senior people who communities choose (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.

Whilst changes have occurred, particularly in the negotiation and implementation of a new AHW Career Structure, and the implementation of a Best Practice initiative, the allocation of further resources for the development of AHWs remains a major hurdle. There are still many communities with no or grossly inadequate numbers of AHWs. The training of new AHWs continues to occur without consideration of particular community's needs. Recommendations from various reports have not been acted on, and it is clear that there are still inadequate resources allocated to support AHW education, professional practice and continuing education.

Recommendation 11
We urge funding bodies (OATSIH & THS) and the major employers of AHWs (THS and AMSANT members) to take immediate action to ensure that adequate professional support is provided to AHWs. We suggest that the NTAHF oversee the development of collaborative strategies to achieve this.

Recommendation 12
We recommend that the NTAHF enter into discussions with AHW education providers (especially Batchelor Institute) to develop ways that entry requirements for AHW students can take account of particular community's needs.

Specialist and Allied Health Visits

Rare health service resources will need to be delivered through a regionally organised schedule of visits. Currently there is no single agency taking responsibility for the coordination of these visits – they are either organised by Specialist Outreach Services (SOS), the Community Physician and the Community Paediatrician, all within THS. These visits are best organised and coordinated at a regional level. THS is the main employer of these professional groups, and this organising and coordinating function is thus best located within THS. However, work needs to be done to ensure better equity of coverage, and to facilitate multi-disciplinary community visits enabling particularly better chronic disease management.

The unit will take responsibility for organising specialist visits to all PHC services in the Top End. We expect that the majority of medical specialists would be employed primarily through the Royal Darwin Hospital (RDH). This Unit would negotiate with the hospital and the specialist, to ensure appropriate coverage and regularity of bush community visits.

Recommendation 13

We propose that a regional function be developed within THS to employ allied health professionals and to organise medical specialist and allied health visits to communities.

Pharmaceuticals

Recommendation 14

We propose that Community or Regional Pharmacies involved in the supply of pharmaceuticals to Aboriginal health services under the Section 100 arrangements develop regional supports to PHC services involving training in the maintenance, storage and dispensing of pharmaceuticals to PHC staff and to Medicine Kit holders; and develop systems of management for the supply of dosette boxes, blister packs or other methods of provision of medications to patients with chronic illnesses or disabilities.

This arrangement should include the supply of medicine kits to designated holders in out-stations, including the monitoring of expiry dates.

Technical Support

Busy PHC practitioners poorly manage the maintenance and calibration of medical equipment. The responsibility for this function should rest with a regional function. Information Technology (IT) support is also of increasing importance to best practice in PHC. This could be developed as part of the Hub Centre concept. A further issue is the lack of clear funding sources for the updating and upgrading of computer hardware and software.

Recommendation 15

That technical support for the maintenance and calibration of medical equipment be the responsibility of THS or Hub Centres whether through regional hospital employed technicians, or through contracts.

Recommendation 16

That IT support be provided to PHC services through strengthening the capacity of this function of the AMS Hub Centres.

Recommendation 17

That funding bodies (OATSIH & THS) develop regular funding arrangements to ensure that PHC services have both software and hardware upgraded in a three-year cycle.

Transport

Transport is a key issue in the ability of people to access PHC services. PATS have restrictions that limit access to people living more than 200kms from the site of the referred service. This is highly problematic for people within this 200km radius.

Recommendation 18

That the restrictions on PATS that disallow people access to support if they live less than 200 km from the service provider be reviewed and consideration given to replacing PATS with other forms of transport for the communities affected, or the distance of eligibility be substantially reduced.

Special Preventive Health Programs

Special Preventive Health Programs are an integral part of comprehensive PHC services and are those which require community agency (action) for there to be sustained success.

Resources to support community action 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 types 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.

Funding for these programs needs to be directed at strengthening an integrated and comprehensive PHC service in the community, but funding needs to be organised differently to that for clinical services which need to be delivered to all communities in a more or less similar way. Funding bodies need to develop some flexibility in terms of available funds to support community initiatives in a timely manner.

Recommendation 19

That health promotion strategies, especially attempts at community capacity building and community development be brought under the influence of the NTAHF to enable the Aboriginal health leadership (AMSANT) to better direct how these processes should operate.

Recommendation 20

That funding bodies maintain a funding pool whose expenditure is overseen by the NTAHF, and which aims to support programs that groups in the particular communities wish to pursue. The development of these programs may involve the hub centres in developing a framework for the program activity and a means of evaluating progress.

Recommendation 21

Existing OATSIH and THS health promotion funds should be pooled to make up this funding line.

Recommendation 22

That this program be directed by the Aboriginal leadership as represented in AMSANT.

Improving Access to PHC

We have proposed a three-prong approach to ensuring universal access to PHC services. These are:

- visiting PHC professionals[6];
- the development of a network of medicine kit holders; 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 Darwin, Katherine or Nhulunbuy.

Recommendation 23

We recommend that PHC services be resourced adequately to provide regular visiting services to their associated out-stations/ homelands, and that staff be clearly oriented to the expectation that this is a core part of their work.

Recommendation 24

We propose that a system be developed to issue designated kit holders in small communities with no resident health service staff, with medicine kits geared to the knowledge and experience of the holder.

Recommendation 25

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

C. Community Control

Community control of PHC service has been a Commonwealth policy plank for more than two decades. Since the National Aboriginal Health Strategy (NAHS) other jurisdictions, including the NT Government have embraced this as policy. However, it has proved a difficult policy to implement. We have argued in this report that community control is not just a matter of rhetoric, but an essential component of PHC if the current causes of, particularly young, adult mortality are to be effectively addressed. We suggest that there will be greater success if moves to community control are pursued within a collaborative framework represented by the NTAHF.

Recommendation 26

We propose that, wherever possible, PHC services be developed under community control arrangements, whether through health committees under existing community councils, or through the establishment of incorporated Health Councils/ Boards, 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 NTAHF should facilitate these processes, rather than funding bodies attempting to implement programs alone. The special role of AMSANT should be recognised and utilised.

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[6] Visiting PHC professionals to small out-stations may be quite infrequent and focused on maintaining medicine kits, rather than frequent visits focused on providing regular face to face clinical care.

Recommendation 27

That OATSIH, THS & AMSANT work collaboratively to facilitate a simplified process for implementing PHC service development policies, including:

- *the establishment of a PHC Service Working Group under the NTAHF to oversee the implementation of all PHC Service development programs, including the RCI and the PHC Access Program, with regionalised sub-groups in the Top End and Central Australia;*
- *the provision of adequate resources to the proposed AMS PHC Hub Centres to enable them to carry out identified regional support to PHC services, including the facilitation of community control;*
- *the withdrawal of the current guidelines to RCI programs, and specifically the abandonment of the concept of Technical Advisory Groups;*
- *the adoption of uncomplicated and flexible implementation plans developed collaboratively through the PHC Service Working Group;*
- *ensuring clarity about the amount of funds available for particular health service development before discussions with communities are undertaken.*

Barriers to community control include the need to manage multiple funding sources with different accountability requirements and the lack of funding for adequate delivery of PHC services and support for administrative functions.

Recommendation 28

That funding bodies (THS and OATSIH) move towards collaborative arrangements with AMSANT, through the NTAHF, to:

- *develop a single instrument of accountability suitable for all funding bodies and that is able to be readily provided by the health service;*
- *ensure an adequate level of funding that enables delivery of comprehensive PHC, including adequate administrative resources.*

We have argued that AMSANT is the single most important organisation in terms of experience in successfully implementing community control of PHC services. The role of AMSANT needs to be better recognised by funding bodies, and resources made available to enable AMSANT to better perform their role.

Recommendation 29

That both THS and OATSIH modify the way they work with remote communities to ensure that AMSANT is fully informed and involved in the whole process of health service development from the development of guidelines, consultations, implementation strategies, and continuing support.

Recommendation 30

That adequate resources be provided to AMSANT so that it can more effectively service its membership, and play its pivotal leadership role in the continuing implementation of improved health service to Aboriginal communities, and specifically the development of community control of PHC services.

Health Leadership and Aboriginal Society

Part of the role of the Aboriginal health leadership is to engage with community members on health issues – both what community members are concerned about, and the leadership providing feedback and information about what progress is being made. Over the past few years AMSANT have organised annual Health Summits that have been both well attended and dynamic with people struggling to come to terms with difficult health issues. It is essential that these continue.

Recommendation 31

That the annual AMSANT Health Summits be strongly supported and that secure funding be identified to enable them to continue and grow in their significance.

D. Collaborative Planning Processes

Under the Framework Agreement progress has been made in terms of improved collaborative planning processes. However, further work is needed to improve the effectiveness and efficiency of these arrangements. It is time that the operations of the collaborative structures are reviewed.

Recommendation 32

That the current planning structures of the NTAHF, TERIHPC and CARIHPC be reviewed with a view of ensuring that they remain effective, efficient and relevant whilst continuing to be appropriately regionally focused.

Whilst we recognise that there is a place for a wide diversity of research, a significant amount of research should be directed at the project of improving Aboriginal health status. Thus the main research bodies in the NT, Menzies School of Health Research and the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH), should provide information to the NTAHF about their research strategies, and work with the Forum in addressing issues identified by the Forum.

Recommendation 33

That research institutions, specifically Menzies School of Health Research and CRCATH, provide a report to the NTAHF twice a year outlining their Aboriginal health research strategies and seek input from the Forum a regarding particular issues that may inform the further development of their research work.

E. NT Indigenous Health Authority

Much of our discussion and recommendations have focused on how to make existing systems and relationships more effective, and easier for communities to engage with. However, many of these problems relate to the existence of two jurisdictions (the Commonwealth & NT Governments) that are able to buck pass responsibility for problems. This is a waste of energy – too many meetings, too many compromises, and consequently at times enormous delays in getting services on the ground. We cannot exaggerate the degree of frustration that has been expressed to us in the course of this consultancy from community members, AMSANT, other consultants, service providers and people in the bureaucracy itself. This dynamic appears to be never-ending. We thus consider that a singular authority that receives all funding sources and then purchases services to be worthy of serious consideration.

Recommendation 34

That an independent Indigenous Health Authority be established in the NT which will receive all funds for Aboriginal PHC and take responsibility for the delivery of Aboriginal PHC services in the NT through contracting community organisations as providers wherever possible.

Gaps in Services

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 10 HSZs in the four ATSIC Regional Council Areas of Yilli Rreung, Jabiru, Miwatj and Garrak-Jarru that largely correspond to the Top End Region of THS. We have then ranked these to identify which HSZs have greatest need. However, there are enormous differences 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. Our rankings are based on staff to population ratios and we do not purport that these are an overall measure of health service need.

The results of these analyses show that the following areas are in greatest need of a better PHC service. These communities should be the starting point for the prioritising for any new resources that become available for PHC services in the Top End. Clearly this data needs to be considered alongside other qualitative data, and the need for structural changes required for effectively pursuing a reconstructive strategy for improving Aboriginal health. They should also be part of the focus for negotiations about any reorganisation of health care services.

The priorities identified are organised into three groups:

A. There is urgency to operationalise the first round of the Remote Community Initiative (RCI) funding. This includes:
   1. Robinson River;
   2. Miniyeri;
   3. Groote Eylandt – Milyakburra, Umbakumba and Angurugu;
   4. Dagaragu;
   5. Marthakal Homelands (Galiwin'ku)
   6. Binjari.

B. The population groups most in need are:
   1. South East Top End HSZ (1/10)
      - **Borroloola (5/27)**
   2. Darwin HSZ (2/10)
      - **Belyuen (10/23)**
   3. Top End West HSZ (3/10)
      - **Peppimenarti (2/23)**
      - **Palumpa (4/23)**
      - **Wadeye (16/23)**
      - **Daly River (18/23)**
   4. Katherine East HSZ (4/10)
      - **Jilkminggan (1/23)**
      - **Wugularr (6/23)**
      - **Bulman (8/23)**
      - **Ngukurr (13/23)**
   5. South East Arnhem HSZ (4/10)
      - **Numbulwar (12/23)**

6. West Arnhem HSZ (6/10)
   - **Minjilang (8/23)**
   - **Warruwi (14/23)**
   - **Oenpelli (17/23)**
7. North East Arnhem HSZ (8/10)
   - **Laynhapuy Homelands** (3/23)
   - **Yirrkala** (7/23)
   - **Ramingining** (10/23)
   - **Milingimbi** (15/23)

This list includes all those population groups that have 50% or less of their *Actual: Ideal Health Staff Costs*, but excludes non-remote locations, those who are part of a Coordinated Care Trial (CCT), and those who are selected for support in the First Round of the RCI sites.

C. Other Identified Needs

We consider that there are some special needs that urgently need consideration. Specifically the funding base of Danila Dilba, Wurli Wurlinjang and Miwatj Health needs to be reviewed if these organisations are to play the role of Hub Centres in a Hub-Spoke Model. Danila Dilba especially needs consideration as it is the one service that constantly falls outside the remote classification (eg NTRHWFA criteria, RCI guidelines, Section 100) but has enormous demands placed on both its services (with a high proportion of visitors with chronic illness) and its leadership role (eg with AMSANT and the NTAHF). As can be seen by the rankings of need the Darwin HSZ is the second most in need.

Prioritising health service needs is not a simple process. Clearly the urgency is to get more PHC 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 PHC in communities. AHWs continue to have inadequate access to educational support. Investing in regional support for PHC must be a priority.

Recommendation 35

We propose that the PHC service needs identified above be used, (along with other criteria such as assessments of capacity to benefit) as a basis for allocation of funds for PHC services.

Other Issues in Aboriginal Health Development

Child and Maternal Health

Recommendation 36

That the development of child and maternal health programs be collaboratively developed through a Working Group of the NTAHF.

Male Health Programs

Recommendation 37

That PHC services reorganise their facilities where possible to accommodate the needs of men's health and that resources be allocated to supporting men to address both their physical needs (in terms of chronic disease) and their emotional and spiritual needs.

Preventable Chronic Disease

Recommendation 38

That multi-disciplinary chronic disease clinics be organised within PHC services as the cornerstone of a strategy to address preventable chronic disease in Aboriginal communities.

Recommendation 39

That a strategy be developed under the guidance of the NTAHF to ensure that Aboriginal people have timely access to the methods of diagnosis and treatment of ischaemic heart disease that are available to other Australians.

Recommendation 40

We recommend that THS urgently reconsider its decision to delay implementation of decentralised dialysis or self-dialysis programs, and that such programs are implemented in multiple sites as part of a more comprehensive evaluation strategy as a matter of urgency.

Interpreter Services

Recommendation 41

That an Aboriginal interpreter service be developed as a matter of urgency and that interpreter resources be made available to PHC services in communities as well as to the centre based hospital and specialist services.

CHAPTER 1 - BACKGROUND TO THE PLAN

The Top End Aboriginal Health Planning Study was tendered by THS with the support of the other NTAHF partners - OATSIH, ATSIC and AMSANT in order to provide an overview of health services to population groups as a tool for the planning of health services and to inform decisions on where new resources should be directed. It follows the Central Australian Health Planning Study that has formed the basis for decisions for RCI funds and the development of other funding models based on HSZs.

It is worth revisiting the recent history of Aboriginal health funding in order to provide a fuller understanding of where Aboriginal health policy is heading[1].

In 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 responsibility for the funding of Aboriginal health services from ATSIC to the Commonwealth Department of Human Services and Health (now the DHAC). 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 PHC, 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 PHC facility at Urlampe.

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, Urlampe, and Mutitjulu), representatives of the Anmatjere Community Council, THS, OATSIHS, and the Aboriginal Medical Services Alliance NT (AMSANT).

The Final Report of the Central Australian Health Planning Study was presented in July, 1997.

[1] The following paragraphs are largely taken from Bartlett, B et al *Central Australian Health Planning Study: Final Report,* PlanHealth/ OATSIHS, Canberra, 1997.

The Framework Agreement

The NAHS[2] set out structures through the state based Tripartite Forum (TPF), and the National Aboriginal Health Council as a means of overcoming the conflict and cost shifting that has plagued Aboriginal health strategies since the 1967 Referendum. However, this was ineffective largely (at least in the NT) because of the inclusion of non-health organisations whose work impacts on health status. This was attempted as a means of implementing the concept of inter-sectoral collaboration, a key component of PHC identified in the Alma Ata Declaration of PHC[3] and the NAHS.

AMSANT and NACCHO had been advocating for a formal agreement to further the notion of collaborative effort since 1994. When Dr Wooldridge became Minister for Health in 1996 he proceeded to negotiate with State and Territory Ministers and the community controlled health sector to formalise arrangements with the States/ Territories and to spell out in these agreements how Aboriginal health issues would be approached. These are known as the Framework Agreements. The NT Minister for Health, Chair of ATSIC, Commonwealth Minister for Health and the Executive Secretary of AMSANT signed the NT Framework Agreement in October, 1998. The NTAHF was established shortly after in line with the Agreement.

Regional Indigenous Health Planning Committees

In Central Australia, the Central Australian Aboriginal Congress (Congress) (later along with AMSANT) had been advocating for a regional collaborative process since 1989. The Central Australian Health Planning Study recommended that a regional planning committee be established and suggested how it might work. The Central Australian Regional Indigenous Health Planning Committee (CARIHPC) was established in April, 1998. This was before the signing of the Framework Agreement. TERIHPC was established in late 1998 specifically to oversee the conduct of this plan. Both committees report back to the NT Forum.

The Aims of this study are in Appendix 2.

From the beginning we were under firm and explicit instructions from TERIHPC to get information as much as we could without consulting with communities. In other words we were to gather together data that already exists, much of which already is based on community consultations. Further we were to use the same methodology as the Central Australian plan.

The most significant existing documents or processes informing our planning process have been:

- Central Australian Health Planning Study;
- Yilli Rreung, Jabiru, Miwatj and Garrak-Jarru ATSIC Regional Plans;
- Ove Arup The ATSIC NAHS: NT Health Impact Assessments. Brisbane, May, 1999.

[2] Working Group *National Aboriginal Health Strategy*, Canberra, 1989.

[3] WHO *Alma Ata Declaration of PHC*, Alma Ata, USSR, 1978.

CHAPTER 2 – METHODOLOGY

Our methodology is largely based on that of the Central Australian Health Planning Study[1] and involved assessing and ranking PHC staff: population ratios.

Contextual Issues

We have considered that developing a plan for health service development in the Top End of the NT requires the issues to be placed in a geographical, historical and political context. Thus we have included sections on:

- Strategic directions of health service development in the NT including NT and Commonwealth Government policies as well as Aboriginal community perspectives (see Chapter 3).
- A consideration of existing regions and Indigenous languages in the Top End (see Chapter 4).
- Geographical and historical profiles of the ATSIC regions of the Top End (see Chapter 5).
- An overview of the Determinants of Health (see Chapter 6). This is particularly relevant to the central question underlying this plan that is what strategies are required to improve Aboriginal health? This chapter informs this question.

The Development of an Aboriginal Health System

In order to address the poor status of Aboriginal health it is essential that a strategic approach be followed by those involved. This does not mean that all communities or health services approach issues the same way, but it does mean that funding bodies and service providers are operating within an agreed strategic framework. Whilst the Framework Agreement (see Chapter 1) provides an overview of how the Commonwealth and Territory Governments will work together with the community sector, it does not specify a clear strategy for addressing Aboriginal health. Thus we have also included an overview of the reasons Aboriginal people are sick (see Chapter 6) and draw from that a suggested strategic framework for tackling these underlying causes (see Chapter 8).

From a strategic approach, a system for delivering services to Aboriginal communities needs to be developed. We have endeavoured to develop the outline of such a system that takes into account the determinants of health outlined in Chapter 6. We believe our proposal offers a simplified, and integrated system that facilitates local community control, as well as fostering flexibility and diversity in program delivery. In developing this proposal we have considered the views of the current service providers and funding bodies, as well as other informants. The essence of this plan is outlined in the Executive Summary and detailed in Chapter 8.

Population Estimates

This includes estimating size, distribution and mobility of population groups in the Top End of the NT. The various sources of population data were examined, and a 'best estimate' was made. Data sources that were considered included ABS, HLG, ATSIC, and THS. Local informants including local health services and resource centres were also considered. As much as practicable, a verification of this data was carried out using local informants as to the current situation. ABS can only give data to a collection district level. This is unhelpful when attempting to estimate homeland/ out-station populations. However, local informants were very helpful in this regard.

[1] Bartlett, B et al *Op Cit.*, 1997.

The plan is focused on Aboriginal health. However, in most communities there are some non-Aboriginal residents. All residents in these communities will access the same health service resource and there is little point in only including Aboriginal residents in population estimates. However, at the other extreme, Darwin clearly has a large majority of its population non-Aboriginal and health services set up for this population is mostly not readily accessed by Aboriginal people and it would be ludicrous to include the whole population in our analyses. Thus, only Aboriginal residents were included in our population estimates for the following communities:

- Darwin;
- Katherine;
- Alyangula;
- Nhulunbuy; and
- Jabiru.

For smaller places such as Pine Creek, Mataranka, Timber Creek and Adelaide River that also have a large number of non-Aboriginal residents, we have included estimates for the whole population, as it is appropriate that the one health service addresses the health needs of the whole population.

For our best estimates we have rounded off to the nearest 5. However, the smallest population is recorded for our purposes as 5. That is, if a homeland has a population of 2 people, we have recorded it as 5 rather than zero. Only unpopulated out-stations are recorded as zero.

Population figures are always rubbery especially in the context of Aboriginal communities. Thus planning processes must deal with 'ball park' figures, and not expect that more effort, sophisticated technology, or complex formulae will produce the correct figure.

Some mobility is significant as a single event with large numbers of people moving at the one time as a group. However this is uncommon, except for some communities during the wet season. Most movement involves smaller groups from out-stations/ homelands to larger communities in the same region. The issue for health service development is that local PHC services are best placed to be aware of these movements, and to modify their service delivery logistics accordingly.

Population Mobility and Health Service Delivery

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

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 over the past 25 years. There has been a plethora of homelands/ out-stations developed with small family groups and clans 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 and/ or town house in a major centre.

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

The movement of people occurs without regard for administrative jurisdictions, and indeed crosses State/ Territory borders (eg the Miriuwong-Gadjerrrong people whose country is divided by the NT/ Western Australian border) as well as smaller administrative regions, and the recognised language group areas.

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 homelands/ out-stations throughout the Top End. The history of particular 'communities' in the Top End has been that different language groups and clans 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. The current publicised events in Maningrida are an example of this. 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 that 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.

The unreliability of population estimates. There is a tendency to under-estimate populations in the census with people hiding from census collectors because of, for example, 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 of people with mobile clients being included in the database of more than one community. Organisations in some 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 homelands/ out-stations/ communities will always contain inaccuracies. Populations are highly mobile[2] 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[3].

Mobility of people in the Top End is determined by relationships with country and people as well as climate. This presents a challenge for health services, and is a major factor in the complexity of health service delivery.

The provision of a flexible structure where services are attached to the client population rather than just a place can help overcome the problems of mobility. 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 Darwin, Katherine or Nhulunbuy as major 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.

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2 Young, E & Doohan, K *Mobility for Survival: A process analysis of Aboriginal population movement in Central Australia.'* ANU North Australia Research Unit, Darwin, 1989.

3 Young, E *'Aboriginal Population Mobility and Service Provision: A Framework for Analysis.'* Chapter 15, p 186-196 in Meehan, B & White N (Eds) '*Hunter-Gatherer Demography: Past and Present.'* Oceania Monograph 39, Sydney, 1990.

Allocation of resources based on the overall population size in an area can help services better identify their client populations and define their service delivery responsibilities. Whilst this approach has some important strengths, it fails to adequately paint a picture of the distribution of people within that area. How the population is dispersed through an area has important implications for the allocation of appropriate levels of health service resources. For example, if a community of 500 people are all located in the same area and live in walking distance from a central clinic, then there is little need to do more than provide a clinic, health service staff, drugs, equipment, etc. A vehicle may be required, but mainly as a run around vehicle, and possibly a 4WD to transport clients to hospital for investigations, etc. But if these 500 people are living in small out-stations of say no more than 50 people, many kilometres apart, then the resources required to provide a service are quite different.

Thus we have developed a system of categorising homelands/ out-stations as part of developing a picture of *HSZs* that show the mobility and density of people throughout each zone.

Out-station Categories

In consultation with the steering committee, and based on the categorisation used in the Central Australian Health Planning Study, a categorisation of out-stations has been developed as part of painting a picture of the population dispersion of the region. This is different to the one used for the Central Australian Health Planning Study because seasonal climatic changes are not a factor in determining people's mobility in the Centre. However in the Top End this is a major factor in some communities.

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 homelands/ out-station occupancy is likely to be remain the same, the details of occupancy are likely to be highly changeable. The categories are shown in Table 1.

Table 1: Out-station Categories.

Category 1	an out-station occupied permanently, apart from particular crises or outings.
Category 2	an out-station generally occupied permanently, but currently unoccupied due to 'sorry business' or other cultural matter.
Category 3	an out-station occupied more than half the time in a year.
Category 4	an out-station that is not occupied in the wet
Category 5	an out-station occupied less than half the time in a year mainly because of lack of service (eg schools) or weather related access problem.
Category 6	an out-station that is occupied only on weekends or holidays.
Category 7	an out-station that is not occupied at all.
Category 8	an out-station being planned, but not yet occupied

The limitations of this categorisation are that the status of homelands/ out-stations tends to change fairly rapidly. Common reasons people occupy only intermittently, or vacate, previously viable and vibrant out-stations are:

- lack of resources (eg transport);
- 'sorry business';
- school age children needing access to a school;
- sick people requiring more ready access to health care services;
- young people seeking employment/entertainment; and
- old people requiring access to support care.

Population projections

Using ABS Census data from 1981 to 1996 we have examined population growth and extrapolated to 2016. (See Chapter 4)

Health Service Zones

These were developed from a consideration of existing administrative regions including THS, ATSIC, and the NLC. The Steering Committee also provided direction on this matter. The Zones are largely consistent with ABS collection districts, and ATSIC Regional boundaries. The exception is that part of the Darwin HSZ is within the Yilli Rreung ATSIC Region and part in the Jabiru Region. Table 2 shows the Health Service Zones used in this plan. Ten HSZs were developed as a way of better focusing on needs. To some extent these are arbitrary but are broadly based on:

- language and cultural affiliations;
- current use of health services;
- knowledge of relationships;
- existing administrative/ governance arrangements (eg Homelands Resource Centre coverage);
- how communities currently relate to each other in regard to accessing general services;
- historical associations; and
- geographic proximity and other logistical considerations.

Table 2: Top End Health Service Zones

1. Tiwi HSZ.
2. Darwin HSZ.
3. Top End West HSZ.
4. West Arnhem HSZ.
5. Maningrida HSZ.
6. North East Arnhem HSZ.
7. South East Arnhem HSZ.
8. Katherine East HSZ.
9. Katherine West HSZ.
10. South East Top End HSZ.

Core Functions of PHC

We have further developed the Core Functions of PHC, including the incorporation of essential components of PHC, as a means of determining what Comprehensive Community Controlled PHC Services include. Potentially this can then be used as a standard from which to measure the adequacy of PHC provision to communities.

Levels of PHC Service Resources

Estimating the level of health service resource that population groups have access to involved collecting health service staffing levels from funding bodies (THS, OATSIH, NTRHWFA) and local health services.

The following decisions were applied to this process:

- The inclusion only of PHC resources that were part of an actual PHC service. Thus we did not include selective PHC programs focusing on narrow areas.
- In Darwin we included a proportion of the THS Community Care Centres staff in our analysis as they do provide some general PHC service to Aboriginal people.
- Our main quantitative analysis used numbers of AHWs, nurses and doctors working in PHC either resident in the community, or regularly visiting. Other PHC staff are documented in this report, but were not part of the analysis from which needs are identified.
- Only health service resources actually present at the time of our investigation were included. Thus we did not include funded positions that had not been operationalised.

Analysis of PHC staff to Population Ratios.

In order to measure access to health services we:

- used a concept of Core Functions of PHC (see Chapter 8).
- developed ideal staff: population ratios for AHWs, nurses and doctors. These were graded according to community size (see below).
- In order to provide comparison between and within HSZs, we ranked the need for each type of health professional, and used a cost factor to combine them (see Chapter 9).
- We have not included RCI or NTRHWFA resources that have been allocated to particular communities unless the resource is actually in place. However, in our commentary Zone by Zone we do point out which communities have been selected for these funds.

Priorities in primary health service development have been determined by examining a number of factors independently of each other. We have ranked each HSZ according to the following staff: population ratios:

- Ratio of AHW: population
- Ratio of Nurse: population
- Ratio of Doctor: population

With these measures the lower 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 HSZ 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 calculated 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 basic staff to populations ratios that we have adopted are in Table 3:

Table 3: Basic Staff: Population Ratios.

AHWs	– 1 for every 50 people.
Nurses	– 1 for every 200 people
Doctors	– 1 for every 400 people.

These ratios were then modified to be more realistic for larger communities. For example, if the 1:50 ratio for AHWs were applied to Darwin, there would need to be 168 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/ homelands will depend on visiting services. Thus smaller staff: population ratios help accommodate some of the time spent travelling.

Thus, we have adopted the scaled ratios as shown in Table 4.

Table 4: Standard of Health Service Staff to Population Ratios Scaled by Community Size.

	Scaled Staff: Population Ratios		
Population Range	AHWs	Nurses	Doctors
> 3,000	1:350	1:500	1:1,000
1,300-2,999	1:250	1:450	1:1,000
800 – 1,299	1:200	1:300	1:800
400 – 799	1:100	1:200	1:600
250 – 399	1:75	1:200	1:400
75 – 249	1:75	1:150	1:400
< 75	1:50	1:150	1:400

We have used these ratios to compare community access to PHC.

This provides a basic and relative assessment of needs between Zones. It is not, on its own, a sufficient assessment. The other factors that need to be taken into account on the ongoing planning of health services are:

- Distance from other significant health services;
- Number of people in population;
- The availability of other health services.

In the ranking of HSZs, there are some anomalies that have had to be taken into account. For example, Danila Dilba in Darwin, and Wurli Wurlinjang in Katherine employ doctors as clinicians rather than nurses. Thus they appear to be terribly under resourced when 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 PHC requires all three. However, we have applied a financial value to these positions according to what they actually cost to employ. These are:

- AHWs - $35,000
- Nurses - $70,000
- Doctors - $120,000

However we have presented the rankings for each category of PHC staff, as well as a combined ranking weighted by the salary costs.

Identifying Gaps in PHC Services

The ranking of staff: population ratios have allowed us to prioritise health service needs for particular population groups. However, it should be kept in mind that this is a very basic assessment of need using quite limited parameters. The results indicate that the level of need is high, and in this context it makes little sense to use this to make marginal decisions. Other issues such as the ability of the community to make quantum leaps forward in terms of health advancement need also to be considered.

We have presented the ranked health service needs of health service Zones and population groups. We have then analysed the situation for each population group considering the major community and the associated population groups (out-stations/ homelands) within each Zone.

To provide a more current priority list, we have presented a list ranked according to the method explained above, but excluding those subject to CCT, RCI fund (first round), communities with population < 100, and those that are relatively not remote.

Community Profiles

We have included, as an appendix, Community Profiles for each community/ out-station/ homeland organised by HSZs. The information in these profiles is inconsistent, 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. We have included in these profiles information, albeit varying in completeness, about issues that impact on the opportunities for developing community control of PHC services. (See Appendix 7)

Other

In collecting data from funding bodies and health services, we have looked at how PHC services are currently delivered and provided some discussion on these various models (see Chapter 7). We have also analysed hospital separation data, and length of hospital stay for various DRGs (see Chapter 7), and have provided some discussion on health financing matters (see Chapter 10).

We have collected some basic information about substance abuse services in the Top End. This includes brief descriptions of organisations operative in this area, as well as specific programs operating in particular communities.

Historically aged care services have been administered separately to PHC services. Thus we have not looked at this area in detail, but have included a list of communities who receive Commonwealth funding for aged care services.

Finally we have provided brief commentaries on significant current issues in Aboriginal health including issues of transport, women's and children's health, men's health, special preventive health programs (environmental health & nutrition), ischaemic heart disease and renal disease. This includes some discussion on the Chronic Disease Strategy.

Methodological Guidelines from TERIHPC

This project was explicitly designed, in line with directions from TERIHPC, to avoid repeating consultations with Aboriginal communities. A number of projects have involved community consultation over the years, and a strong message from many community 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.

We have analysed relevant reports and drawn out of those reports information relevant to this plan. This has then been verified by local informants.

The main message from all previous consultations has been that people want services. It is clear that the primary need is for services that care for the sick and frail. Thus clinical services are of primary concern. Preventive strategies are only likely to be seriously addressed by communities once their sickness needs are being adequately addressed.

However, this does not mean that community leaders do not have a view about the underlying issues and priorities for other types of action to improve health. Support for community action to tackle these identified needs must also be addressed.

In the course of our work we encountered a level of hostility and cynicism from health service staff and community leaders who expressed dismay at yet another consultancy when so little action was evident from previous processes.

CHAPTER 3 - STRATEGIC DIRECTIONS IN NATIONAL/ TERRITORY CONTEXT

Commonwealth Policies[4]

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 community controlled medical services, first in Redfern, NSW, and then in many other parts of the country. The 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 funded after pressure from the Central Australian Aboriginal Congress (Congress) including Urapuntja Health Service (UHS) 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 (PHHS) at Kintore was funded after the collapse of Lyappa Congress. The PHHS was established through the efforts of the National Aboriginal and Islander Health Organisation (NAIHO) and Congress. In the Top End, Kalano in Katherine was established in the mid 1980s. In 1991 the health service separated from the Kalano Housing Association and was constituted as Wurli Wurlinjang Aboriginal Health Service. Danila Dilba health service was established in Darwin in 1991. Miwatj Health Service was established in 1991. This service has operated somewhat differently to other AMSs. Both Danila Dilba and Miwatj were established as part of the NAHS funding program through ATSIC.

Before ATSIC was established, 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 have had some characteristics in common. Firstly, they emphasised the importance of environmental health issues. Secondly, they recognised that 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. The Commonwealth Department of Health (CDH) also tended to this 'expert' view. Thus, there was a persistent fragmentary approach in attempts to address Aboriginal health.

[4] Expanded from Bartlett, B et al *Central Australian Health Planning Study* PlanHealth, 1997.

National Aboriginal Health Strategy

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 Australian Aboriginal Affairs Council (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 NAHS.

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

- Aboriginal community control of PHC services as a guiding principle,
- the establishment of a number of structures for overseeing the strategy, including:
- A National Council of Aboriginal Health at the national level
- A TPF at the State/ Territory level.
- An inter-sectoral approach to housing and infrastructure developments.
- Improved educational opportunities for Aboriginal people.
- Strengthening of the role of Aboriginal Health Workers (AHWs).

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. Cabinet determined how these funds would be allocated and this is represented in Table 5.

Table 5: NAHS Commonwealth Funding 1990-1995[5].

Program	'90-'91 $M	'91-'92 $M	'92-'93 $M	'93-'94 $M	'94-'95 $M	Total $M	Estimated need $M
ATSIC Environmental Health	2.10	18.38	33.57	58.96	61.00	174.01	2,500.0
Aboriginal Health Services	6.74	9.47	10.36	10.80	11.24	48.61	74.3
ATSIC Health Branch	0.17	0.36	0.38	0.4	0.42	1.73	2.4
DCS&H; National Campaign Against Drug Abuse	1.33	1.40	1.47	1.54	1.60	7.34	-
Australian Institute of Health	0.10	0.11	0.11	0.12	0.12	0.56	-
TOTAL	10.44	29.72	45.89	71.82	74.38	232.25	2,576.7

Source: ATSIC.

It was expected that 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 TPFs in each State and Territory. These bodies comprised of representatives of State/ Territory Government, Commonwealth Government and the Aboriginal community.

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[5] ATSIC Information Package, Attachment B '*Proposed NAHS funding to 1994-95.'* Prepared for National Conference Aboriginal Health Services, Melbourne, 12-15 March, 1991.

The Council met officially only twice, and a Review of the Council[6] 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 TPFs 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:

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

Transfer of Funding – ATSIC to Commonwealth Health

The dissatisfaction of Aboriginal health services with the implementation of the NAHS was not confined to the NT. The 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 the CDH.

Aboriginal health services in the NT took this up as a major campaign and lobbied Commonwealth Ministers, Opposition members and health bureaucrats. This campaign included calls for the establishment of a more effective health system around the needs of Aboriginal health[7].

Pressure on the Government to transfer responsibility for funding of Aboriginal health from ATSIC to Commonwealth Health continued from Aboriginal health services, and from some public health bodies, including the Australian Medical Association. Some details are outlined in Chapter 1 *Background to the Plan.* The Office of Aboriginal and Torres Strait Health Services was established in 1994, but without funding responsibilities. 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 CDH. Later Framework Agreements were signed in all jurisdictions.

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6 Codd, M. *'Developing a Partnership: A Review of the Council for Aboriginal Health.'* Canberra, March, 1993.

7 Bartlett, B & Legge, D *'Beyond the Maze: Proposals for More Effective Administration of Aboriginal Health Programs.'* Central Australian Aboriginal Congress, Alice Springs & National Centre for Epidemiology & Population Health, ANU, Canberra, 1994.

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 inter-sectoral collaboration and reporting and monitoring arrangements are also covered in the agreement.

Public Health Partnerships

The other significant policy direction of the Commonwealth Government is the development 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.

However, OATSIH have been active in ensuring that specific funds are quarantined for Aboriginal & Torres Strait Islander health.

Previous arrangements with these vertical programs were 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 have inadequate services to begin with, the parameters that had been developed to drive these vertical programs were quite inappropriate. Further the model of health service delivery in Aboriginal communities provides different opportunities for the implementation of public health programs. Incorporating public health programs into community-based services is implicit in the model of comprehensive community controlled PHC.

Aboriginal and Torres Strait Islander HIV/ AIDS programs are not included in the Public Health Partnerships, but are managed by OATSIH and subject to decisions of the NTAHF. This needs to be developed in other areas as well.

Coordinated Care Trials

In 1994, the Council of Australian Government (COAG) endorsed a proposal to develop a different way of funding health services. Three levels of health service were identified, the third being Coordinated Care. This was to apply to people with chronic and/ or multiple conditions, or the aged with multiple needs. It was perceived that people in this category would do better to be able to access a wider diversity of services and support, than being restricted to accessing doctors who is all Medicare will pay for. Thus the idea was that the National average per capita expenditure of the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) could be 'cashed out', the money held by a fund holder, and released for the benefit of the signed up individual at the direction of a care coordinator.

In the mainstream this is broadly how the scheme, known as the CCTs, works. However, in four Aboriginal communities/ areas the Trials have been applied to provide all PHC services to these population groups. In the NT there are two sites, the Tiwi Islands and Katherine West (see Chapter 7). The other two are in Wilcannia, NSW and the South-West Perth area in WA.

These trials were due to finish in December '99. However, both the NT and Commonwealth Governments are committed to these working, and it is expected that ongoing arrangements will be made. Both National and local evaluations are being conducted. We have not been able to access complete results of the evaluations of the NT trials.

Remote Community Initiatives

In the 1997-98 budget, Minister Wooldridge announced a new funding program to improve Aboriginal people's access to PHC services. This program is known as the RCI. It provides around $220,000 per site (community) for increased health service resources. In the NT there were 12 sites approved in the first round in 1997. These were:

- Top End of NT
  - Marthakal Homelands
  - Robinson River
  - Miniyeri
  - Groote (Umbakumba, Milyakburra, Angurugu)
  - Dagaragu
  - Binjari
- Central Australia
  - Northern Barkly (Nicholson River, Barkly Tablelands)
  - Ikuntji
  - Bonya
  - Yuelamu
  - Alekarenge
  - Tara
  - Titjikala

In 1999, a second round of RCI funds was announced. CARIHPC have recommended that as well as basic need (as expressed in access to PHC services), the capacity for communities to benefit also be considered. Thus the following criteria were developed:

- *Need*: this was assessed using staff: population ratios updated from the Central Australian Health Planning Study, as well as specific criteria developed by the OATSIH relating to remoteness and size of community.
- *Community Capacity*: this was to be assessed using all sources of knowledge, but especially the community sector's knowledge and experience to ensure appropriate and prompt implementation of the initiative including:
  - Community leadership;
  - Community infrastructure;
  - Sustainability.

Primary Health Care Access Program

Since 1997, AMSANT has been concerned about how funds are allocated to Aboriginal health. It has been widely understood that Medicare fails to address Aboriginal health needs because a doctor must be present in order to access the funds. Some work has been done in an attempt to identify what dollars are needed. This has varied from assessing health status of communities to looking at what communities need and costing it. Formulas incorporating increments for disease load and remoteness have been discussed.

In 1998 AMSANT produced a discussion paper[8] on how Aboriginal health might be able to access MBS and PBS funds, without some of the perceived disadvantages of the CCTs.

[8] *Possible funding arrangements for the development of Aboriginal primary health care services.* AMSANT Position Paper, August, 1998.

Perceived disadvantages include:

- a capped funding level at an inadequate level;
- the need to sign up participants;
- the possible cashing out of the 'high tech' end of health care such as hospital services, pathology and diagnostic imaging risking a budgetary blow out.
- The administrative burden of billing back MBS for CCT clients seen elsewhere.

AMSANT has proposed a *cash out* at around 2-4 times the national utilisation rate for MBS and PBS on the basis of increased disease load in Aboriginal communities, but excluding all services not performed in the community (ie hospital care, pathology, and PHC services accessed outside the community). Further, it was recommended that indicative populations (rather than numbers signed up) be used as the basis for the per capita payment. In a later version of this paper[9] the loading for morbidity was revised to 2-3 times after discussions with the Commonwealth and THS.

THS and AMSANT were involved in negotiations in early 1999 to ensure an agreed proposal be presented to the Commonwealth for consideration in the budgetary process. However, it was made clear that many of the details of how the program would be implemented were not agreed at that time. However, this collaboration indicated in principle agreement for how MBS funds could be accessed.

In late 1998, after negotiations with NACCHO, AMSANT, Pharmacy Guild and Commonwealth Health, Minister Wooldridge announced Aboriginal Health Services in remote areas would be able to get PBS drugs free through local pharmacies under the Section 100 arrangements.

In the 1999-00 budget, Minister Wooldridge announced the PHC Access Program for Aboriginal health. This allows for HSZs, or some combination of Zones, to be the basis for an MBS equivalent payment up to 4 times the average National utilisation. This is made up of 2 times MBS for increased disease load and 2 times for remoteness. Central Australia, South Australia and Queensland were identified as areas where the program could be applied as planning process in these areas had been completed. As other areas develop planning processes, then they will become eligible to access this program. Unfortunately, DHAC have informed us that the Cabinet has insisted on both a registration with Medicare, and a sign up by individuals to the local service.

OATSIH is to provide information regarding the effective uptake and utilisation of these funds, and information about more recent planning in other regions to Cabinet for consideration in the 2001-2002 budget process.

Implementation issues are still being worked out.

[9] *Possible funding arrangements for the development of Aboriginal primary health care services.* AMSANT Position Paper, Revised February, 1999.

Northern Territory Policies

The development of health services in the NT has been directed predominantly at securing white settlement in Darwin. Parry[10] quotes Chief Medical Officer Cook from original records as follows[11]:

> *'The 'White Australia' Policy is the keynote of Australian nationalism. Medical opinion is agreed that there is no reason why the white race should not successfully settle tropical Australia, provided protection from endemic tropical disease is assured. The native, after decades of uncontrolled exposure to tropical disease, had become the natural host of endemic disease by which successful white settlement is gravely menaced, and it is manifestly impossible for the hygienist, with any pretence to bona fides, to undertake the safeguarding of the health of the white community and its future unless he has full powers over the native population, not only in regard to treatment for apparent ailment, but also in relation to hygiene, community life, migration and dispersion through the white community.'*

Cook was not only the Chief Medical Officer but also the Protector of Aborigines, and as the above quote illustrates, he saw the two as being intimately related. This quote is important because it illustrates the main focus of early health services and the degree of control over Aboriginal people asserted by the colonial authorities of which health authorities were a part.

During World War 2 the NT was under military control. When civil control was re-established after the War, the CDH insisted that they were only responsible for health services in the main settlements – Darwin, Katherine, Tennant Creek and Alice Springs. Thus services (mainly nursing visits) to Aboriginal people outside these centres were provided inadequately by either missions or the Department of Native Welfare. In the late 1960s-early 1970s some effort was made to better service Aboriginal communities mainly focusing on child health and communicable disease, such as leprosy. In 1973 the CDH took over responsibility for nursing services from the Department of Native Welfare. In this same year the Congress was established (see below).

Self-government of the NT was decreed in 1978, and the CDH was taken over by the NT Government and the THS (then known as NT Department of Health) was established. In 1988 the Department of Health was combined with Community Services to become the Department of Health and Community Services. The Department has varied in its structure from time to time, with varying degrees of power being vested in either regional or central bureaucracies. In early 1992, for example, a review of the Department, known as the CRESAP Review, was conducted. This review abolished the then existing 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 THS and the regional structures were again put in place. Another restructure is currently underway.

Aboriginal health has been an issue for the Department since the late 1970s. AHWs became part of the way PHC services were delivered from that time. There has been some dispute about whether THS or Congress began AHW training first. It is likely that Congress did begin this process first, but in an informal way, whilst THS were the first to formalise an AHW training scheme through the establishment of the Basic Skill Programs and Training Centres in 1977. A formal AHW Policy was adopted in 1978. This development was recognised and advocated for adoption elsewhere by the 1979 House of Representatives Inquiry into Aboriginal Health. AHWs in the NT were recognised as registered health professionals in 1985.
Aboriginal health is a major concern for the Department, and it has significant PHC service delivery responsibilities to Aboriginal communities through Remote Area Services (previously known as Rural Health). A Division of Aboriginal Health was established in 1982. 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[12].

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10 Parry, S *'Disease, Medicine and Settlement: The Role of Health and Medical Services of the Northern Territory 1911-1939.'* PhD Thesis, University of Queensland, 1992. p337

11 AAC, CRS A452/1, Item 52/451 Part 2, Cook to McEwen, 2 September, 1938.

12 Aboriginal Health Development Group *'Report to Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health.'* December, 1989.

THS developed a revamped Aboriginal Health Policy that was endorsed by the NT Government in 1996[13]. This policy endorses the NAHS, promotes community control of health services and recognises PHC 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 inter sectoral action.

THS policy has promoted community control of health services for some years. Attempts at operationalising this policy has been largely through Service Agreements (SA), previously know as Grant-in-Aid, arrangements mainly with Community Councils.

Other relevant policies include the NT Cattle Stations Health Policy[14]. A number of people live on pastoral leases in remote areas of the Territory, 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 as much as it advises that there should be no inquiry by health care providers as to the ethnic origin of patients.

In 1996 THS commissioned the Menzies School of Health Research to conduct a review of their Remote Services in Central Australia. Their Report[15] was released in August 1997 and recommended the development of HSZs similar to those of the Central Australian Health Planning Study.

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13 *'Aboriginal Health Policy'* Territory Health Services, Darwin, 1996.

14 *'Northern Territory Cattle Stations Policy.'* Territory Health Services, undated.

15 Wakerman, J, Bennett, M, Healy, V, Warchivker, I *'Review of Northern Territory Government Remote Health Services in Central Australia.'* Menzies School of Health Research, August, 1997.

CHAPTER 4 - TOP END REGIONS AND DEMOGRAPHICS

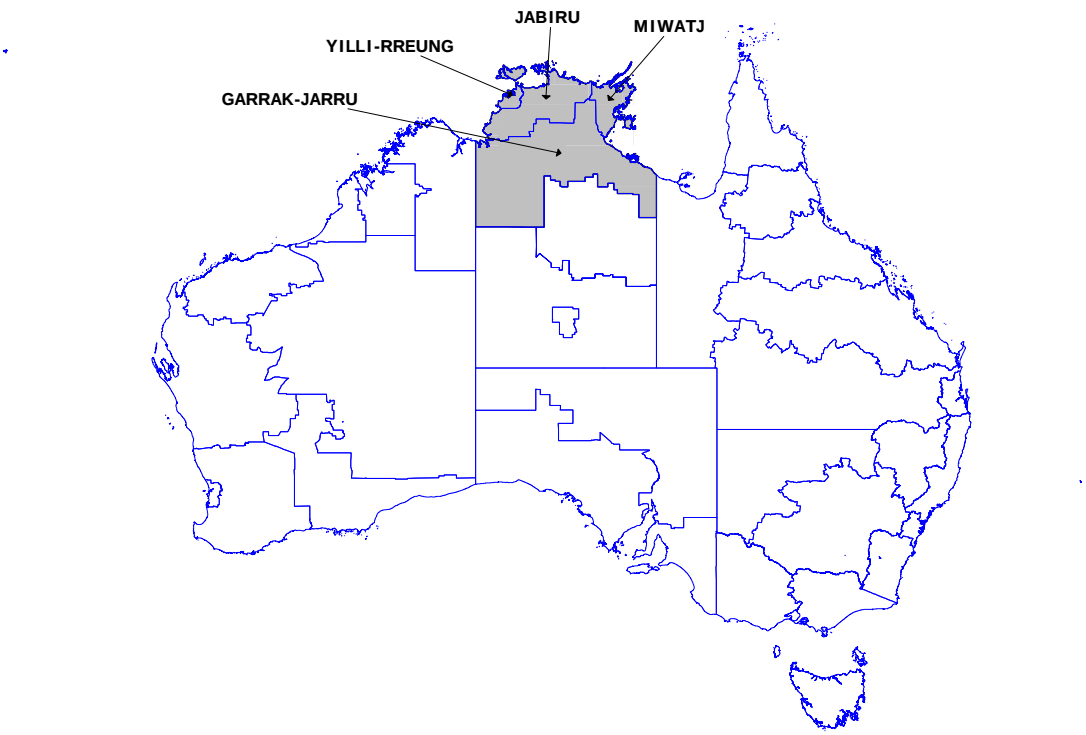
Definition of Regions

There are a number of administrative regions in the Top End of the NT. Those most relevant to this plan are ATSIC, THS and NLC Regions.

ATSIC Regions in the Top End of the NT are:

- Yilli Rreung;
- Jabiru;
- Miwatj;
- Garrak-Jarru

Figure 3: Map of Australia showing the ATSIC Regions of Yilli Rreung, Jabiru, Miwatj and Garrak-Jarru.



The four ATSIC Regions of the Top End and the THS Operations North (OPN) correspond fairly closely with the southern boundary being virtually the same. However, three out-stations of Lajamanu - Ngarnka (Blue Bush), Parrulyu (Mt Davidson), Piccaninny Bore (Talywari, Tjabalajabala, Picininny Bore, or Black Hills) – are part of the Central Australian region of THS as well as being part of the Papunya ATSIC Region. They apparently have not been included in the Katherine West CCT.

Territory Health Service Regions/ Districts

THS organise their operations in the following administrative hierarchy:

Territory Health Service Operations North

THS Districts

- Darwin Urban
- Darwin Rural
- East Arnhem
- Katherine

The Darwin Urban District of THS bears no relationship with the Yilli Rreung ATSIC Region.

Northern Land Council Regional Areas

The Northern Land Council (NLC) organises its administrative operations through a number of Regional Areas. These are:

- Darwin/ Daly/ Wagait with offices in Darwin and Pine Creek;
- West Arnhem with offices in Jabiru and Palmerston;
- East Arnhem with an office in Nhulunbuy;
- Katherine with an office in Katherine;
- Ngukurr with an office in Ngukurr;
- Victoria River with an office in Timber Creek; and
- Borroloola/ Barkly with an office in Borroloola.

The western end of the southern border between the jurisdictions of the NLC and Central Land Council (CLC) divides the Garrak-Jarru ATSIC Region in two, thus communities in the south-western part of this ATSIC region are in the CLC area. The central and eastern part of the southern border divides the Yapakurlangu ATSIC Region in two. Thus the communities in the north eastern part of the Yapakurlangu ATSIC Region are in the NLC area whilst being in the Central Australian THS Region.

Tiwi Land Council represents traditional Aboriginal landowners of the Tiwi Islands and has offices in Nguiu and Darwin.

Anindilyakwa Land Council - represents traditional Aboriginal landowners on Groote Eylandt and Bickerton Island and has an office at Angurugu.

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 of people's health issues such as housing and community infrastructure where there is a different jurisdiction involved.

Population of the Top End of the NT

Population data has been gathered from the following sources:

1. Australian Bureau of Statistics (ABS) – 1981, 1986, 1991 and 1996 Census data. We have analysed these data by age and gender, and have examined population growth in order to show population trends that have implications for health service development.
2. Health Infrastructure Needs Survey (HINS) that was conducted by ATSIC in 1992. This gives some population figures for some out-stations but is now quite out of date.
3. The NT Department of Housing and Local Government (HLG) have provided us with some population data (CIAS[1]) from 1992 through to 1998. However, whilst this information has provided us with some recent data to consider, it is inconsistent as figures are available for some communities in some years, but not others. Thus it has not been useful in determining population projections.
4. THS[2] and other health service providers provided us with population figures for some communities.
5. The ATSIC NAHS NT Health Impact Assessments (Ove Arup) conducted in May '99 includes population estimates for many communities and homelands/ out-stations.
6. Out-station/ Homeland Resource Centres and other previous reports have also provided us with population figures. These include the Bawinanga Aboriginal Corporation, Demed Association Inc Homeland Resource Centre, Djabulukgu Association, Gumatj Association, Jawoyn Association, Jibulwanagu Out-station Resource Centre, Laynhapuy Homeland Resource Centre, Marthakal Homeland Resource Centre, Murin Association, Ngadunggay Homeland Resource Centre, NLC, Numbulwar Homeland Council Association Inc, Peppimenarti Association, Ramingining Homeland Resource Centre, and Yantjarrwu Out-station Resource Centre.
7. Information from the Katherine Language Centre, Aboriginal Resource Development Services (ARDS) and local informants been used to identify language groups as one of the main factors determining a health service delivery framework.
8. Homeland/ out-station population estimates have also come from knowledgeable local community informants.

Analysis of these data has demonstrated that people are living in small groups dispersed across large 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. The mobility of people is important to appreciate. It means that our (like all other) population estimates are inaccurate. 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 the demographics in the Top End.

From an examination of these population 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.

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[1] Community Information Access System database.

[2] THS *Doing it Better in the Bush*, Darwin, Dec '97.

Populations Projections

Methodology
From the ABS census data for collections between 1981 and 1996, the numbers of identifying Indigenous people were extracted for collection districts within the Top End. These collection districts were aggregated into geographical regions and the population data over this fifteen year period was analysed by age group and gender categories.

Whilst some of the collection districts and boundaries have changed over time, analysis at the region level largely eliminates the impact these boundary changes have on the long run aggregated trends in the statistics.

Following initial analysis at the Region level it was decided to amalgamate the Arnhem land zones because the boundaries used in the census have changed significantly over time. This involved amalgamating Maningrida, North East Arnhem, South East Arnhem and West Arnhem Zones.

The average annual percentage change in a particular age/gender population over the period 1981-96 was generally used as the means to estimate the Indigenous population through to the year 2016. The long run average rate of increase was compared with the rate of increase for the most recent period (1991-96) to check that the rate was not significantly different. In the case of the Gulf Region the average rate of increase was adjusted downwards to reflect the trend in the most recent period inter-censal period. The small population numbers in the Nhulunbuy Region generated an unreliable estimate. The average rate of increase for the Nhulunbuy Region was therefore adjusted to reflect the rate of the adjoining larger Regions which were considered more indicative of the true rate of change.

Overview
In the Top End in 1996, 30,904 people identified themselves as Indigenous, this is a 65% increase from 1981 and an average rate of growth of 4.5% a year over this period. Table 6 shows the composition of Regions and the distribution of Indigenous people by Region across the Top End at this time.

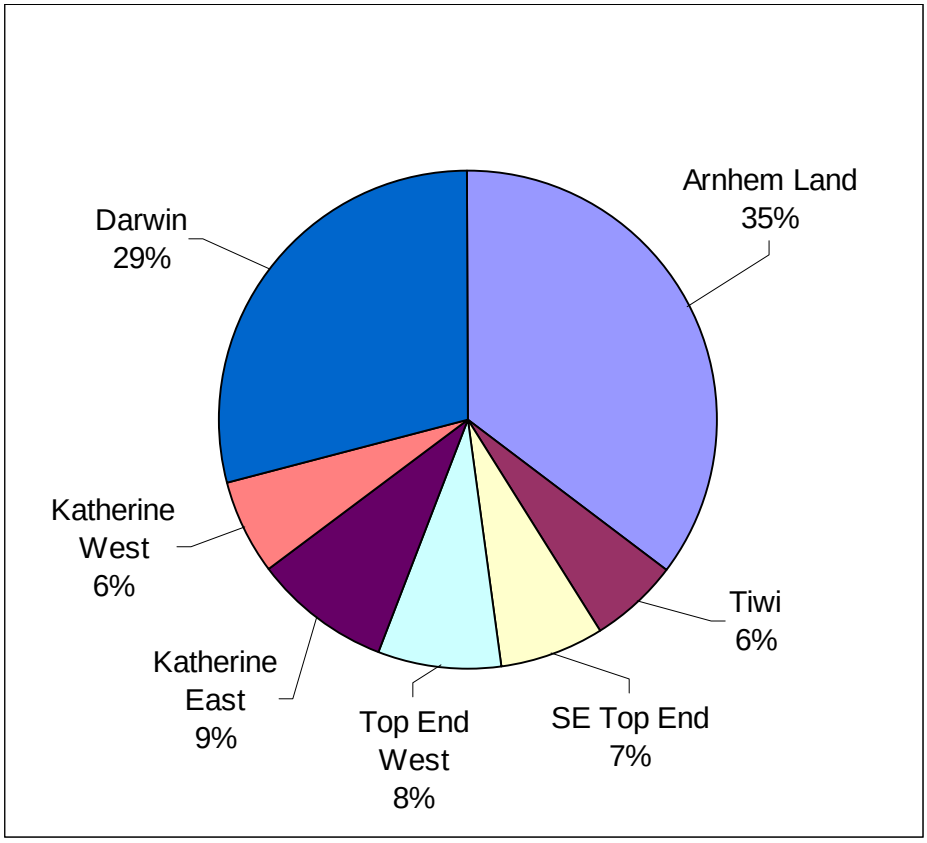
Table 6: Distribution of Indigenous People by Top End Region 1996

Region	Collection Districts	1996	Av. PA Increase.	% Total
East Arnhem	Nhulunbuy, Groote Eylandt	1,502	3	5
West Arnhem	Jabiru, South Alligator, W Arnhem	3,863	4	13
East Arnhem Balance	East Arnhem Balance	5,495	3	18
Arnhem	**Total of three Arnhem Regions**	**10,860**	**3**	**36**
Tiwi	Bathurst, Melville	1,805	1	6
Katherine West	Victoria	1,890	1	6
SE Top End	Gulf	2,133	5*	7
Top End West	Daly	2,471	7	8
Katherine East	Elsey Balance, Katherine	2,707	3	9
Darwin	39 Collection Districts	9,038	7	29
Total	**Top End**	**30,904**	**4.5**	**100**

Source: ABS Census Collections, NT 1981-1996
* Estimate adjusted from long run trend of 11% average per year which was statistically generated by a relatively small 1981 base population. Inter-censal 1991-96 shows a 3% per annum increase.

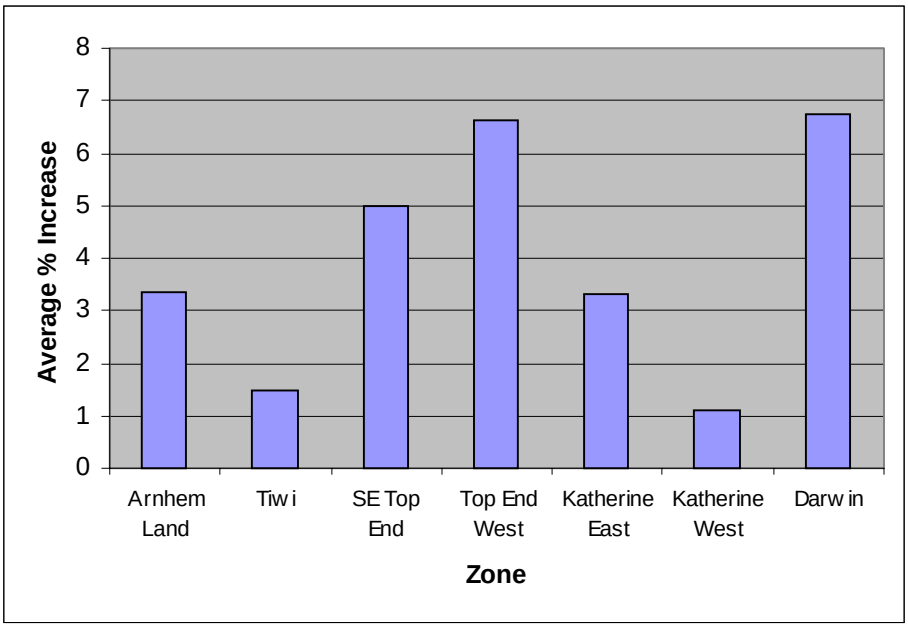
In 1996, 30% of the Top End's Indigenous people were in the Darwin Region for the census taking with a further 36% living in the regions covering Arnhem Land . To the west there were 8% in Daly and to the south, from Katherine to the Gulf a further 22% of Indigenous people. This is represented pictorially at Figure 4.

Figure 4: Distribution of Top End Indigenous Population by Region, 1996.



The average annual rate of increase of the Indigenous population across the Top End has been 4.5% over the fifteen year period, 1981-96. Indigenous populations have been increasing in all regions with the greatest rates of annual increase in Darwin and in Top End West (7%). The South East Top End and Arnhem Regions have been increasing at 3% however Tiwi and the regions around Katherine (Victoria, Katherine & Elsey Balance) have long run annual rates of increase around 1%. (See Figure 5 and Appendix 5, Table 46)

Figure 5: Average Percentage Increase in Indigenous Populations1981-1996 by Health Service Region.



For Indigenous people the rates of population increase between 1991 and 1996 differ across age groups and, to a lesser extent, between the genders. Figure 6 depicts the long run average annual rates of increase by age group and gender for the Top End population. (See Appendix 5, Tables 47 & 48)

Figure 6: Average Percentage Population Increase per annum by Age Group and Gender1981-1996.

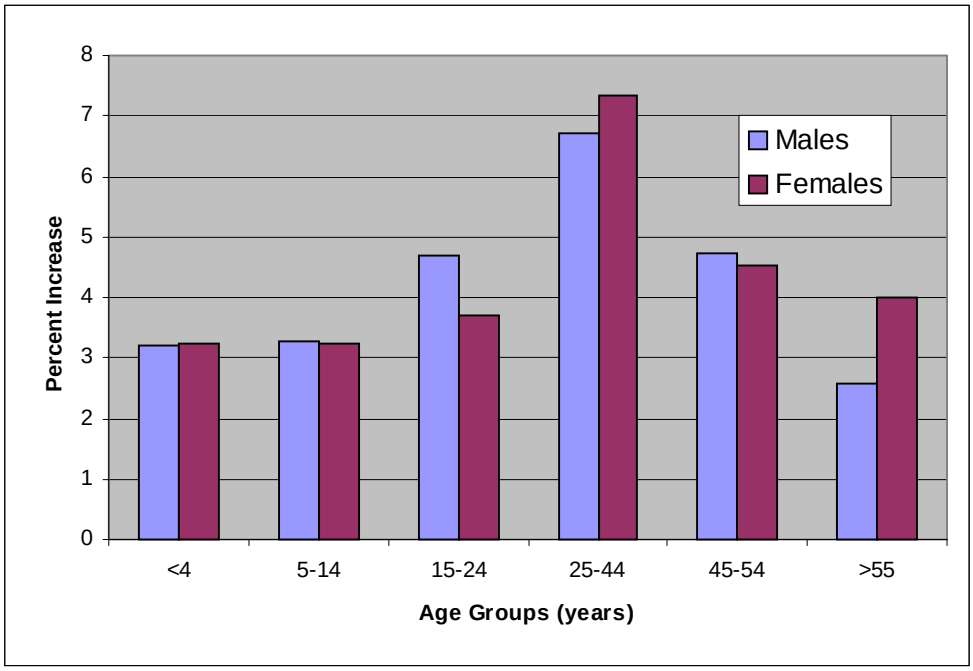


Figure 7: Indigenous Population of Top End by Age Group – Estimates from 1981 – 2016.

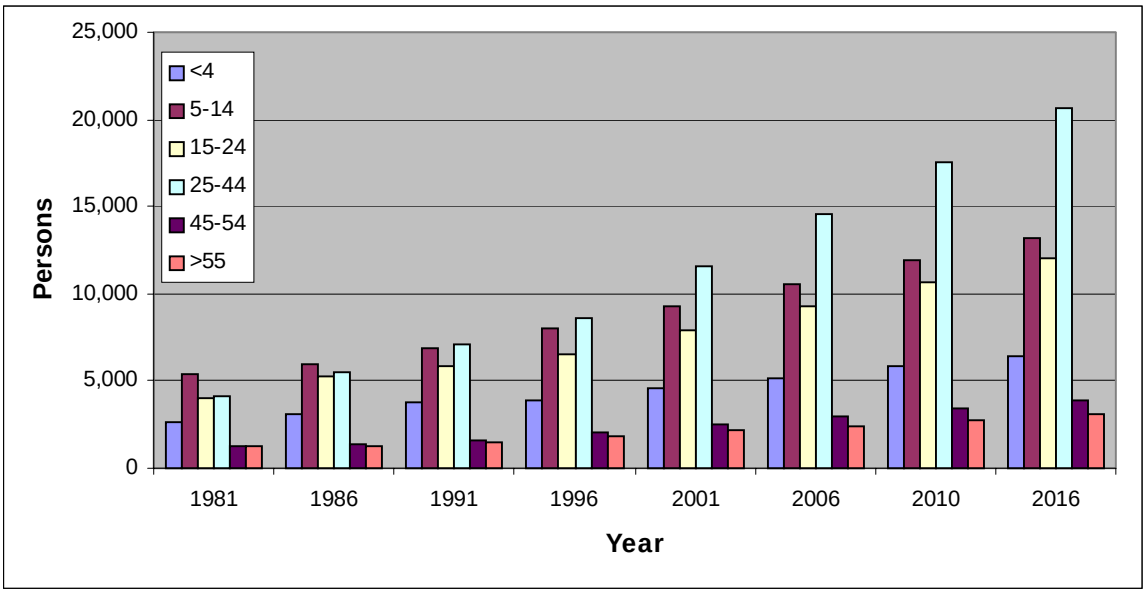
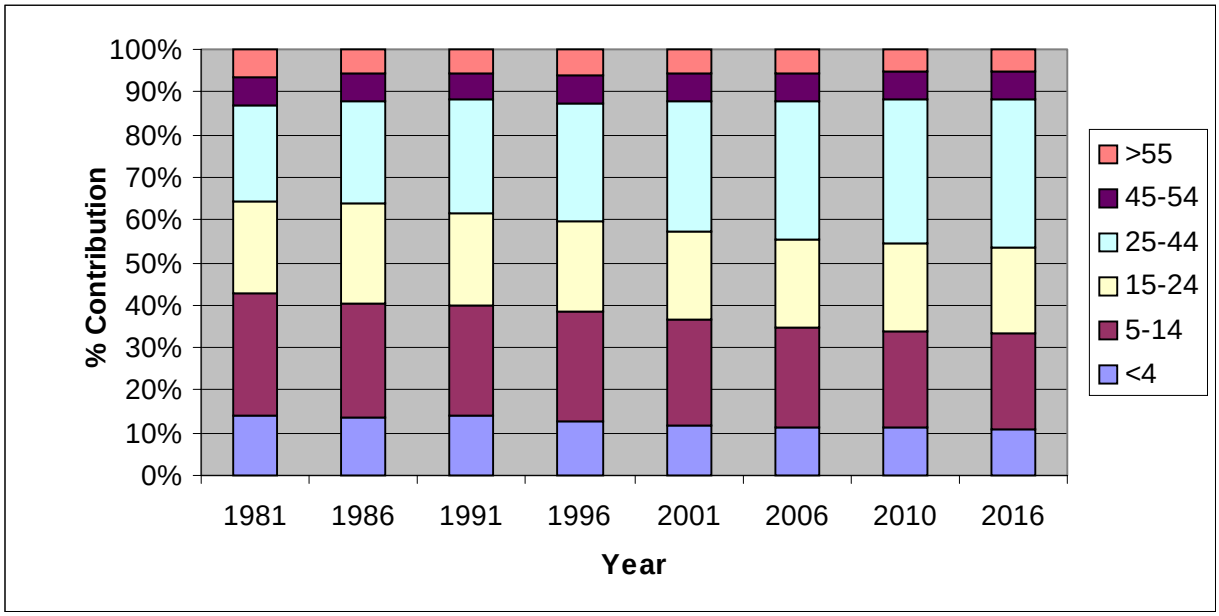


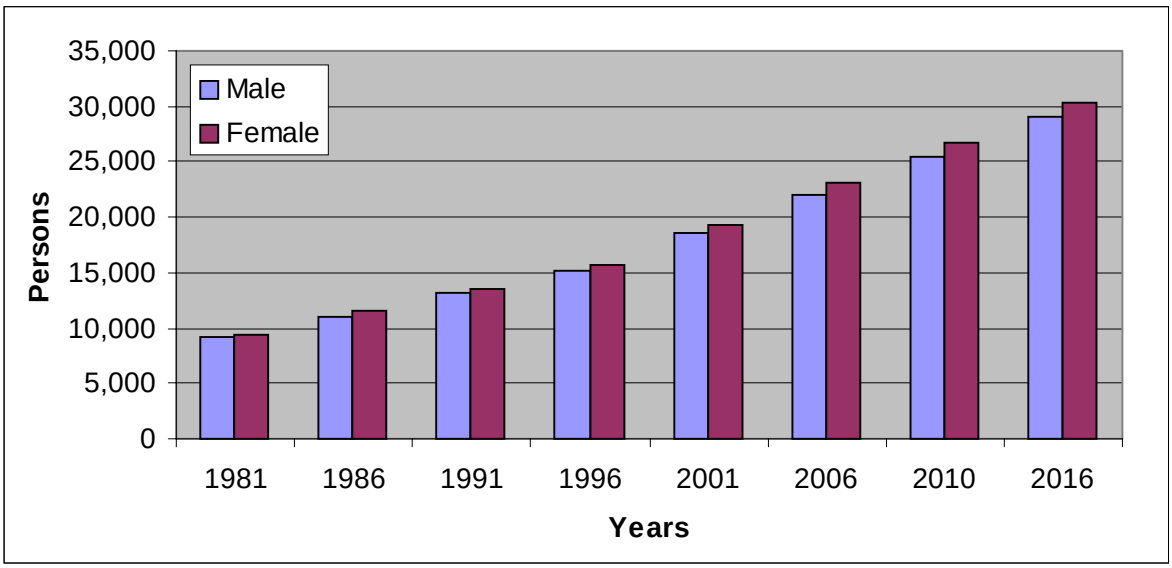
Figure 7 shows the changes in the size of each age group over the 15 year period with these long run trends projected out to the year 2016. Figure 8 depicts this data in a proportional way. Whilst the population is increasing in all age groups, of most immediate note is the significant increase in the number of Indigenous people in the 25 to 44 age group (both males and females) and the decline in infants and children as a proportion of the total population. (See Appendix 5 , Table 49)

Figure 8 Top End Indigenous Population Estimates 1981-2016 showing Percentage Contribution by Age Group.



As a resultant of the differential growth rates, the gender balance is estimated to change very little over the period 1996 to 2016. This can be seen from Figure 9.

Figure 9: Top End Population and Estimates 1981-2016 Showing Gender Distribution.



Language Groups

There are many language and cultural groups in the Top End (see below) 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 are almost certainly getting higher in some areas), those people with literacy have mostly developed it through English rather than their first language.

The distribution of language groups is not necessarily geographically determined. This is due to a number of factors including people's relationship to country[3], 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.

[3] We have often used the term 'country' in this report, as the term 'country' is in very common usage amongst Aboriginal people in the Territory, and has some connotations about relationship that is not quite expressed by the term 'land'. For example, the term country incorporates sea rights as well as land rights.

The other important issue in regard to language is the need for health professionals to be able to access interpreters when interviewing patients/ clients who have poor English as a second, third or fourth language. A recent Inquiry looked into this issue, and the strongly called for interpreters to be made available to Aboriginal people. It is indeed ironic that a full interpreter service is available for non-English speaking migrant groups who may make up only 5% of the NT population whilst Aboriginal languages are ignored. This is another example of the colonial continuities which impact on how health services have been developed in the NT. One of the barriers to addressing this need is that the Commonwealth insists that it is a Territory Government responsibility whilst the NT argue that the Commonwealth should provide the funds. This is a further example of how jurisdictional conflict allows for political argument whilst Aboriginal communities are denied appropriate services.

Top End Languages[4]

The Top End is the home of a great many Aboriginal languages. Some are related to other languages traditionally spoken on the Australian mainland, like the Yolngu languages of the northeast which are related to Pama-Nyungan languages. Others belong to language families confined to the Top End. Yet other Top End languages appear to be language isolates - unrelated to any other language of the region - for instance Tiwi spoken on Bathurst and Melville Islands. Members of a particular language grouping may speak a distinct language or they may speak a distinctive dialect. In the latter case, they will understand the speakers of the other dialects within that language grouping.

When Europeans first attempted to create settlements on the north coast near Darwin in the 1800s, they recorded that Aboriginal people addressed them using a Malay pidgin which had presumably been acquired through their long term contact with Macassans or other seafaring peoples from the archipelago to the north.

European Invasion

The history of the European invasion of the Top End is important to the understanding of the present linguistic situation. In areas where Europeans settled early and in large numbers, such as around the Darwin region and along a corridor extending southwards following the Stuart Highway, traditional languages are no longer spoken.

In the drier open savannah country, cattle stations were set up using the labour of Aboriginal people. Aboriginal station 'employees' had to be able to communicate in English. Where Aboriginal station 'employees' were predominantly from the same language group like Wave Hill Station (Gurindji language group) and Humbert River Station (Ngarinyman language group), it was possible for people to continue speaking their own language in some situations, such as in seasonal nature of the work.
Around the Top End coastline, missions were established and in some instances they forbade the use of traditional languages and in others, Europeans were expected to learn it. At some missions, the so-called 'dormitory system was enforced whereby children were housed separately from their parents. This was particularly disruptive to the transmission of traditional languages.

[4] The following is adapted from pp179-213, *Australian Phrasebook*, Lonely Planet Publications, 1998.

Language Shift

Establishment of large permanent communities this century through missions, reserves or cattle stations and in more recent times Aboriginal communities (small townships) has seen shifts in the traditional use and acquisition of languages. Although in some remote areas linguistic diversity is maintained, in most of the larger communities one language has become the language of common use. This may be a local language, Kriol or a Koine, a new local language resulting from contact of traditional languages. As traditional languages are intrinsic to Aboriginal people's identity - their connection to their country, their ceremonies and songs - there is widespread concern about the maintenance of traditional languages.

In communities where traditional languages continue to be used, some languages are growing in numbers of speakers while others are declining. This is due to language shifts from one traditional language to another, in part because of changing demographic patterns. Formerly, small numbers of people lived in isolated clan groups and this isolation fostered the maintenance of many distinct language varieties. These days, even in relatively isolated areas, people tend to live for at least some of the year at large regional communities populated by members of different language groups. In such multilingual communities there's a trend for one language to emerge as a lingua franca.

At Maningrida where there are members of at least eight different language groups, two of the local languages are gradually emerging as lingua francas: one used by people who affiliate with the 'west side' (Kunwinjku and its eastern dialects); the other used by people who affiliate with the 'east side' (Burarra). Children growing up at Maningrida tend to learn one of these emergent lingua francas because these are the languages which they hear spoken around them most often and which enable them to communicate with the largest number of people.

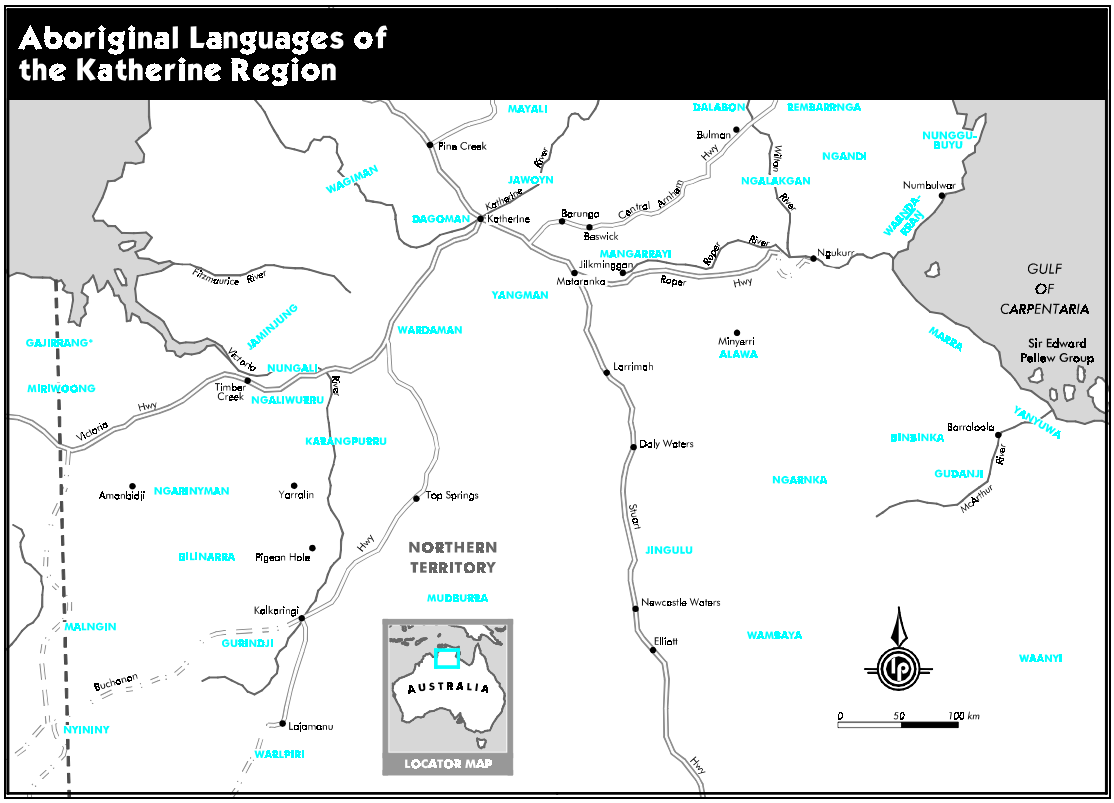
Katherine Region

Of the three Aboriginal languages traditionally spoken in and around Katherine, Dagoman is no longer spoken, Jawoyn is spoken only by some older people, Wardaman is slightly 'stronger' in that it's been transmitted to some younger people who speak or understand it. The Aboriginal language that visitors to Katherine will definitely hear is Kriol. With the exception of Lajamanu in the far south-west, Aboriginal communities have a variety of Kriol as a first or main language.

Lajamanu is now a Warlpiri speaking community because white authorities moved large numbers of Warlpiri people away from their traditional homelands farther south and onto lands traditionally owned by Kartangarrurru and Gurindji people. Kartangarrurru might no longer be spoken, but Gurindji is still spoken in the communities of Kalkaringi and Dagaragu.

At Kalkaringi and Dagaragu Gurindji is still spoken, however the main language of the children and young adults is a variety of Kriol which is influenced by Gurindji. To the east of Gurindji is Mudburra which is spoken across as far as Elliott. To the west are Nyininy and Malngin, language varieties that are closely related to Gurindji.

Figure 10: Aboriginal Languages of the Katherine Region



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Bilinarra country lies to the north of Gurindji speakers around Pigeon Hole and Yarralin communities. However, Ngarinyman is the main traditional language represented at Yarralin and it's spoken over a large area to the north-west as far as Kununurra and northwards to communities around Timber Creek.
Speakers of the following four main language groups have settled in communities in and around Timber Creek: Ngarinyman, Ngaliwurru, Nungali and Jaminjung. Nungali appears to be a threatened language with very few remaining speakers. Jaminjung is spoken to the west as far as Kununurra and to the north in some Daly Region communities. To the west of these languages, two further language groups occupy country in the NT: the Miriwoong and the Gajirrang (also known as Gajirrabeng and Gajirrawoong), although members of these language groups mostly reside in Kununurra and nearby communities in Western Australia.

Directly to the west of Katherine lies the traditional country of the Wardaman people. Most Wardaman people live in and around the town of Katherine. However, the Wardaman Association owns and operates Innesvale Station and there are also a number of small family out-stations on Wardaman country. Wardaman was mutually intelligible with the traditional languages spoken near Katherine (Dagoman) and Mataranka (Yangman).

The eastern side of the Katherine Region extends from the Stuart Highway across to the 'saltwater Country' bordering the Gulf of Carpentaria. The environments pass (south to north) from the 'dry country' north of the Barkly Tableland, through to 'freshwater country' associated with the Roper and Katherine River systems and their tributaries, to he stone country' of the Arnhem Land escarpment.
Borroloola is situated on the traditional Country of the Yanyuwa, although members of surrounding language groups such as Garrwa, Kudanyii and Marra still live in and around Borroloola. An interesting feature of Yanyuwa is that women's speech is structurally different to the variety spoken by men.

To the north of Borroloola on the Roper River is the community of Ngukurr and several smaller communities and out-stations. The linguistic situation here is highly complex. People affiliated with numerous language groups including Ngalakgan, Warndarrang, Yugul, Marra, Ngandi, Alawa, Nunggubuyu, Ritharrrnu and Rembarrnga now reside at Ngukurr. Of these languages, Warndarrang and Yugul are no longer spoken, Ngandi and Ngalakgan have very few remaining speakers and Alawa and Marra are spoken fully only by some older people, while Rembarrnga and Ritharrrnu probably have relatively greater numbers of speakers in more remote communities.
Miniyeri and Jilkminggan, communities further east in the Roper Valley, are on Alawa and Mangarrayi country respectively. Mangarrayi, like Alawa and Marra mentioned above, is only spoken fully by some older people.
Barunga, Beswick and Bulman communities are located in Central Arnhem Land to the north of the Roper Valley on the Central Arnhem Highway. Barunga and Beswick were formerly part of Bamyili, a government reserve. The traditional owners for this country are Jawoyn. However speakers from other language groups including Mayali, Dalabon and Rembarrnga also form a large proportion of the population there. At Bulman the major language groups represented are Dalabon and Rembarrnga which are spoken fully by some older adults, while younger adults tend to be able to understand their traditional languages but don't usually speak them fully.

Kriol

Kriol is a new Aboriginal language that has upwards of 20,000 speakers spoken throughout most of the Katherine Region and the neighbouring Kimberley Region in Western Australia. The name 'Kriol' has been applied to it relatively recently and it has not yet gained widespread currency among all of its speakers.

As the name suggests, Kriol is a Creole language - this means that it's a kind of 'emergency language' which has a specific origin. Kriol first arose early this century when surviving members of many decimated language groups congregated at the Roper River Mission in order to escape the brutal killings being carried out by cattle station companies in the area at that time. Many of the adults who came to the Roper River Mission were multilingual, but they were certainly not multilingual in exactly the same languages. Moreover, children had not yet developed full competence in as many languages as their parents. In this situation, the only form of language available for communication among everybody - including the English-speaking missionaries - was a pidgin that had entered the NT a few decades previously with the cattle trade and had become fairly widespread. Children acquiring language at the mission heard more of this pidgin than of any other language, not least because the missionaries housed them in dormitories away from their elders. The children acquired the pidgin as their first language and in doing so they created a full language which was able to meet all their communicative needs.

Kriol speakers use large numbers of words from their traditional languages especially for domains of traditional knowledge like place names, traditional material culture, names for local flora and fauna and for personal information like Aboriginal personal names, relationship terms and body parts. As Kriol speakers who live in different areas draw on different traditional Aboriginal languages for vocabulary of this nature this gives rise to a great deal of regional variation in Kriol.

Kriol remains primarily a spoken language, used for everyday communication in all-Aboriginal contexts. The popular Aboriginal band, Blekbala Mujik (as well as other bands from the Katherine Region) have used Kriol in their songs. However, it's also used as a language of instruction and in initial literacy work in the bilingual school program at Barunga Community where many Kriol texts for children have been produced. There's also a Kriol Bible translation and a Kriol-English dictionary.

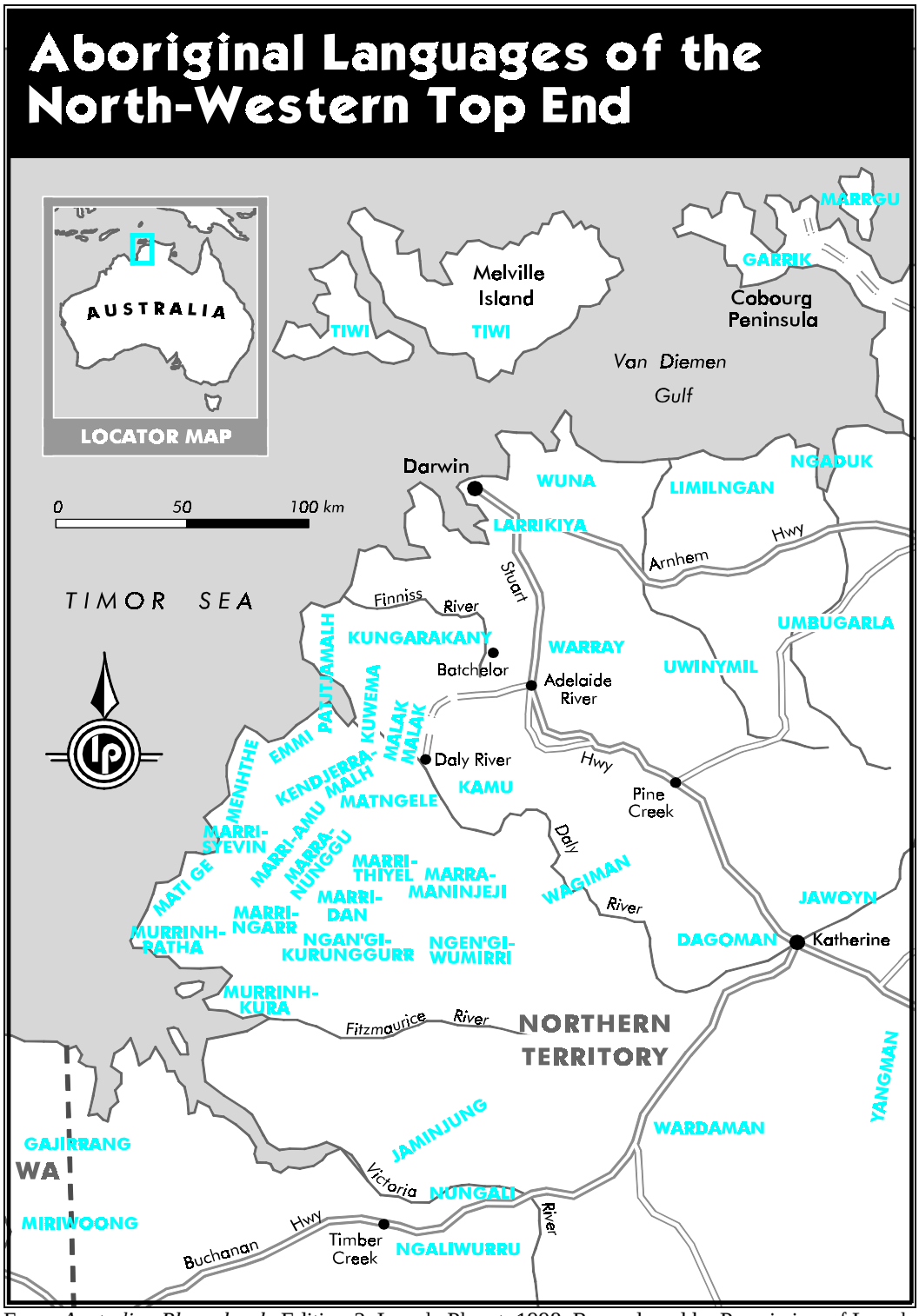
Darwin & The Nearby Coast

Larrakia is the language of the traditional owners of Darwin. Today it's spoken mainly by elderly people. For other languages of the Darwin region, such as Wuna and Limilngan, the situation is the same. Members of the Larrakia community are currently working to record and revive their ancestral language. Larrakia words are used in songs written and performed by the Darwin group, the Mills Sisters.

Tiwi continues to be spoken on Bathurst and Melville Islands immediately to the north of Darwin. Traditional Tiwi is a highly complex language.

Along the coast to the east of Darwin are several different groups of languages. Very little is known about any of the languages spoken between Darwin and Kakadu. Only very old people still speak the languages of Kakadu and the Gurig Peninsula; most younger people now speak Mayali/Kunwinjku. On the islands off the coast, Iwaidja and Maung are spoken. Kunbarlang is a coastal relative of Kunwinjku and was spoken west of the Liverpool River, however most young Barlang people now speak Kunwinjku. There's a small language group comprising distant relatives of the Kunwinjkuan language family spoken in the area around Maningrida in central coastal Arnhem Land between the Liverpool and Blyth Rivers. The languages in this group are Ndjebbana (also called Kunibidji), Nakkara, Burarra, Gun-nartpa and Gurrgoni.

Figure 11: Language Map of North West Top End



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Northern Central Region

Most of the languages spoken in the interior part of the Top End are related to one another as members of the Kunwinjkuan family. Languages in this family include Warray, Jawoyn, Bininj Kunwok (dialects include Mayali, Kunwinjku, Kuninjku, Kune), Kunbarlang, Rembarrnga, Dalabon (also called Dangbon and Ngalkbon), Ngalakgan, Ngandi and Ngunggubuyu. Kunwinjkuan languages are spoken around the Arnhem Land Escarpment.

Warray is spoken by a few elderly people in the Pine Creek area. Jawoyn is spoken by some older people in Katherine, Pine Creek, Barunga and Beswick, around the south-western edge of the escarpment. Bininj Kunwok - literally, 'people's language'- is a series of dialects spoken in a chain around the western and northern rim of the escarpment: these are called Mayali in the west, Kunwinjku in the north-west (Gunbalanya area), Kuninjku in the Liverpool River area and Kune on the eastern rim of the escarpment.

Dalabon, also known as Dangbon and Ngalkbon, and Rembarrnga are traditionally spoken around the eastern edge of the escarpment. Dalabon and Rembarrnga are today spoken on the northern rim of the escarpment at Homeland Centres such as Korlobidahda, Buluh Ka-rduru and Malnjangarnak, and also at communities situated south of the escarpment such as Bulman, Beswick and Barunga. Both the Ngalakgan and Ngandi languages, once spoken to the south-east toward the Roper River region, are today spoken by just a few elderly people.

At Maningrida there are significant cultural differences between Arnhem Landers who affiliate with the 'west side' and those who affiliate with the 'east side'. Burarra people affiliate with the 'east side' and the 'Burarra language has been used in popular music recently recorded by the Maningrida Sunrize Band. A variety of Bininj Kunwok is the language for inhabitants of Maningrida who are affiliated with the 'west side'.

Figure 12: Aboriginal Languages Map of North Central Top End

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The Daly Region

Languages of the Daly region, south-west of Darwin belong to several groups. Murrinh-patha has become one of the more widely spoken languages in the region. At Wadeye members of eight traditional language groups moved in from their traditional countries to live at the mission.

Missionaries encouraged the use of Murrinh-patha, the language of the traditional owners of the country in which the mission was located. A Murrinh-patha bible was produced and linguists and language workers produced a dictionary and other documentary materials. Subsequently the school introduced a bilingual education program in Murrinh-patha. From the 1960s to the 1990s, Murrinh-patha gradually became the standard language of the whole community, arguably partly under the influence of its support by European institutions such as the Church and the school. An unintended side effect of supporting Murrinh-patha has been that few young people now speak any traditional language other than Murrinh-patha fluently and almost no children understand community languages other than Murrinh-patha. This is perceived as a serious issue by the community so the school and the local language centre have recently begun work on documenting the other community languages.

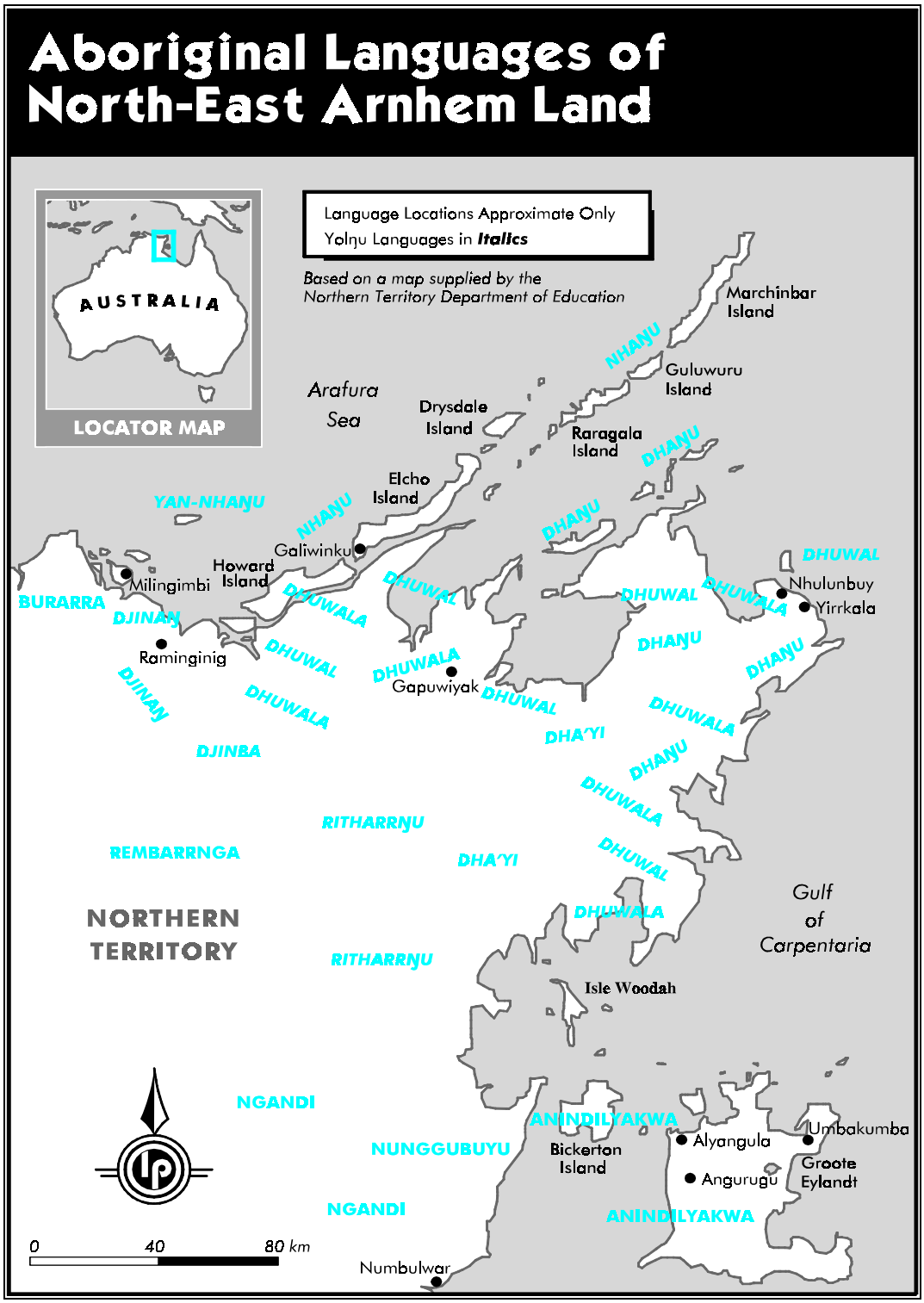
North-East Arnhem

The languages of the north-east corner of Arnhem Land are of the Pama-Nyungan type. They have become commonly known outside the region as the Yolngu (yuulngu) languages. In this area, each clan claims to have a distinct language variety and there are some 50 clans. The relationship of these languages to each other is complex.

The Yolngu languages in this north-east corner are surrounded by the non-Pama-Nyungan type. From the north-west these are Burarra, Rembarrnga, Ngandi, Nunggubuyu on the mainland and Anindilyakwa, the language of Groote Eylandt. In all communities the population is still linguistically diverse. Only one language in the region has no living speakers.

The most widely spoken Yolngu varieties are Djinang round Ramingining; a Dhuwal variety usually referred to as Djambarrpuyngu (but somewhat different to the traditional Djambarrpuyngu) spoken from Milingimbi to Gapuwiyak; Dhuwaya a Koine (a new Yolngu language) that has evolved around Yirrkala. At Numbulwar, Kriol is the first language of most young people but there is a major effort being undertaken in the community to maintain other languages, particularly Nunggubuyu. Anindilyakwa is still the first language of Indigenous people on Groote Eylandt.

Figure 13: Language Map of North East Arnhem Land



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CHAPTER 5 - PROFILE OF THE TOP END OF THE NORTHERN TERRITORY

This section is intended to provide an overview of the social, geographic, economic and political environment within which communities operate and within which health services are to be delivered. It includes some contemporary issues which are considered to have some impact on people's health.

Overview of Northern Territory

The NT is divided into two distinct regions: the Centre encompassing the vast desert lands of the south and the southern end of the pastoral domain; and the Top End, the monsoonal tropical region of the north. With the exception of Darwin and Alice Springs, both regions are sparsely populated with a majority of Aboriginal people. The Top End is covered by the NLC and the Centre by the CLC. These are among the most powerful Aboriginal organisations in Australia as traditional Aboriginal landowners now own almost half of the land mass of the NT. There are seven ATSIC regions in the NT.

Historical

In 1863, the British Colonial Office agreed to the annexation of the NT by the still young, lightly populated and relatively poor colony of South Australia. The South Australians hoped they would be able to develop the NT at little cost. However, by Federation in 1901, the Territory had a huge debt and pastoralism, although well established, was hardly booming. The greatest successes were the establishment of the Overland Telegraph Line in 1870 and the establishment of a permanent settlement on the north coast of Australia.

By the end of the 19th Century, virtually all of the NT was covered in pastoral leases. However, many of these were owned by wealthy land speculators in London and Adelaide who had no intention of trying to force an existence out of the harsh conditions in the NT. As the land was grabbed and the pastoral, timber cutting and mining industries expanded throughout the Territory, the local Aboriginal peoples who had occupied their traditional lands since time immemorial came into often violent contact with the colonisers.

At the turn of the century, contact with non-Aboriginal people was largely with Catholic missionaries, except in the centre where Lutherans were prominent. In 1911administration of the Territory was transferred from South Australia to the Commonwealth.

The 1930s saw the establishment of vast Aboriginal reserves in Arnhem Land and the central desert areas. The rail link from Adelaide to Alice Springs was established in 1939. The 1950s was marked by the accelerated building of roads and airstrips and the development of the mining industry, especially in the uranium-rich north-east. The 1960s saw the advent of equal wages for Aboriginal pastoral workers and the increasing mechanisation of the industry. These saw many Aboriginal people locked-off their traditional lands – many still locked-off to this day.

In the 1970s, Aboriginal people began returning to their traditional clan lands to establish small communities known as out-stations which are now dotted all over the NT despite a severe lack of resources and services[1]. This 'homeland' or 'out-station' movement can be seen as an attempt by Aborigines to moderate the rate of cultural change caused by contact with European ways and commodities and to re-establish a physical, social and spiritual environment in which traditional elements will be once more dominant and the influence of the alien culture made more marginal. The 1970s also saw the passing of the Aboriginal Land Rights (Northern Territory) Act, 1976 (ALRA) under which now almost half of the land mass of the NT has been returned to the original Aboriginal owners of that land.
The NT was granted self-government in 1978 and the conservative Country Liberal Party has governed since that time.

Population & Economy

In seven out of the last ten years, the NT's population has grown at a slower rate than the Australian total. Every year since 1986 there has been a net interstate migration out of the NT. This means that NT population growth has been dependent upon natural increases, which have come increasingly from the Territory's Aboriginal population. The key reason for the migration out of the NT is the lack of economic opportunities due to a narrow and volatile private sector which is heavily reliant on tourism and mining. The mining sector has relatively small multiplier linkages to the rest of the NT economy, and the tourist sector is highly seasonal. Both have expanded in recent years but have not contributed substantially to diversification of the NT economy. So, the NT Government (NTG) continues to push ambitious plans for the Alice/ Darwin railway, despite an inquiry chaired by former New South Wales Premier Neville Wran which concluded there were limited opportunities for Darwin from this project[2].

Overall boom years were 1994 and '95 with real gross Territory product increasing by 7.9 per cent. A significant factor in this boom was the relocation of military personnel to the Top End which is the largest single source of population growth for the Darwin region. In 1996 defence personnel comprised 5.2 per cent of Darwin, 9.3 per cent of Palmerston and 18.5 per cent of Katherine[3].

The NT's size (accounting for over 17 percent of the Australian land mass), the remoteness of many communities and the high proportion of Aboriginal people in its population (over one quarter), means the NT attracts large per capita levels of financial support from the Commonwealth. These funds have underpinned a capacity by the NTG to undertake a substantial level of discretionary expenditure. Commonwealth funding has allowed the NTG to divert considerable resources to community amenities and services for town-based non-Aboriginal populations, whilst at the same time making negligible progress in alleviating the social and economic problems of the majority of the NT's Aboriginal population. This approach includes opposing land claims and 'five-point' community service standards which effectively deny the provision of water and other basic services to small communities[4].

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1 Coombs H.C. *'Decentralisation Trends Among Aboriginal Communities'*, in an address to the 45th ANZAAS Congress, Perth, 1973.
2 Evatt Foundation *The State of Australia*, Southwood Press, 1996.
3 *Ibid.*
4 *Ibid.*

Spending in Aboriginal communities is not a priority of the NTG. Within a budget encompassing $1.9 billion in general government outlays in 1995/96 the NTG specifically chose to spend no money at all on rural and remote Aboriginal housing, except that provided through tied Commonwealth housing grants. At that time an estimated 30 per cent of Aboriginal people were homeless and a further 22 per cent had substandard accommodation. This has led to a number of Aboriginal organisations over recent years to argue for the development of 'regional agreements', new funding arrangements which would effectively by-pass State and Territory Governments in order to make direct allocations to Aboriginal communities on a regional basis[5].

The fiscal irony is that whereas the NT Aboriginal population and dispersed population provides the basis for high per capita general purpose payments, the NTG is not obliged to construct its Budget in accordance with meeting these needs as much of the funding is untied. This has enabled the NT to divert considerable financial resources to projects of dubious social and commercial merit such as the Yulara financing deal, Darwin's Trade Development Zone, and then 1994 State Square (including a huge new Parliament building) that cost $174 million[6].

The NT has only one daily newspaper, the tabloid NT News, owned by Rupert Murdoch. Other media include ABC Radio and Television, SBS Radio and Television, and commercial television networks. There are also a number of commercial and community radio stations and international and interstate newspapers which are flown in daily. In areas outside of Darwin there is access to ABC Radio and TV, Imparja Television and Central Australian Aboriginal Media Association (CAAMA) Radio which emanate from Alice Springs, as well as the Top End Aboriginal Bush Broadcasting Association (TEABBA). TEABBA and CAAMA are networks which broadcast to remote Aboriginal communities.

Aboriginal Land Rights Act

The *ALRA* was passed by the Federal Parliament and came into force on 26 January 1977. Most of the existing Aboriginal reserves became Aboriginal land (including Arnhem Land), with freehold title held by local Aboriginal Land Trusts (ALT) on behalf of all Aborigines with traditional interests in the land. A procedure was also established for the claiming of unalienated Crown land – that is, land which no one else is using or has an interest in – and Aboriginal-owned pastoral leases. Under this legislation the two major Aboriginal land councils were set up – the NLC based in Darwin, and the CLC based in Alice Springs. In later years the Tiwi Land Council based in Nguiu on the Tiwi Islands north of Darwin and the Anindilyakwa Land Council based on Groote Eylandt were established. Permits are required to enter onto Aboriginal land and can be obtained through the land councils. Aboriginal landowners have the power to veto developments on their land under the ALRA[7].

The functioning of the ALRA is largely financed from mining activity on Aboriginal land. Mining royalty equivalents are paid by the Commonwealth Government to the Aboriginal Benefits Reserve (formerly the Aboriginal Benefits Trust Account [ABTA]), which then disperses 40 per cent of these funds to the four land councils, 30 per cent goes back to the communities directly affected by mining usually via 'royalty associations' and the remaining 30 per cent comprises grants to other Aboriginal organisations or individuals in the NT[8].

On 4 June 1997, a 'sunset' clause came into effect for the ALRA. This meant no new land claims could be lodged under this Act. This artificial cut-off date resulted in a rush of last-minute claims by the two major land councils.

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5 Evatt Foundation *Op. Cit.*, 1996.

6 *Ibid.*

7 Northern Land Council *Annual Report 1997-98*. Commonwealth of Australia 1998.

8 Altman, J *Aboriginal Economic Development and Land Rights in the Northern Territory: Past Performance, Current Issues and Strategic Options*, Land Rights: Past Present and Future Conference Papers, Northern and Central Land Councils, Canberra, 1996.

In 1997 John Reeves QC conducted a review of the Act and has recommended abolishing the major land councils in favour of a new model controlled by the NT Government. This has been vehemently opposed by all land councils and prominent Australians including former Prime Minister Malcolm Fraser, whose government introduced the legislation. A House of Representatives committee examining the Reeves Review recently found that the main recommendations of the Reeves Review should not be implemented[9].

Native Title Act

The Keating Labour government introduced the *Native Title Act, 1993* in response to the High Court's 1992 Mabo decision. In this case, the High Court found that native title continued to exist in Australia after annexation by the British. This started a new era for land rights in Australia. The Act aimed to protect native title rights and to create processes which would give some certainty for developers and other land interests.
The Native Title Act was the result of a historic compromise by Indigenous Australia which saw the validation of exclusive land tenures (eg: freehold title) issued since colonisation in exchange for the right to negotiate over developments on native title lands. The form of tenure offered under the Act is not as strong as that under the Aboriginal Land Rights Act but it enabled Aboriginal people to become stakeholders in development[10].

In 1996 the High Court found in the Wik decision that native title rights could coexist with other land interests on pastoral leases – this issue, and the issue of native title sea rights, had been left unresolved by the Mabo decision and Native Title Act. In response to the Wik decision, the conservative Howard government set about attacking the basic principles of the Act by putting up the Ten Point Plan which would erode Indigenous native title rights. This set in motion one of the biggest debates on 'race' this country has seen since the 1967 Referendum. The Prime Minister also threatened to call a Federal election on the issue if his amendments were not passed by the Senate[11].

In 1998 the Federal Parliament passed the Native Title Amendment Act which effectively extinguished native title rights over vast areas of Australia. Native title applicants now have to pass a stringent test to have their applications accepted and successful applicants have lost the statutory right to negotiate over pastoral leases (which cover 40 per cent of the Australian land mass), vacant Crown land in towns and cities, national parks and waterways[12].

Several cases before the Federal Court have now asserted greater rights to native title holders than allowed under the amended Act and these are now going through appeals which are expected to end up in the High Court. Therefore, the 'certainty' the Howard Government argued it was trying to achieve with its amendments has not been achieved[13].

Community Living Areas

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9 Land Rights News, Vol 2 No 44, Feb 1998; Vol 2, No 45, May 1998; Vol 2, No 43, September 1997; Vol 2, No 47, December 1998.

10 Yunupingu, G. (Ed.) '*From the Bark Petition to Native Title*'; Our Land is Our Life, University of Queensland Press, 1996.

11 *Ibid.*

12 *Ibid.*

13 Levy, R. *Native Title – A Catalyst for Sea Change*. Land Rights: Past Present and Future Conference Papers, Northern and Central Land Councils, Canberra, 1996.

Community Living Areas are small parcels of land excised from pastoral leases to give a form of title to traditional landowners whose lands are now occupied by pastoral leases. These people have been unable to claim these leases under the ALRA unless the leases are Aboriginal-owned and their native title rights were severely eroded by the Howard Government's 1998 changes[14].

Since the introduction of the Community Living Area (CLA) legislation in March 1990, very few CLAs have been granted. The poor results continue to demonstrate the failure of the NTGs legislation to address the needs of dispossessed Aboriginal people in the pastoral regions.

Aboriginal people are often only eligible to apply for a CLA if they have been residing or working on the pastoral lease in question. Given that almost all Aboriginal people were removed from pastoral leases with the introduction of equal wages in 1968, it is very difficult for anybody under 40 years of age to prove historical and residential association with a station[15].

CLAs are highly dynamic environments in which populations fluctuate quite radically within a very short time. Some CLAs can be vacated for a period when a resident or important landowner dies. Others experience substantial increases in population over time with births, the completion of periods of mourning and immigration (for various reasons) from other areas.

Furthermore, unless Aboriginal people on pastoral leases can secure CLAs, funding agencies such as ATSIC are reluctant to fund infrastructure developments because of the insecurity of title[16].

Constitutional Change

The NT Government has, for many years, sought to elevate the status of the NT to that of a State. The Legislative Assembly has a Legal & Constitutional Affairs Committee which has sought the views of the community on how this should be done. A draft Constitution was prepared and public comment sought, but it was rejected by Aboriginal people in the NT.

In January 1998 the NT Government held a Constitutional Convention in Darwin and hand-picked delegates to attend. This caused a public outcry about the process being undemocratic and saw the birth of the group *Territorians for Democratic Statehood.* Some Aboriginal representatives also attended the Convention. However, the two major land councils boycotted it, because they saw the Convention as being not truly representative of Aboriginal people in the NT and because the Draft Constitution did not recognise prior Aboriginal ownership of land, failed to recognise existing native title rights, and failed to adequately protect peoples' rights under the Land Rights Act[17].

The NTG then held a referendum on whether it should become a state and adopt the Draft constitution. Despite strong support for statehood across the NT, the referendum was defeated with large 'No' votes by Aboriginal people in remote areas.

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14 Smith, D. (Ed.) *Aboriginal Autonomy* University of Cambridge Press, 1994.

15 *Ibid.*

16 *Ibid.*

17 Land Rights News, Vol 2 No 44, Feb 1998; Vol 2, No 45, May 1998; Vol 2, No 43, September 1997; Vol 2, No 47, December 1998.

In response the land councils held their own Indigenous Constitutional Conventions. They demanded the NT and Federal Governments guarantee to commit themselves to three principles in the development of a Territory Constitution. They are: statehood will not be granted to the NT without the informed consent of Aboriginal people; any NT Constitution must recognise Aboriginal law as a source of law; and the NT and Federal Governments must recognise the Convention as a truly representative voice of the Aboriginal people of the NT[18].

The Legal and Constitutional Affairs Committee has had another round of consultations and the NT government is now embarking on another statehood educational campaign based on these consultations.

Mandatory Sentencing[19]

The NT Juvenile Justice Amendment Act (No2), 1997, requires a magistrate or judge to impose a period of at least 28 days detention on a juvenile (defined as a person between 15 and 17 years of age) who has been convicted of certain property offences and has at least one prior conviction for a property offence committed after 8 March 1997.

At the same time amendments to the NT Sentencing Act (1995) introduced mandatory imprisonment for adults convicted of certain property offences. The legislation provided for 14 days imprisonment for first offenders, 90 days for second offenders and one year for third offenders.

These offences include stealing (other than from a shop), criminal damage, receiving stolen property, unlawful entry of a building, unlawful use of a motor vehicle (including being a passenger), robbery, and assault with intent to steal. The sentences are cumulative. White collar crime such as fraud and embezzlement is not subject to mandatory sentencing.
The laws were introduced in response to alleged community concern about rising crime and in response to a perception that 'soft, cuddly, pussy-cat magistrates and judges' were to blame for high rates of property crime. Underlying the changes was the idea that increasing penalties would ultimately deter criminals from offending. However, the statistics show that reports of home burglaries are on the increase in the Territory, and there has been no real change in the number of offenders charged with property offences.

Most people currently in prison for property offending are Aboriginal people. The majority come from remote communities. Aboriginal legal aid services report that clients from remote communities have rarely heard about mandatory imprisonment laws. Nor do they understand the concept of 'three strikes'.

The situation is aggravated by poor English, the absence of readily available qualified Aboriginal language interpreters and the fact that many Aboriginal people have already been before the courts on more than one occasion. This means that an individual's first strike may in fact be their third or fourth appearance before a court. At this stage, no research has been conducted into the understanding of people in remote communities about mandatory imprisonment laws.

There has been national and international condemnation of the NT mandatory sentencing regime. The Senate Legal and Constitutional References Committee is about to conduct an Inquiry into the Human Rights (Mandatory Sentencing of Juvenile Offenders) Bill and is due to report its findings to the Senate in March 2000.

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[18] Land Rights News *Op. Cit.,* 1997-'98.

[19] Cuneen, C *ATSIC Submission*, Institute of Criminology, University of Sydney Law Faculty, in consultation with Aboriginal and Torres Strait Islander Services in Western Australia and the Northern Territory, 1999.

Railway

The proposed Alice Springs to Darwin railway is expected to be 1,410 kms long, cost over one billion dollars to build, and will take up to four years to construct. The rail corridor will pass over the lands of many different groups of traditional Aboriginal owners and many different land tenures.

In 1997 the NTG called for expressions of interest for the construction and operation of the project. In 1998 it issued notices for compulsory acquisition of the land needed for the rail corridor. This allowed the land councils to lodge a native title application over the corridor and give legal form to the negotiation required under the Native Title Act 1993.

The Land Councils and the NTG signed a Framework Agreement that set out the offer the NTG was prepared to make for the land. It also set out the land councils' responsibility to consult with traditional owners and native title applicants to ascertain their instructions regarding tenure.

Traditional Aboriginal owners have generally been supportive of the railway project but have sought further information regarding the impact of the railway, assurances in regard to sacred sites, and the economic opportunities from the project.

Administrative Regions

An important consideration in service planning and delivery is that Commonwealth, Territory and local government administrative regions sometimes randomly cut across and artificially divide up Aboriginal people from the same linguistic and cultural groupings. For example, the Miriuwong-Gadjerrrong peoples lands are divided by the NT/Western Australian border.

In administrative terms the Yapakurlangu ATSIC 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.

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 UHS operating from the Angarapa ALT (formerly Utopia Pastoral Lease) in the adjoining Papunya ATSIC region.

Yilli Rreung (Darwin) ATSIC Region

Overview

The Yilli Rreung ATSIC Region covers an area of some 10,620 square kilometres, including the greater Darwin and Palmerston urban areas. It also covers the rural areas of Gunn Point and Howard Springs in the east, south to Adelaide River, west to Batchelor, Litchfield National Park, Wagait and the Finnis River and to the west coast to the mouth of the Daly River. The main language/cultural groups in the region include the Larrakia who are traditional owners of the Darwin region. Tracking south west of Darwin there are the Wadjigan, Wagiman, Kungarakany and Warai centring around Adelaide River, and the Maranungu and Marithel. The Stuart Highway runs north to south from Darwin through Acacia and Adelaide River to Katherine and beyond[20].

Darwin and Palmerston

Darwin is a modern tropical city set on a harbour twice the size of Sydney and boasts 75 nationalities among its population of 80,000. There is a significant Chinese Australian and Greek community. It is referred to as Australia's Gateway to Asia, and is also known as a 'heavy drinking city'. It houses the seat of government in a $174 million State Square that includes the Legislative Assembly of 25 members. The Commonwealth and NT Public Services are the main employers in Darwin, and there appears to be a booming small business sector. There are a number of foreign consulates based here from France, Germany, Indonesia, Japan, Portugal and Sweden. There is also a significant East Timorese community. The Darwin City Council governs Darwin[21].

There are a number of Aboriginal organisations in the area including Danila Dilba Aboriginal Medical Service, the NLC, the North Australian Aboriginal Legal Aid Service, Arnhem Land Progress Association (ALPA), Karu Aboriginal Childcare Agency and a number of Aboriginal hostels. There is a perception and cynicism throughout the NT that government services and expenditure ends at the Berrimah line (an imaginary border just south of Darwin). There is an international airport and Darwin is linked by air north towards Asia and to southern states by air and the Stuart Highway.

The average annual rainfall in Darwin is 1,694mm during the Wet Season from October to April when temperatures range from 25 degrees Celsius to 35 degrees Celsius, and the humidity levels rise from 25% in the Dry Season to 100% in the Wet. The rest of the year is the Dry Season with temperatures ranging between 19 degrees Celsius to 32 degrees Celsius[22].

In and around Darwin and Palmerston the Larrakia have felt the full brunt of European colonisation with the establishment and growth of a small capital city on their traditional lands. But they have continued to protest, lobby and negotiate to regain ownership and control of their traditional country. For example, in 1971 the Larrakia conducted a 'sit-in' on Bagot Road, one of Darwin's major arterial roads, as a protest at the theft of their land[23]. The Larrakia are currently engaged in a major revitalisation of their culture. They have formed the Larrakia Nation, comprising representatives of the main Larrakia families, and recently began operating their own community radio station. They are gaining increasing recognition as the traditional owners of the Darwin area.

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[20] ATSIC *Yilli Rreung Regional Plan*, June 1996.

[21] *ATSIC News*, September 1999.

[22] Finlay, H. Lonely Planet Australia Guide: Northern Territory, 1996.

[23] *The Little Red, Yellow & Black Book*, Australian Institute for Aboriginal and Torres Strait Islander Studies, 1994.

Because Darwin houses the major government agencies and peak Aboriginal organisations, Aboriginal people from across the Top End visit for extended periods, or have settled here. This has contributed to a mixture of words from various language groups being spoken by Darwin's Aboriginal population eg: Gurindji, Tiwi, Yolngu-matha, Kungarakany, as well as local idioms.
Darwin's satellite city of Palmerston is the fastest growing area in Australia, with more and more land being earmarked for residential development. Much of the land in the greater Darwin area is covered by rural blocks and used for agricultural purposes. There are also major defence and communications facilities in the Yilli Rreung Region, some mining operations and many tourism operations including Litchfield National Park south west of Darwin, nature reserves, camping grounds, recreational fishing areas, wildlife parks and artificial lakes[24].

This Region is serviced by a greater number of sealed roads than other regions because of the proximity of centres such as Darwin, Palmerston, Humpty Doo, Batchelor and tourist attractions like Litchfield National Park. However, there are still many dirt roads some of which are inaccessible in the Wet season[25].

Historical

Darwin's Larrakia people have a long history of contact with the people of the Tiwi Islands, some 80kms to the north. Some areas of Darwin were used as Tiwi burial grounds. Signs of the regular visits by Macassan traders and trepang (sea slug) harvesters can be found from eastern Arnhem Land as far west as Darwin. They came from what is now known as Sulawesi in Indonesia between the 1600s and the early 1900s, when the Australian government outlawed their harvesting activities. Unlike the Europeans who followed, the Macassans had largely peaceful contact with the local Aboriginal people[26].

Recorded European exploration of the region began as early as 1644, with Abel Tasman sailing south from the Tiwi Islands and along the western coast of the Yilli Rreung Region to the coast of the Daly region. Philip King charted much of the coast of the region in four voyages between 1817 & 1821. Frederick Litchfield traversed a large part of the area to the east and south of Darwin in 1865.

The first attempt at establishing a settlement in the region was at the mouth of the Adelaide River in 1864. However, the area was unsuitable with waters difficult to navigate and the hinterland becoming bogged in the Wet season. In 1869, South Australian Surveyor General George Goyder established the settlement of Palmerston that officially became Darwin in 1911. The discovery of pearl shell in the 1880s led to the development of a small pearling industry that lasted for 70 years. By the 1900s, there were 50 luggers operating out of Darwin port. Darwin has been levelled by a number of cyclones and was bombed by the Japanese in WWII. It was the war that put Darwin on the map, becoming the focus of military activity in Australia and the navy's northern refuelling base[27].

Darwin was also the site for a number of institutions that housed Aboriginal children taken from their families in other parts of the NT under the 1918 NT Aboriginals Ordinance and subsequent ordinances. These Aboriginal children are now adults who form the Stolen Generations. There are few Aboriginal families not affected by these assimilationist policies. There was the Kahlin Compound on the then outskirts of Darwin but which eventually became the site for the former Darwin Hospital, and is now being redeveloped. This site overlooks the current marina of Cullen Bay. The Retta Dixon institution was situated north of the city towards what is now known as the northern suburbs and Nightcliff. Children were placed in these institutions from as far away as Alice Springs and Borroloola in the Gulf country, and many never saw their parents again.

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[24] NT Government Website: www .nt.gov.au/
[25] Finlay, H. *Op. cit*, 1996.
[26] *Ibid.*
[27] Finlay, H. *Op. cit*, 1996.

Consequently the Stolen Generations have become the dispossessed and displaced Aboriginal people who are struggling to find out where they came from. They are also challenging the Commonwealth government and seeking compensation for damages relating to their institutionalisation as children[28]. The Stolen Generations make up a large part of Darwin's Aboriginal population, and married into the surrounding local Aboriginal language groups. Bagot Reserve in the centre of Darwin is an Aboriginal reserve originally established to house so-called 'full blood' Aborigines from the Darwin environs and elsewhere. It is now called the Bagot community and continues to house Aboriginal people from across the Top End – especially people visiting Darwin for social or business reasons. It has its own health clinic.

Aboriginal Population

The Aboriginal population of the region in 1994 was estimated to be 8,140, with about 75 per cent of these concentrated in the Darwin and Palmerston urban areas. These numbers increase at certain times of year, including the Wet season and major sporting events. The population is a very young one, with some 60 per cent aged 24 years and younger. This youthful population trend is likely to be maintained in the short-term[29].

There are Aboriginal housing developments in the Darwin city area including suburban Minmarama Park, Railway Dam near the central business district, Bagot community, and Kulaluk community. Indigenous communities are also found in 'town camps' like 15 Mile near Howard Springs, moderate size communities like Belyuen on the Cox Peninsula and unhoused areas like Fish Camp behind Minmarama Park and Lee Point on the outskirts of Darwin. Indigenous people are also scattered throughout the rural blocks in the greater Darwin area. There are also some out-stations in the Yilli Rreung Region[30].

The community of Batchelor, south west of Darwin was the former workers' dormitory town for the Rum Jungle Uranium Mine which has long-ceased production. The town is now host to the former Batchelor College that, in 1999, became the independent *Batchelor Institute of Indigenous Tertiary Education*. The Institute has campuses in Batchelor and Alice Springs, and annexes in Darwin, Katherine, Tennant Creek and Nhulunbuy as well as 43 study centres. It offers a wide range of courses to Aboriginal people including the Certificate of Health Sciences for AHWs[31].

According to an ABS survey in 1994, 24 per cent of people aged 15 years and over, were involved in voluntary community work, for example, hunting, fishing or gathering bush food or working on communities. Of people who were unemployed, 22 per cent were unemployed for 12 months or longer. Of people aged 15 years and over, 62 per cent received government payments as their main source of income while 28 per cent received wages and salaries. The average gross income for people in this Region was $264 per week. 69 per cent of dwellings were rented. Of these, 42 per cent of dwellings were rented from the NT Department of Lands, HLG and 20 per cent from private landlords. For people aged 13 years and over, 76 per cent identified with a clan, tribal or language group, 83 per cent said that they recognised a homeland and 95 per cent believed the role of elders is important[32].

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28 *ATSIC News*, September 1999.

29 National Aboriginal and Torres Strait Islander Survey, Australian Bureau of Statistics, 1994.

30 ATSIC *Yilli Rreung Regional Plan*, June 1996.

31 *ATSIC News*, September 1999.

32 National Aboriginal and Torres Strait Islander Survey, Australian Bureau of Statistics, 1994.

Services

As Darwin is the capital of the NT and where most government agencies are headquartered, many Indigenous organisations have located their sole or main base in Darwin. A number of these are Territory-wide or multi-regional organisations. The capital-city location means large visitor numbers place great pressure on service and accommodation providers and support agencies. ATSIC's Yilli Rreung Council has consulted more than 30 Indigenous organisations in the Darwin area and all reported difficulty in meeting demand for their services. The Council notes that one problem is funding agencies often take into account criteria such as remoteness and population base, but ignore visitor numbers. Significantly, the Council reports that the majority of organisations expressed a need to know more about other services for the purpose of more effective service coordination and referral[33].

There is a great demand for health services in Darwin from across the Top End of the NT, with a preference for Indigenous controlled health services over government-provided services. For example, the Danila Dilba Biluru Butji Binnilutlum Aboriginal Medical Service has some 12,000 individual patient files – a figure which is about 50 per cent more than the total number of Indigenous people living in the Yilli Rreung Region. Danila Dilba was established in 1990. More details about this service can be found in the Darwin HSZ section of this report[34].

Based on consultations with communities in the region, The Yilli Rreung Regional Council has identified the following priority issues[35]:

- economic development
- employment
- environmental health
- health services
- community administration
- gender issues

Land[36]

The Yilli Rreung Region lies within the Darwin/ Daly/ Wagait region of the NLC. The NLC's head office is in Darwin and its Darwin-Daly Regional Office is in the satellite city of Palmerston, south of Darwin. In the southwest there are some areas of Aboriginal-owned land in the region including the Delissaville-Wagait-Larrakia ALT, the Upper Daly Land Trust, the Finnis River Land Trust, the Malak Malak Land Trust and the Gurudju Land Trust. To the southeast lies the Limilngan-Wulna (Land Holding) Aboriginal Corporation that takes in Cape Hotham, Tree Point, and the Djukbinj National Park in the east and15-Mile Dam south of Darwin on the road to Humpty Doo. However, the Limilngan-Wulna land is held under NT freehold via a special purpose lease and its tenure isn't as strong as Aboriginal freehold land in the west and any native title rights have been extinguished.

Much of the land remains alienated from its traditional owners covered by urban areas and rural lease-holdings. There are a number of outstanding land claims under the *ALRA* including the Kenbi claim on the Cox Peninsula which is the longest-running claim under the Act – it was first lodged in 1978 and the Larrakia are still waiting for title to that part of their traditional country. The Larrakia have also initiated an application for determination of native title over many areas of land in the greater Darwin region.

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33 ATSIC *Yilli Rreung Regional Plan*, June 1996.
34 Danila Dilba, *Annual Report* 1999.
35 ATSIC *Yilli Rreung Regional Plan*, June 1996.
36 Northern Land Council *Annual Report 1997-98*. Commonwealth of Australia, 1998.

The NLC has signed various lease agreements on behalf of Aboriginal landowners in this region including the sub-lease of a prawn farm over 12 years at Kulaluk, near Darwin. The annual rental for the prawn farm was paid in advance to traditional Aboriginal owners; one full-time employment position will be available for local Aboriginal people, with several part-time employment positions available at harvest time. Djukbinj National Park was negotiated as a settlement of the Limilngan-Wulna Land claims for a joint management arrangement between the Limilngan-Wulna (Land Holding) Aboriginal Corporation and the NTG through its agencies the Conservation Land Corporation and the Parks & Wildlife Commission. Under the Lease and Deed of Management it was agreed that the Board of traditional owners would have power to control the administration and management of the park. Regrettably, when the Djukbinj National Park Board regulations were eventually gazetted, the NTG had reduced the Board to a purely advisory role. This and other inconsistencies amount to major breaches of the Lease that is against the interests of the Corporation and the Aboriginal landowners.

The Mangalpu Fisheries Committee which speaks for country from the Finnis River to the West Australian border, was established during 1997/98 and met for the first time at Wadeye (Port Keats) with Aboriginal landowners, the NT Fisheries Division and the fishing industry. Larrakia representatives have also met with the Fisheries Division and the Office of Aboriginal Development to establish a committee. The Warai Association has established a successful live cattle export depot. While it continues to operate successfully, there has been a reduction in the numbers of cattle going through. The community has been carrying out extensive property improvement and is a leader in the control of *Mimosa Pigra*, a noxious weed that strangles water systems. During 1997/98 negotiations were completed between the NLC and the NT's Parks and Wildlife Service regarding joint management for the Tjuwaliyn (Douglas) Hot Springs Reserve west of Adelaide River. The joint management deed, negotiated under s.73 of the Parks and Wildlife Commission Act is the first of its kind.

Through the NLC's Caring For Country Unit, National Heritage Trust funding was secured to conduct consultations with landowners of Aboriginal lands west of Darwin to initiate regional planning.

Major events in the Yilli Rreung region are artistically and culturally diverse. They include celebrations marking national holidays like Australia Day, May Day and Anzac Day as well as the Royal Darwin Show, the Darwin to Ambon Yacht Race, the Darwin Beer Can Regatta, the Darwin Cup (an eight day racing festival), the Darwin Rodeo which includes international team events between Australia, New Zealand, Canada, and the USA, and the World Solar Car Challenge from Darwin to Adelaide when the Stuart Highway is overtaken by what looks like large mechanical cockroaches, and the Adelaide River Races. The Festival of Darwin in August is mainly an outdoors arts and cultural festival highlighting Darwin's unique position in Australia with its large Asian and Aboriginal populations. A popular and significant national event is the National Aboriginal & Torres Strait Islander Art Awards, and acquisitive award hosted by the Museum & Art Gallery of the NT. Each year Indigenous artists from around the country enter this prestigious award that has a first prize of $10,000[37].

[37] *Explore Australia 2000*, Penguin Books, 1999.

Jabiru ATSIC Region

Overview

The Jabiru ATSIC Region covers 114,211 sq. kms in a crescent shape around the ATSIC Yilli Rreung Region[38]. It stretches from Bathurst and Melville Islands (the Tiwi Islands) in the north off the coast of Darwin, eastwards to the Coburg Peninsula and Goulburn and Croker Islands, then south incorporating western Arnhem Land and moving in an arc westwards around the Darwin area taking in Kakadu National Park continuing west through the Daly River area to Wadeye (Port Keats) and the coast.

The Jabiru region has several of the NT's biggest Aboriginal communities including Nguiu on Bathurst Island and Wadeye. Other Aboriginal communities are found at Milikapiti on Melville Island, Minjilang on Croker Island, Maningrida and Ramingining in the east of the region, Kunbarllanjnja (Oenpelli) near Jabiru, as well as Peppimenarti and Daly River in the west. There are also some 130 communities or out-stations of under 100 people in the region. The establishment of out-stations has been strong throughout the region. Jabiru, with a population of approximately 1,750, is a regional and tourist service centre for both the Ranger Uranium Mine and Kakadu National Park[39].

The geography of the Jabiru region ranges from the woodlands of the Tiwi Islands, to mainland coastal areas, to the floodplains of Kakadu National Park and the Daly River area, to the stone country of western Arnhem Land all interspersed with large areas of monsoonal forest. There are two distinct seasons typical of monsoonal climatic zones – a "Wet" and a "Dry". However, Aboriginal people recognise up to six seasons in some areas.

Major roads in the area include the Stuart Highway traversing north-south and the Arnhem Highway traversing east to Jabiru and Kakadu National Park. Other sealed roads are limited. Island and mainland coastal communities are serviced by barges and air transport. Many dirt roads and some air strips are closed during the Wet season. Some communities in the Daly River region were evacuated in January 1998, following massive flooding of the region[40].

Historical

Signs of the regular visits over hundreds of years by Macassan traders and trepang (sea slug) harvesters can be found from eastern Arnhem Land as far west as Darwin[41]. They came from what is now known as Sulawesi in Indonesia between the 1600s and the early 1900s, when their harvesting activities was outlawed by the Australian government. Unlike the Europeans who would follow, the Macassans had largely peaceful contact with the local Aboriginal people.

Recorded European exploration of the region began as early as 1644, with Abel Tasman sailing across the northern coast of the mainland, westwards across the north of the Tiwi Islands and south along the western coast of Bathurst Island to the coast of the Daly region. Ludwig Leichhardt crossed the central area of the region to Coburg peninsula in 1845, with Augustus Gregory traversing the western areas of the region in 1855 and John Stuart traversing northwards to the east of Darwin in 1862. Philip King charted much of the coast of the region in four voyages between 1817 and 1821.

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38 *Jabiru ATSIC Regional Council Plan*, ATSIC, 1997.
39 *Ibid.*
40 *Ibid.*
41 Finlay, H., *op cit*

European settlement of the region started in earnest in 1824 with the establishment of a military colony on Melville Island. Despite its failure another colony was set up on the mainland near Croker Island but was abandoned in 1829.
A wave of Chinese and Europeans went to the gold fields in the Pine Creek region in the 1870s and 1880s. Pine Creek is a small town of 450 people and is 245 kms from Darwin. Many Chinese workers were brought in by the Europeans to do all the tough work and by the mid 1880s Chinese outnumbered Europeans 15 to one. Once the gold ran out the population dwindled; many Chinese returned home or were driven away by the depression and the racism they were subjected to. The pastoral industry has been the mainstay of the town throughout this century, although recently gold has regained a place in the town's economy as an open-cut mine right on the edge of town.

The Pine Creek "gold rush" was followed by the expansion of the pastoral, mining and timber cutting industries throughout the region at the end of last century. The establishment of the vast Arnhem Land Reserve in 1931 limited European contact mainly to missionaries and government agencies. The Arnhem Land Reserve reverted to Aboriginal control with the passing of the *ALRA*[42].

In the 1950s uranium was discovered in the eastern areas of the region (western Arnhem Land) particularly in the southern part of the area now covered by Kakadu National Park. Mines such as Narbarlek and Ranger were subsequently established with only the Ranger Mine still productive. Other small-scale mining operations exist throughout the region. In 1997/98, an extensive area of the Daly River/Port Keats Land Trust came under the process of applying for petroleum exploration licences.

Aboriginal Population

The Aboriginal and Torres Strait Islander population of the Jabiru Region in 1994 was estimated at 8,500[43]. Ninety six per cent of people five years and over in the region speak an Indigenous language and there is strong identification with family, culture and land. The region covers a diverse range of language groups and cultures. For example, in the Maningrida area alone there are at least nine distinct language groups.

While the majority of the population rents housing and reports access to services, less than one-quarter report they are satisfied with their current dwelling. Much of the housing is old and needs repair and/or replacing. Most houses are located on unsealed roads creating dust problems. While school attendance rates are around 75 per cent, only 4 per cent of Aboriginal students leave school and gain further qualifications. Despite the presence of major industries in the parts of the region such as Kakadu National Park and the Ranger Uranium Mine, as well as large population centres, one-third of the Aboriginal people are long-term unemployed. Approximately 80 per cent of Aboriginal people in the region earned $12,000 or less in 1994. Only three per cent earned more than $25,000. Ten per cent earned no income and fully two-thirds received government payments[44].

ATSIC's Jabiru Regional Council[45] has identified the following priority health issues:

- inadequate housing and infrastructure;
- inadequate government funding;
- lack of appropriate housing for AHWs;
- status and role of AHWs in remote communities;
- promotion of community and individual health.

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42 *Ibid.*
43 ABS, *National Aboriginal and Torres Strait Islander Survey*, Canberra, 1994.
44 ABS, *Op. Cit.*, 1994.
45 *Jabiru ATSIC Regional Council Plan*, ATSIC, 1997.

The **Nguiu** community on Bathurst Island is one of the largest Aboriginal communities in the NT, with mostly Tiwi speakers. Out-stations on the Tiwi Islands are for the most part transitory weekend or holiday camping settlements rather than permanent groupings. Until the early 1970s Nguiu was almost entirely under the control of the Catholic Mission. Since then many functions have been transferred to Tiwi control, although the mission is still responsible for schools and some housing and is heavily involved in religious activities.
The Nguiu Council is responsible for town maintenance and public utilities and servicing associated with these, general administration and housing. In addition, there are several independent enterprises, ranging from dress manufacture to pottery and artefact manufacture and marketing. The Nguiu store is the only source of purchased groceries and hardware in the community, and, except for eggs and bread from the restaurant and a few clothes from other enterprises (Bima Wear, Tiwi Design) it provides most other needs[46]. Other important sources of sustenance are the restaurant (largely take away), the Beer Club and fish and meat obtained through hunting and gathering. The Olympic torch will go to Nguiu by charter plane.

Daly River lies about 240 kms south of Darwin near a main Daly River crossing point, and is 81 kms west of the old Stuart Highway[47]. The bulk of the population are part of the Nauiyu Nambiyu Aboriginal community about six kms from the rest of the town. There's a well-stocked general store, service station and medical clinic and visitors are welcome without a permit. The cattle and tourist industries are the mainstay of the area's economy. The present church mission dates from 1955 when it was set up by the Missionaries of the Sacred Heart to provide facilities for education, religious instruction and health care. Today, Daly River remains the main centre of the region with the main airstrip and store which, until 1980, was run by the Catholic Mission but is now run by the Nauiyu Nambiyu Community Government Council.

The Aboriginal population mostly lives in the settlement although the numbers fluctuate seasonally (according to pastoral employment) and a small group of Marrithyal people camp semi-permanently on the other side of the river from the Mission. Malak Malak people have also set up their own permanent community at Woolliana, about 15 kms from the Daly River Mission[48].

The Nauiyu Nambiyu Council is responsible for government and private funded services such as electricity, water, roads, housing, and for groceries, clothing and hardware in the immediate region[49]. Since the Daly River road is now virtually all bitumen supplies are rarely interrupted by bad weather and hence the store does not have to carry a large stockpile of goods through the wet season. The Daly River flooded in January 1998 as a result of tropical cyclone Les and 400 residents were evacuated to the nearby town of Batchelor as floodwaters raged through the community. Virtually every building was inundated.

Peppimenarti (also known as Peppi) was established in 1969 as an out-station of the Daly River Mission[50]. Its main founders were an Aboriginal family that, although brought up on the mission, had traditional links to the land in the Peppimenarti area. By 1982 Peppi had a population of 259, of whom seven were European. It was administered by the Peppimenarti Association (formerly the Unia Association), which performed the function of local government council, and housing and ran pastoral operations and other enterprises. Pastoral activities occurred within a mustering zone that in traditional terms, mostly belonged to people living elsewhere, such as Port Keats, Belyuen and Daly River.

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46 Young, E. *Outback Stores: Retail Services in North Australian Aboriginal Communities*. North Australia Research Unit, ANU, Darwin, 1984.
47 Finlay, H *op cit,* 1996.
48 Northern Land Council, *Annual Report - 1997/98*. Commonwealth of Australia, Darwin, 1998.
49 NT Department of Local Government Web Site.
50 Young, E *Op. Cit.,* 1984.

Kunbarllanjnja (Oenpelli) lies north-east of the township of Jabiru and outside the boundaries of Kakadu National Park and 15 kms into Arnhem Land across the East Alligator River and the spectacular Magela wetlands[51].
The Jabiru to East Alligator road is sealed to the East Alligator River and provides access across the river through to Kunbarllanjnja and Arnhem Land during the Dry Season. This road can become impassable during the wet season when the Magela Creek and/or the East Alligator River systems flood. A permit is necessary to visit here and can be obtained from the NLC's Jabiru office or through the Kunbarllanjnja Council.
Nearby Kakadu National Park provides ready access to a large number of tourists and the successful day tour operators have tapped this market. They have also provided tours for those people who seek quick, easy access to an "Aboriginal experience". The Kunbarllanjnja community has supported the introduction of self-drive access to the Injalak Arts and Craft Centre. This has provided financial benefits to the community through the charging of a small access fee, direct art sales and increased employment opportunities. The Kunbarllanjnja annual open day features scenic helicopter and aeroplane flights, rock art tours, football and basketball competitions, traditional dancing, bush tucker, information displays, artwork, and music from local Nabarlek Band. Another highlight of the area is the rock art tours - one site known as Muwunndadja, features the famous painting of a Macassan sailing boat. From the low rock overhang you can look back to a magnificent view across vast flood plains and the East Alligator River.

Maningrida lies on the eastern bank of the Liverpool River estuary in north central Arnhem Land on the Arafura Sea half-way between Darwin and the Gove Peninsula. It now supports a population of about 1,800 people in the community and in the 20-30 out-stations on ancestral land spread across an area of some 10,000 square kilometres[52]. In the Ndjebbbana language of the Kunibidji people who are its traditional owners, the name is Manayingkarirra. This means "the place where the dreaming changed shape". In per capita terms, it is perhaps the most multilingual community in the world. People speak Kuninjku, Kune, Rembarrnga, Dangbon/ Dalabon, Nakkara, Gurrgoni, Djinang, Wurlaki, Ganalpingu, Gupapuyngu, Kunbarlang, Gun-nartpa, Burarra and English. Most people have command of three, four or more of these languages. Traditionally none of these languages were written. Since European contact, linguists, educators and language speakers have developed writing systems for these languages.

Maningrida has long been recognised as a centre for some of the finest weaving in Australia[53]. The community has developed an enviable reputation for the quality and innovation of its fibre crafts - objects which range from baskets and bags through to fishing traps, mats and other ceremonial and decorative pieces. The vibrancy of Maningrida weaving is due in part to the stimulating interaction of the many Aboriginal peoples of differing traditional languages groups that reside in the township or in the 34 out-stations spread in the region between the Goomadeer and Goyder Rivers.

In 1949 Syd Kyle-Little arrived at the mouth of the Liverpool to set up the trading post of Maningrida. By 1967 the Maningrida Progress Association was subsidising the creative output of bark painters and weavers, and in 1971 Maningrida Arts was established with a full time Arts Adviser. The Bawinanga Aboriginal Corporation was established in the early 1970s as a support agency for those Aboriginal people who wanted to live on their traditional estates in central Arnhem Land, rather than in the settlement of Maningrida[54].

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51 Finlay, H *Op. Cit.*, 1996.
52 West, M *Rainbow Sugarbag and Moon*, Museum & Art Gallery of the NT, 1995.
53 West, M, Carew, M & the Artists *Maningrida: The Language of Weaving*. Australian Exhibitions Touring Agency, 1995.
54 *Ibid.*

Bawinanga became aware of incursive biological threats with the discovery of a small but potentially devastating outbreak of the invasive weed, Mimosa Pigra on the flood plains of the Tomkinson River in the early 1990s[55]. Negotiations with Territory and Commonwealth agencies secured funding for Bawinanga to undertake an eradication program and this success provided further impetus to establish formal land management programs and seek training and resources for community rangers. Since 1990 there has been a rapid increase in local Aboriginal involvement in a variety of specific land and wildlife management projects at Maningrida aimed at retaining control of, and developing local capacity to contribute to, environmental management, and to ensure beneficial outcomes for the local population. The Bawinanga Corporation has established a training and research centre aimed at maintaining and developing sustainable uses for wildlife. The dual goal is to conserve biodiversity through sustainable use and to create a sustainable economic base for the Aboriginal communities, based on both traditional and introduced land use activities.

During World War Two, there was a substantial southerly migration of Aboriginal people from the Arnhem Land stone country to the Katherine region[56]. It was the first time that many Aboriginal people had experienced such intensive contact with other groups. In the 1970s, people returned to establish out-stations on their own clan lands. People in the area come together for ceremonial purposes from a number of local centres such as Kunbarllanjnja, Maningrida, Bulman, Barunga, and from the many out-stations in between. In this region major ceremonies such as Kunabibi are led by senior men who share knowledge of the Ancestral affiliations of the major sites within the region. While these men know their own clan lands intimately, they also know details relating to those other lands that they have traversed during their lifetimes. In major regional ceremonies men and women perform the more important dances in separate groups.

Croker Island is located 200 kms to the north-east of Darwin, on the western edge of Arnhem Land[57]. It is the largest of a group of islands that enclose an area of seas that is sheltered from the rough waters existing to the north. The islands were scheduled as Aboriginal land under the *Aboriginal Land Rights Act* in 1977. The island adjoins Bowen Strait, an area that was regularly visited by the Macassans. The main community on Croker is Minjilang.

Land

The Jabiru ATSIC Region covers the West Arnhem and Darwin-Daly regions of the NLC that has regional offices in Jabiru and Palmerston[58]. The Tiwi Islands are covered by the Tiwi Land Council that has offices in Nguiu and Darwin. Large areas of land are Aboriginal-owned under the *ALRA*. These include the Tiwi Islands, western Arnhem Land and Kakadu National Park and the Daly River/Port Keats area. There are also areas of land and sea in the region covered by outstanding claims under the ALRA and the *Native Title Act 1993.*

While no Community Living Areas or "excisions" have been granted on pastoral leases in the region, there is an outstanding application for a CLA on Elizabeth Downs near the Daly River township. It was lodged in 1993, approved in 1994 and retrospectively invalidated in 1996[59].

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55 Langton, M. *Burning Questions: Emerging Environmental Issues for Indigenous Peoples in Northern Australia.* CINCRM, NTU Print, Darwin, 1998, Pp63-64.

56 West, M *Op. Cit.*, 1995.

57 NLC Web Site: *www.nlc.org.au.*

58 NLC, *Op. Cit.*, 1998.

59 *Ibid.*

Aboriginal landowners in the Daly River-Port Keats ALT have opened up 10,500 square kilometres to a multinational company to explore for petroleum[60]. Over 1,400 Aboriginal landowners were required for consultation for the broad area to be explored. Funding has also been secured from the Cooperative Research Centre for Tropical Savannas for planning sustainable management for the Upper Daly Land Trust area. Each year the annual the Merrepen Arts Festival is held at Nauiyu Nambiyu which showcases art and crafts from Wadeye (Port Keats), Nauiyu and Peppimenarti,

Sea

> *"We, Aboriginal people believe that all human beings go together with the Land and Sea. If we have Land, and no Sea, we will die. If we have Sea and no Land, we will also die. If we have Land and Sea, people will live free."*[61]

In 1983 the NT Government announced its intention to declare a Marine Park around the Coburg Peninsula and Croker Island (and associated islands)[62]. The above quotation is taken from a letter in which the people of Croker opposed the proposal.
The traditional owners simultaneously requested a closure of seas within two kms of their islands. The Coburg Marine Park was declared in 1996. It does not include the seas surround Croker and associated islands. After negotiations between the NLC and the government a clause has been inserted into the empowering statute that protects native title interests.

In 1994 the Mandilarri-Ildugij, Mangalarra, Muran, Gadurra, Minaga, Ngayndjagar and Mayorram people lodged a native title application in respect of the seas surrounding the island group[63]. The claim asserts substantial native title interests of "ownership, occupancy, possession, and rights of use" in respect of the sea and sea-beds covered by the application. Aboriginal people assert the same rights to their 'sea' country as they do to their 'land' country. The area claimed includes both NT and Commonwealth waters.

The Croker Island Seas claim was the first claim to an area of sea lodged under the Native Title Act. The Federal Court found that limited native title rights existed to the sea and marine resources, but the case has been appealed to the High Court and its outcome could have considerable implications for coastal people. Traditional owners of the area have shown they are prepared to negotiate over marine developments, concluding two agreements for commercial pearl harvesting - to Tiwi Pearls Pty Ltd in 1992 for a term of ten years at Port David on the Island; and in 1998 to Japanese company Barrier Pearls for ten years with a ten-year option for a pearl culture farm over an area of about 2 sq kms which lies within the native title claim area. The seas claimed are also subject to the numerous fishing licences, many of which apply throughout Territory waters[64].

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60 *Ibid.*
61 Letter to the Chief Minister of the NT from Minjilang Community, 27 May 1983.
62 NLC Website, *Op. cit.*
63 *Ibid.*
64 NLC, *Op. Cit.*, 1998.

Kakadu

Kakadu National Park is an Aboriginal cultural landscape located in the monsoonal tropics of northern Australia[65]. The park covers an area of 19,804 square kilometres within the Alligator Rivers Region. It extends from the coast in the north to the southern hills and basins 150 km to the south, and from the Arnhem Land sandstone plateau in the east, 120 kms through wooded savannas to its western boundary. Major landforms and habitats within the park include the sandstone plateau and escarpment, extensive areas of savannah woodlands and open forest, rivers, billabongs, floodplains, mangroves and mudflats. A feature of the park is that Aboriginal people have occupied the landscape for at least 50,000 years. The natural and cultural heritage of the park has been recognised by the inscription of the park on the World Heritage list. The park is proclaimed under the *National Parks and Wildlife Conservation Act, 1975* and is jointly managed by the Aboriginal traditional owners and Parks North. Approximately 50 per cent of the land in the park is Aboriginal land with more land under claim by Aboriginal people.

A national park in the Alligator Rivers region was proposed as early as 1965[66]. In the early 1970s significant uranium deposits were discovered at Ranger, Jabiluka and Koongarra. A formal proposal to develop the Ranger deposit was put to the Commonwealth government in 1975 and the government established the Ranger Uranium Environmental Inquiry to conduct an inquiry into the proposal, focusing on environmental issues and the social impact on Aboriginal people. The Ranger Inquiry tried to work out a compromise between conflicting and competing land uses, including Aboriginal people living on the land, establishing a national park, uranium mining, tourism and pastoral activities. In 1978 the Commonwealth acquired title to the land that now forms Kakadu National Park and an arrangement was made for the Aboriginal traditional owners to lease the land that had been granted to them under land claim for management as a national park. As per the Ranger Inquiry recommendations the park was established in stages: Stage one, including an area of land for the township of Jabiru, was declared in 1979; Stage two in 1991; and Stage three, successively, in 1987, 1989 and 1991. The staged declaration was due to the debate over whether mining should be allowed to go ahead at Guratba (Coronation Hill). Guratba is in the middle of the culturally significant area referred to as the Sickness Country.

Kakadu National Park lies within the West Arnhem Region of the NLC. The NLC has played a major role, over the years, in establishing and developing joint management arrangements for the park. In 1989 a Board of Management with a majority of Aboriginal members was established for the park. The Aboriginal representation on the Board covers the geographic spread of Aboriginal people in the region as well as the major language groupings[67].

Kakadu is a major international tourist attraction. In 1985 approximately 100,000 people visited the park and by the early 1990s visitor numbers averaged about 230,000 people per year. Significantly, visitors mostly come in the Dry Season, with approximately 70 per cent visiting between May and October. In 1995 about half of the visitors to the park were on organised tours. Visitors are permitted to use roads (other than designated service roads) and public access tracks except where access has been prohibited or restricted. All public roads in the park are on land that is vested in the Director of National Parks and Wildlife. They are maintained by Parks North, the NT Government and the relevant Aboriginal associations/leaseholders. The NT Government maintains the major roads in the park: the Arnhem Highway; Kakadu Highway; Old Darwin/Jim Jim Road; Jabiru to East Alligator Road; Cooinda Road; and the Gimbat Road.

Jabiru township is on a special lease within Kakadu National Park and has a population of approximately 1,750. It was built to accommodate the Ranger Uranium Mine workers when the mine first started in the early 1980s. The intention was that it would be only a temporary settlement, but it has developed into the major service centre for Kakadu[68].

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65 Kakadu National Park - *Draft Plan of Management 1996.*, Commonwealth of Australia, 1996.

66 *Ibid.*

67 *Ibid.*

68 Kakadu National Park *Op. Cit.*, 1996.

Jabiluka. In 1982, acting on instructions from traditional Aboriginal owners, the NLC entered into an agreement with Pancontinental Mining Ltd and Getty Oil Development Co Ltd for uranium mining in the Jabiluka Project Area (JPA)[69]. As a result, the NT Government granted a mineral lease to the mining companies covering the JPA (while the JPA, adjacent to the Ranger Uranium Mine, is surrounded by Kakadu National Park, it is not a part of it). However, uranium mining could not proceed because export approval for uranium could not be obtained under the Hawke Labour Government's 1983 "Three Mines" policy. The Jabiluka lease was then sold to Energy Resources Australia (ERA) in 1991. Since the election of the Coalition government in 1996 and the removal of the "Three Mines" policy, ERA has moved to develop the JPA. Having experienced the impact of the Ranger mine on the region for the last 15 years, a new generation of traditional Aboriginal owners now expresses serious concerns about extending uranium mining activities on their land and have carried on a very strong public campaign to stop the development of the mine[70]. ERA proposes to mill ore from Jabiluka at its Ranger site some 22kms away, which would mean building a new road through Mirrar country from one site to the other - the Mirrar do not agree with this, and state that if mining goes ahead at Jabiluka it should be milled at Jabiluka and not trucked to Ranger[71].

Despite differing opinions with the NLC, whose legal advice has been that the 1982 mining agreement remains legally binding on the NLC, and to address the Mirrar concerns regarding the environmental and social impact of Jabiluka and other developments in the region, the NLC instigated the Kakadu Regional Social Impact Study (KRSIS)[72]. The study examined developments such as Kakadu National Park, Jabiru township and the Ranger Uranium Mine. Make up of the Study Advisory Group included Pat Dodson (chair), NLC Chairman Galarrwuy Yunupingu and representatives from the Federal Government, Parks Australia, Energy Resources Australia, Jabiru Town Council, the NT Office of Aboriginal Development and the NT Department of Mines & Energy. Among the key recommendations were the following:

- Jabiru township should be scheduled as Aboriginal land;
- major employers in the region should be required to develop an employment and training strategy for local Aboriginal people;
- a program should be established for ongoing monitoring and research of the social impact of mining in the region;
- the Indigenous Housing Authority of the NT (IHANT) should assess current and future Aboriginal housing needs and the options for meeting those needs;
- a joint committee made up of government, ERA and the NLC's representatives to oversee the implementation of the community action plan.

Former Labour Senator Bob Collins has been appointed to implement the KRSIS recommendations and the Mirrar have suspended any negotiations with ERA for the next five years[73].

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69 NLC, *Op. Cit.*, 1998.

70 *Ibid.*

71 NLC *'Traditional owners again reject ERA proposal'* Media Release, 27/10/99.

72 NLC, *Op. Cit.*, 1998.

73 NLC, *Op. Cit.*, 27/10/99.

Miwatj (Nhulunbuy) ATSIC Region

Overview

The Miwatj ATSIC Region covers the north-eastern corner of the Top End of the NT, including Groote Eylandt in the Gulf of Carpentaria. Apart from some sealed roads around the townships of Nhulunbuy (Gove) and Alyangula on Groote Eylandt, there are few other sealed roads in this region. The main highway is the graded and well-maintained dirt Central Arnhem Highway that goes from the Stuart Highway just south of Katherine north-east to Nhulunbuy. The highway becomes cut in some sections by rising waterways in the Wet Season. There are many other minor dirt roads servicing out-stations and smaller communities in the region that generally are impassable during the Wet. Most communities are serviced by airstrips and some coastal communities are serviced by barges. There are major mining operations near Nhulunbuy (Nabalco – bauxite) and Alyangula on Groote Eylandt (the Gemco manganese mine until recently owned by BHP) that has seen the development of significant infrastructure at both places such as ports and airports capable of servicing commercial jet services. While there are significant Aboriginal communities in centres such as Yirrkala near Nhulunbuy, on Groote Eylandt and at Galiwin'ku on Elcho Island off the north coast, the Region is dotted with small out-stations primarily in coastal and hinterland areas. Over the past three decades, the region has gained a large, settled non-Aboriginal presence in the mining towns of Alyangula and Nhulunbuy and in the nine larger Aboriginal communities of the region[74].

Historical

The Aboriginal peoples had a great deal of contact with outside peoples for several hundred years at least. Yolngu (Aboriginal people of the region) speak of a people they call Bayini coming to Daliwuy Bay in eastern Arnhem Land in sailing ships, living among Yolngu, building houses and planting rice. These Macassan fishermen sailed in fleets of praus every year from Ujang Pandang in Sulawesi to the land they called Marege. They would arrive on the Arnhem Land coast or on northern Groote Eylandt in late December-January when the northwest monsoon winds began to blow[75].

The Macassans came to trade for the right to fish for trepang, the sea slug or beche-de-mer, which Yolngu call dharripa, an alleged aphrodisiac that is a delicacy in many styles of Asian cooking. The Macassans traded the lunginy, the long smoking pipe, dugout canoes and metal weapons like axes. Hundreds of Macassan words remain in today's Yolngu Matha language of the region.

Dutch navigator Willem van Colster, in the pinnace 'Arnhem' is believed to be the first European to see eastern Arnhem Land in 1623, sailing on after he named it. Then came Abel Tasman who sailed the western coastline of the Gulf of Carpentaria and named Groote Eylandt. In 1803 Matthew Flinders visited in the 'Investigator', mapped the area and named places after his patrons and other notables in contemporary English society. The coastline was surveyed in 1827 by Captain Philip Parker King in the 'Mermaid', and the explorer Ludwig Leichhardt crossed the southern part of Arnhem Land in 1844. By 1862 the administration of the new NT was the responsibility of the South Australian Government, which meant very little to Arnhem Landers. In the 1880s the South Australians introduced customs duty on the trepang trade and licence fees that saw an almost immediate decline in trade. In 1906 the government eventually withdrew all licences and severed Australia's first and longest standing trade links with Asia.

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[74] Miwatj ATSIC Regional Plan, ATSIC, 1997.

[75] Duffy, M *Living in Eastern Arnhemland: Your Guide to the Region* Nhulunbuy Community Neighbourhood Centre, 1998.

Elsewhere in the Top End and in central and south-east Arnhem Land, the late 19th and early 20th centuries saw the arrival of more and more non-Aboriginal cattlemen, crocodile hunters, prospectors and other adventurers which gave rise to a bloody conflict between them and Aboriginal people. By late 1908 the Church Missionary Society (CMS) had set up a mission station on the Roper River and moved into Arnhem Land with their first mission at Emerald River, on Groote Eylandt in 1921. The missions were there to 'civilise' Aborigines and eventually allow them to be assimilated into white society. The missionary influence helped break down cultural traditions and this caused great conflict between clans over the trespass on the lands because mission policy was to gather people in one spot.

The Government eventually created the Arnhem Land Aboriginal Reserve in 1931 but the pressure from outsiders didn't abate. Australian and Japanese trepangers encroached on Aboriginal land, violated protocols of behaviour and, it is said, attempted to steal Yolngu women. In 1932 five Japanese were killed at Caledon Bay and two Australian men were killed at Woodah Island in Blue Mud Bay the following year. Southern newspapers were full of talk of a 'Black War' in Arnhem Land and there was pressure for a punitive expedition to be sent in - a Peace Expedition was sent instead. The Yolngu involved were taken to Darwin by boat to stand trial in 1934.

In 1935 Methodist missionaries established the Yirrkala mission near Nhulunbuy township.

In 1938 Qantas set up a flying boat refuelling base at Port Langdon, on the north east coast of Groote Eylandt which later became the Umbakumba mission when it was taken over by the CMS in 1948. During the war the Royal Australian Air Force (RAAF) built a flying boat base near Drimmie Head on Melville Bay at what became known as Catalina Bay. The Catalinas flew as far as Singapore on surveillance and bombing missions. The RAAF also built an airstrip behind the Yirrkala mission, where there was also a radar station, and this became today's airport. There were about 500 service men and women in the region between 1942 and 1945. Ventura bombers of 13 Squadron were based at the airstrip, which became known as Gove Airstrip - and the area the Gove Peninsula - after Flight Sergeant William Gove was killed in a mid-air collision over Milingimbi in April 1943.

The war over, normality as far as the Yolngu were concerned was never restored. More and more non-Aboriginal people came into the area. Sheperdson had set up Galiwin'ku on Elcho Island as a Methodist Mission and in 1952 the CMS established the Rose River mission at what later became known as Numbulwar.

In 1954 the Gove Peninsula was host to the Top End's original space base at Dhupuma, southeast of Nhulunbuy. The European Launcher Development Organisation (ELDO) was testing first-stage rockets at Woomera in South Australia and Dhupuma was the site of the Down Range Guidance and Telemetry Station for the rockets, monitoring progress and sending navigational correction signals. More than 30 people worked at the station until it closed in 1970.

The first geological survey of the bauxite deposits on Gove happened in 1952, although bauxite had been found at Marchinbar Island in 1949 and noted much earlier by Flinders on his voyage. The 1960s saw major changes across the western Gulf region. In 1965 Nabalco joint venture partners gained a special mining lease over 20,000 hectares on the Gove Peninsula to look for bauxite deposits. BHP's Groote Eylandt Mining Company was granted special mineral and special purpose leases to develop an open cut manganese mine and a town and ore loading facilities. The CMS, which had moved from Emerald River to Angurugu in 1942, negotiated prospecting rights on behalf of Groote Eylandt people. Mainland Yolngu, protesting against the excision of their land from the Arnhem Land Aboriginal Reserve presented the Bark Petition to the Commonwealth Parliament in 1963. Clan leaders of the area created the painting that showed the important stories of the Yolngu clans and their land and took it to Canberra. It now hangs in Parliament House. They hoped that Balanda (white people) would recognise the stories as legal proof of who really owned the land, according to Law.

A House of Representatives Standing Committee into the development recommended a number of safeguards for the interests of Yolngu, but failed to recognise that they had any interests in their own land. When the Commonwealth Government negotiated an agreement for the mining and export of alumina and bauxite, Yolngu took the Government and Nabalco to the NT Supreme Court. This was known as the Gove Land Rights Case and was the first attempt to establish Aboriginal land rights in Australian law. Their challenge to the right of the parties to enter an agreement without the consent of traditional owners and without compensation was rejected in 1971. Justice Blackburn found that their communal title did not form any part of land law in Australia and dismissed the action.

Although they were unsuccessful in these attempts to communicate with Europeans, their actions helped bring about a national movement of support for Land Rights that led to the Fraser Government passing the ALRA in 1976.

The Yolngu had to watch as a town, a loading wharf and a bauxite processing plant were built on their land. They were against the building of a town because they saw it would create social problems. Their requests that there be firstly no licensed premises, and then no take-away sales, were ignored. Nearly 30 years on there is a measure of coexistence but there is lingering resentment at the treatment of revered elders during the dispute years.

The position of Yolngu, and in fact all the Aboriginal peoples of the region, changed dramatically in the 1970s. The passing of the ALRA saw all of the Arnhem Land Aboriginal Reserve returned at a stroke to traditional owners under a new form of title. The Act belatedly gave Yolngu the right to negotiate access to their land and proposals for its development. The Aboriginal people of the region now play a major role in the economy of the region and have achieved a degree of self-determination, although that is by no means complete near the end of the decade. They have gained a measure of economic independence through royalty payments that have been invested into community enterprises. The arrival of the ALRA saw the departure of the last of the missionaries from community administration, although Christian religion in various forms continues to be a force in the lives of many Aboriginal people.

Aboriginal Population

Almost all of the Aboriginal population aged five years and older (96 per cent) speak an Indigenous language well enough to carry on a conversation and almost all (98 per cent) identify with a clan, tribal or language group, believe the role of elders is important and recognised a homeland. Almost all (98 per cent) of Aboriginal people in the region are happy with their local health services and some 20 per cent used bush medicine. Alcohol is considered by almost one-third of people to be a major health problem. Ninety four per cent of dwellings were rented and of these fully three-quarters were rented from community organisations. Two-thirds of people renting reported the dwelling did not satisfy the needs of the people living there. Ninety five per cent of Aboriginal people who had left school did not have post-secondary qualifications. Significantly, 97 per cent of school student were being taught about Indigenous cultures with 91 per cent being taught in an Aboriginal language. Two-thirds of unemployed people are long-term unemployed, 42 per cent receive government payments as their main source of income. In 1994, the average gross income in the region was $242 per week[76].

In the Miwatj Region the Aboriginal peoples of Arnhem Land see themselves as being members of culturally distinct groups and distinct from other Aboriginal peoples in Australia - and they are. In eastern Arnhem Land there are about 20 languages spoken everyday.

[76] ABS, *Op.Cit.*, 1994.

The biggest single cultural group, and about half the population, is the Yolngu, which is the word for Aboriginal human being in many of the local languages. The term has only recently been widely accepted as the name of a cultural group. Miwuyt, or Miwatj is the name for the administrative region of ATSIC that also corresponds with the NT Government's East Arnhem region, both of which include Numbulwar and Groote Eylandt. Yolngu are both 'saltwater' (coastal) and 'freshwater' (inland) people. Each clan has its own named language, although today their languages are called Yolngu-matha, which means 'the way Aboriginal people speak', or 'Aboriginal people's language'.
Further south on the eastern coast, the community of Numbulwar is home to people who speak a number of languages including Nunggubuyu and Ritharrngu. Many also speak Kriol, which was a form of Pidgin and is now recognised as a language along with other forms of Aboriginal English. Numbulwar people are culturally distinct from Yolngu but have ceremonial and family connections. Groote Eylandt people have ceremonial and family links with mainlanders, but speak Anindilyakwa. For many people in the region, English may be a third, fourth or even fifth language.

Many Aboriginal people now live in the larger communities of Yirrkala, Galiwin'ku, Gapuwiyak, Milingimbi, Ramingining, Numbulwar, Angurugu and Umbakumba. Most of these have been set up either by government or missions over the past seven years. Since the earliest times, they have lived in family groups on their own country, usually getting together in larger groups only for ceremony. From the early 1970s, many Aboriginal people have made the move back to living on their clan estates that they call homelands or country.

Among the wealth of food the Arnhem Land environment provides is wild fruits, vegetables and grains, bush meats like wallaby and magpie geese and, for coastal peoples, seafood like fish, turtle, dugong and shellfish. Land is the base for building Aboriginal economies because it supplies people with their food, the materials to hunt the food and other materials like ochre they use in ceremony. But land is also part of the spiritual basis of life because it came directly from the creator ancestors. Anything people want to do with it should be in accordance with the Law. Keeping up the connections between humans and land follows Law and, among other things, means you're making sure your economy survives. Without people exercising their responsibilities by looking after the country, there wouldn't be any food.

'Art' is also another very important aspect of Aboriginal life in Arnhem Land because it is another part of the Law. Dances, songs and paintings are unique to each clan and explain the particular connections with the natural and spiritual environment. The exact meaning of clan designs is not usually revealed to outsiders.

In eastern Arnhem Land there are four community-based art and craft centres - Bula Bula Arts at Ramingining, Marthakal at Galiwin'ku, Nambara at Nhulunbuy and Buku Larrnggay Mulka at Yirrkala. These are marketing agencies for outside buyers and for showings in southern galleries, salesrooms, museums or archives, workshops, as well as display galleries for paintings, carvings, weaving and crafts by the Aboriginal artists of the region. The four centres in this region make about one million dollars a year.

Aboriginal people in the region are also involved in local business. Royalties from mining have helped Groote Eylandt people buy a major shareholding in Anindilyakwa Air. And on the mainland, royalties have been ploughed into Yirrkala Business Enterprises that does mining, roads, and general contracting. One of the royalty associations, Gumatj, runs a crocodile farm which breeds and rears hatchlings for other commercial crocodile farms.

Four communities in the region: Milingimbi, Ramingining, Galiwin'ku and Gapuwiyak are members of the ALPA. This is a community-run buying co-operative that has been running since 1972. It has a Yolngu Board of Directors and owns and operates the stores. It employs more than 60 Aboriginal people in the region and, because of a region-wide nutrition policy, totally subsidises freight costs on fruit and vegetables so member stores can offer affordable healthy food. ALPA also manages the Umbakumba store for the community. All ALPA stores have EFTPOS and the co-operative has expanded its operations to create the Traditional Credit Union, which gave many remote communities local banking services for the first time.

Aboriginal councils and other organisations make a big contribution to the regional economy. Money from community-based enterprise, together with Commonwealth and Territory funding contributes more than $50 million a year to the regional economy.

Young men from many of the eastern Arnhem Land communities serve in Norforce, the Army's reserve unit in the NT. Some are away studying at high schools in Darwin or boarding schools in other states. Older students are studying at Batchelor College to be teachers or health workers. Others are working alongside their fathers and uncles on homelands.

The region has already produced two generations of leading figures who have made their mark on political and community life in the wider Aboriginal world and in Australian political life. It is home to the former chairman of ATSIC, and the chairman of the NLC, both of whom as young men interpreted for their fathers during the Gove Land Rights case. It is also the home of nationally and internationally famous artists and musicians, like prize winning painters from the Homelands and singer/songwriter Mandawuy Yunupingu of Yothu Yindi fame.

Land & Sea

The NLC represents traditional Aboriginal landowners on the mainland through its East Arnhem Region and Anindilyakwa Land Council on Groote Eylandt. The NLC has a regional office in Nhulunbuy.

Dhimurru Land Management & Aboriginal Corporation is a Yolngu landowners' cultural and natural resource management agency that tries to reconcile two ways of doing things. It works to maintain traditional land management practices within the operations of a Balanda style national parks service. Dhimurru runs revegetation and fauna conservation programs on land and seas in the north-eastern Arnhem Land region. It is also playing a leading role in gathering and archiving cultural information and producing interpretative material for Balanda on parts of the area. Traditional owners have asked Dhimurru to issue permits for access to the recreation areas it manages. Senior traditional owners from the board of Dhimurru have played a major role in establishing the Centre for Indigenous and Cultural Resource Management at the NT University in Darwin.

Coastal, or 'saltwater', people have strong spiritual and cultural connections with the sea as well as the land. The NLC has been negotiating a number of commercial fishing agreements in the area to help traditional owners protect their marine resources and culture and to develop economic opportunities[77]. This includes a number of agreements with commercial mud-crab harvesters in the Blue Mud Bay area on the mainland opposite Groote Eylandt. The NLC has also been working with local people and law enforcement agencies to clamp down on the increasing activities of illegal fishing operations that have often seen incursions into areas significant for Aboriginal people.

[77] NLC, *Marine Agreements with Aboriginal People* (video), July, 1999.

Services

Most Aboriginal communities now have some form of local government that is incorporated either through NT or Commonwealth legislation. Having no rate base like non-Aboriginal councils, Aboriginal councils depend heavily on government funding programs. They carry out the usual local government functions, looking after roads, drainage, sewerage and recreation areas, but they are also involved in many more areas of community life than non-Aboriginal councils. Many build houses for their communities and run their own power and water supply systems. Some receive funds for health services or sponsor community development programs like radio stations, women's resource centres, recreation programs and Landcare activities. Aboriginal councils in the area were among the first to enter the Community Development Employment Program (CDEP) - also known as the 'work for the dole' scheme. The region has the fifth biggest CDEP in Australia, with more than 1800 people who would otherwise be unemployed working on community projects. Some councils are also more directly involved in business enterprises to raise revenue, running community stores and post offices.

It is a mistake to assume that councils are the final authority in all matters to do with Aboriginal communities, any more than non-Aboriginal councils are. Where mainstream councils have power and responsibility for planning and decision-making on land use, Aboriginal councils must get the relevant traditional owners to agree before they can approve any land development proposals. Usually their authority is limited to a town area, but they have to be careful not to give the impression that they are trying to take over from the senior traditional owners.

Most large Aboriginal communities in the region will also have a homelands resource centre. These support people who have moved away from the town style of community and back to living on traditional homelands in small family groups. The centres employ skilled workers to support the homelands with building and infrastructure (roads, power, water supply) services, health services and transport. The Laynhapuy Homelands Resource Centre at Yirrkala services more than 20 homelands in the region, many of which have stable populations of less than 50 people. It runs its own air service to fly essential supplies and visiting teachers, health staff, builders, plumbers and mechanics to bush airstrips on homelands.

Schools have become an important community focus, particularly for Yolngu. Over the past 10 years there has been a significant move across the NT towards greater Aboriginal involvement in designing and delivering the curriculum in Aboriginal communities. Some schools in the region run bilingual programs, which begin teaching the general school curriculum - the three Rs - in the main community language. They are also a focus for passing on cultural knowledge.

With the support of elders of the different clans, Yolngu teachers at Yirrkala Community Education Centre have developed what they call the 'Both Ways' education system. The idea behind this is that Yolngu children need a solid grounding in both Yolngu and Balanda learning to make sense of living in an environment where they need to learn two cultures. Several schools in the region also have Literature Production Centres that research, edit and publish material in community languages.

Miwatj Health, a community controlled health service in northeast Arnhem Land, has its own clinical services for communities and homelands, a health improvement (preventative) program and database. Miwatj Health employs and trains Yolngu as AHWs to work alone or with non-AHWs to provide culturally appropriate services. Miwatj works in co-operation with mainstream health services and is also currently involved in a research project into the effects of kava abuse.

Garrak-Jarru ATSIC Region

Overview

The Garrak-Jarru ATSIC Region covers approximately 355,000 square kilometres. It is perhaps the most geographically and climatically diverse of the ATSIC regions in the NT. It comprises the 'Gulf country' in the east of the region centred around Borroloola; the southern limits of the monsoonal tropics in the north of the region centred around Katherine; the stone country of western Arnhem land, the pastoral rangelands of the northern Barkly and Victoria River District in the south and west of the region; through to the start of desert country south of Lajamanu in the south-west of the region[78].

The Garrak-Jarru Region is also culturally and linguistically very diverse. In and around the town of Katherine alone, there are some 27 language groups. There are many Aboriginal communities throughout the region from Robinson River, Borroloola, Ngukurr, Numbulwar and Bulman in the east, to Beswick, Barunga and Rockhole in the centre, to Bulla, Amanbidji and Yarralin in the west, and, Dagaragu, Kalkarindji and Lajamanu in the south-west[79]. As well as the Jawoyn traditional owners of Katherine, there are high numbers of Aboriginal people from other areas of the Garrak-Jarru Region who visit Katherine and/or live in a number of run-down town camps scattered around the town. There are also many out-stations dotted throughout the region.

The non-Indigenous population is concentrated in only a few centres in the region such as Borroloola, Katherine and Timber Creek. Katherine, with a population of approximately 6,500 is a major regional service and tourism town[80]. It services the surrounding cattle and mining industries, Nitmuluk National Park and the major defence/air force facility at nearby Tindal. Borroloola is a service centre for the surrounding cattle industry, McArthur River Mine and the local fishing industry. Timber Creek is a minor service centre, particularly for the nearby Gregory National Park.

The east of the region is serviced by the Carpentaria and Roper Highways, the centre by the Stuart Highway, the west by the Victoria Highway and in the south to Kalkarindji by the Buntine Highway. There are also a number of unsealed but regularly graded highways in the region, including the Central Arnhem Highway in the north-east, the Buchanan Highway crossing the centre and west of the region and the Buntine Highway south-west of Kalkarindji[81]. There are many other dirt roads in the region affected by Wet season rains and floods.

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78 Garrak-Jarru Regional Council, *Annual Report - 1998-99.*, ATSIC, 1999.

79 McGrath, A *Born in the Cattle.*, Allen & Unwin, Melbourne, 1987.

80 Finlay, H *Op. Cit., 1996.*

81 Finlay, H *Op. Cit., 1996.*

Historical

With the arrival of mobs of cattle in northern Australia in the latter part of the 19th Century the 'battle for the waterholes' began. The resistance of Aboriginal people to the colonisation of their land is well documented. There were frequent cattle spearings, occasional attacks on European outposts and all-too-common indiscriminate retaliatory massacres of Aborigines. The Europeans with their cattle and their guns soon occupied the more fertile lands. They were there to stay; but so were the Aborigines. The Europeans needed Aboriginal knowledge of the country and they needed their labour. By working on the cattle stations Aboriginal people were able to stay on their land and continue their traditional responsibilities to it. Up until the early 1970's the NT cattle industry depended on Aboriginal labour for its success[82]. It was Aboriginal people who built the fences, dug the bores and tendered, mustered and drove the cattle. It was common to find them 'paid' with meagre allowances of flour, tea, sugar and tobacco.

In 1968 Aboriginal stock workers won the right to award wages and conditions equal to white workers. But it was a hollow victory. With the mechanisation of the industry - sub-divisional fencing, modern trapping yards, road transport replacing droving and the advent of helicopter mustering - pastoralists had already begun to do away with Aboriginal labour. The Aboriginal camps that had been pools of cheap labour were no longer needed and many people were forced off the stations[83]. As well, with the establishment of assimilation settlements run by government officers and missionaries, Aborigines were 'encouraged' to move off the pastoral properties.

Ironically, a seminal event in the struggle for Aboriginal land rights occurred in the Garrak-Jarru Region with the 1966 strike by Aboriginal pastoral workers on Wave Hill station. The workers and their families walked off the station protesting against appalling pay and conditions. However, the strike developed into a nine-year struggle for return of traditional Gurindji lands. It culminated in the historic image of then Prime Minister Gough Whitlam symbolically pouring a handful of dirt of through the hands of elder Vincent Lingiari on the return of their lands in 1975[84].

Barunga is also a significant community in the land rights struggle and cultural maintenance. In 1988, the Northern and CLCs issued the 'Barunga Statement' that was presented there to then Prime Minister Bob Hawke and called for a treaty with Indigenous Australia[85]. Every year, five to ten thousand mostly Aboriginal people converge on the community for the Barunga Festival - a showcase of Aboriginal art, culture and sports.

Aboriginal Population

The Aboriginal and Torres Strait Islander population of the Garrak-Jarru Region was estimated at around 7,000 in the 1996 Census - some 37 per cent of the total population of the region. Two-thirds of those people aged five years and over speak an Indigenous language. Kriol is also widely spoken throughout the region. There is a strong identification with culture and family in the region with around 90 per cent of the Indigenous population participating in cultural activity and identifying with a clan, tribal or language group[86].

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82 McGrath, A *Op. Cit.*, 1987.

83 *Explore Australia 2000*, Penguin Books, Melbourne, 1999.

84 NLC Website, *Op. Cit.*

85 CLC & NLC *Our Land, Our Life: Aboriginal Land Rights in the Northern Territory*, Darwin, 1995.

86 ABS, *Op.Cit.*, 1994.

Almost three-quarters of houses are rented and 51 per cent of the Indigenous population reported their dwellings as unsatisfactory[87]. In some cases, such as the Katherine town camps, conditions resemble shanty towns more commonly associated with so-called third world countries. On the other hand, new housing is being constructed by organisations like the Kalano Community Association in Katherine and in areas such as Wugularr (Beswick), north-east of Katherine. The Bulla community near Timber Creek recently had an infrastructure injection through the ATSIC/ Army Community Assistance Project which involved utilising Army personnel for community infrastructure development funded by ATSIC.

Only eight per cent of the Indigenous population have post-secondary qualifications and 61 per cent of unemployed people were long-term unemployed. Some two-thirds of people are receiving government payments as their main source of income, with only 20 per cent receiving wages and salaries[88].

During WWII there was a substantial north-south migration that characterised the movement of people from the Arnhem Land stone country to the Katherine region. It was the first time that many Aboriginal people had experienced extensive contact with other groups and it is estimated that sixteen different language groups were mixing together at Mataranka[89]. These included Rembarrnga, Mayali and Kunwinjku people who worked alongside others from the Adelaide, Roper and Daly Rivers regions.

Land

The Garrak-Jarru ATSIC Region covers parts of the Borroloola/Barkly, Ngukurr, Katherine and Victoria River Regions of the NLC. The south-west of the region covers the north-western corner of the CLC's jurisdiction. The NLC has regional offices in Borroloola, Ngukurr, Katherine and Timber Creek. There are some areas of Aboriginal-owned land in the region such as the Garawa, Alawa and Narwinbi land trusts in the east, south-east Arnhem Land and the Beswick land trust in the north, the Wanimyn and Wagurunguru land trust in the west, and, the vast Central Desert land trust in the south-west corner[90]. There is also the jointly-managed Nitmuluk National Park and Gregory National Park in the region.

However, much of the land in the region is covered by pastoral leases and many of the peoples in the region remain refugees in their own land - alienated and often locked-off their traditional country. These are the people who have been left out by the ALRA and had their rights significantly diminished by the 1998 amendments to the *Native Title Act 1993*. Clinging to the edges of towns or squatting on the pastoral properties that now occupy their traditional country, many live in conditions like those found in the most poverty-stricken parts of the planet. Government agencies are reluctant to provide basic infrastructure like houses and a water supply to those people who have remained on their land because they have no legal title to that land. They cannot claim land under the Land Rights Act that only allows claims over vacant Crown land (land owned by the government that no-one else is using or has an interest in). The changes to the Native Title Act largely removed the right of traditional owners to negotiate over developments on these lands[91].

A number of matchbox-sized CLAs have been secured on some pastoral leases in the Garrak-Jarru Region. These include three in the Borroloola region and three in the Victoria River District. There are a few outstanding CLA applications in the region including Victoria River and Nutwood Downs. There are many outstanding claims under the ALRA throughout the region and applications for determination of native title including St Vidgeon Station, Bing Bong and McArthur River in the east of the region and the Mirriuwung/ Gadgerong claim in the western edge of the region[92].

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87 *Ibid.*
88 *Ibid.*
89 West, M *Op. Cit.*, 1995.
90 NLC, *Op. Cit.*, 1998.
91 CLC & NLC *Op. Cit.*, 1995.
92 NLC, *Op. Cit.*, 1998.

There are a number of Aboriginal-owned pastoral leases in the region including Amanbidji and Fitzroy stations in the west of the region, Elsey Station in the centre and Bauhinia Downs in the east. The focus of land use by traditional owners varies from traditional usage and cultural maintenance to commercial grazing operations[93]. However, where commercial grazing has been pursued, viability is variable with stations like Amanbidji and Fitzroy having limited viability.

The east of the Garrak-Jarru Region has been at the centre of moves in the Top End of the NT for breakaway land councils. One push has been to establish a South-East Arnhem land council, separate to the NLC, centred around the Ngukurr and Numbulwar communities. However, this move appears to have only limited support in these communities. The Katherine-based Jawoyn Association has also been pushing for a separate regional land council, but established under the current ALRA and as part of a larger federation of land councils.

Most of the land in the area is classified as pastoral lease and utilised to run livestock, mostly cattle.

Katherine

Economic research by the NLC in Katherine in 1994-95 showed that 92 per cent of expenditure by Aboriginal organisations was made locally. Further, 43 per cent of Katherine business depended on the Aboriginal dollar for at least 20 per cent of their business and 35 per cent of Katherine businesses said that Aboriginal people and their organisations were their main customers[94].

The land needs of Aboriginal people in Katherine have been pressing for over fifty years. During 1945 over four hundred Aboriginal people were living in camps in Katherine. They were later shifted out to the 'Donkey Camp' located ten miles to the east. This policy of removal of Aboriginal people from the town was again expressed during the late 1940s when all unemployed Aboriginal people were ordered out of Katherine and moved to the settlements of Tandangal and Beswick. The removal of numbers of Aboriginal people continued through the 1950s[95]. Thus the initial government response to land needs was avoidance, removing the problem to other areas.

The Pastoral Industry Wage decision, technological changes on cattle stations and a down turn in the beef market all combined to accelerate the movement of Aboriginal people into Katherine during the 1960s. It is estimated that by 1970 Katherine's Aboriginal population numbered just over three hundred. Whilst removal was no longer an option, government authorities discouraged town camping and those who did camp were persuaded to use the High-level camp on the north bank of the Katherine River. The camp was away from the towns' shopping centre and more populated areas. Government policy addressing Aboriginal land needs in Katherine at this time was non-existent. For instance, a 1973 report on Katherine Land use did not mention Aboriginal people[96].

By the mid 1970s five major illegal camps were established around Katherine with a population base of several hundred. Living conditions in these areas were appalling. The Katherine Town Management Board never addressed the related issues of Aboriginal housing and land needs. The reasons being a pervading perception that any action would attract Aborigines to the town to drink which in turn would cause social embarrassment and lower land values.

The 1980s brought major changes to Katherine. The expansion of the Tindal RAAF base altered the urban structure of the town and brought with it a multitude of planning reports. During the parliamentary Public Works Committee hearing in 1984 the Katherine Aboriginal Action Group (KAAG) protested the developments.

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93 *Ibid.*

94 Ah Kit, J *Land Rights at Work: Aboriginal People and Regional Economies.* in NLC & CLC *Land Rights; Past, Present and Future.* 1996, p52.

95 Stead, J *The Aboriginal Land Rights Act (NT) 1976 - Successes and Failures.* in NLC & CLC *Land Rights; Past, Present and Future.* 1996, p204-205.

96 *Ibid.*

The proposed Tindal development protests eventuated in the commissioning of a report that examined Aboriginal land and housing needs. KAAG also sponsored a land needs study. Some action and improvement occurred, but the land needs were far from satisfied. A 1993 report estimated the need for; at lest 34 houses in current town living areas; a minimum of three new 'dry' (alcohol-free) town camps plus 50 houses along with support facilities; three additional living areas, to cater for 'long grass' (itinerant) campers and basic visitor camping areas. The Katherine Town Council, however, refused to support the establishment of any new town camps until the problem of public drunkenness was resolved, so too did the NT Government.
Aboriginal access to land in Katherine has been obstructed by government disinterest, competing European needs, and parochial European politics[97]. Above all, there is a racist perception that satisfying Aboriginal needs will open the town to immense numbers of 'drunken' Aboriginal people, the result being devaluation of land and property.

Wurli Wurlinjang is a community-controlled Aboriginal Health Service in Katherine set up in 1992. Its name comes from the Jawoyn land near the clinic that is associated with the mosquito dreaming paths. It provides a comprehensive PHC service to the Aboriginal population of the Katherine area. Katherine marks the convergence of three main Aboriginal language groups, the Jawoyn, Wardaman and Mayali, although there are 27 language groups in the region and these groups are represented in the Katherine population[98].

Jawoyn people have occupied their lands since the time of the Burr - the Dreaming. Among people over a large area of land from the Roper River to the Alligator Rivers, the term 'Jawoyn' is used to denote language, people and country. This is recognised by Aboriginal people throughout the region, Jawoyn and non-Jawoyn alike. It is also recognised by non-Aboriginal people: formally through legislative and other legal arrangements in the region, informally through local acknowledgement. Such Aboriginal territoriality is not uncommon throughout the Top End. Jawoyn traditional lands stretch broadly from around Katherine to the south around Mataranka where it adjoins Yangman and Mangarrayi country; from the south east and east to Ngalakan country; east and north east to Mainoru to Ngalkbon and Rembarrnga country; north east and north to Mayali country at the headwaters of the Mary, Katherine and South Alligator Rivers; north towards Pine Creek where it adjoins Wagiman lands and north west and west to Wardaman country[99].

To a large extent, they assert themselves as a single group defined by collective ownership of language and responsibility for traditional lands. Since the mid to late 1980s, this group self definition has increasingly been referred to as 'the Jawoyn nation'. This concept of 'nationhood' is relatively new, and is in the process of development. It should not be confused with western notions of nationality and the nation state, but rather should be viewed as a contemporary response to political and social pressures on the Jawoyn.

It is also a unified response to a variety of government and semi-government imposed administrative arrangements and boundaries that cut across traditional lands. For example, although the Jawoyn people have a role in two national parks, they must deal with instrumentalities from two different governments, Territory and Federal, in dealing with land management and other issues in those parks. Even within the Federal Government, the Jawoyn must deal with different regional offices: for example people at Pine Creek have Department of Employment, Education, Training, and Youth Affairs (DEETYA) programs administered from Katherine while ATSIC programs are administered from Darwin. The only instrumentality that has consistently dealt with Jawoyn along traditional country lines is the NLC[100].

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97 Stead, J *Op. Cit.*, 1996.

98 Jawoyn Association *Rebuilding the Jawoyn Nation : Approaching Economic Independence.* Katherine, 1994, Ch 2.

99 Jawoyn Association, *Op. Cit.*, 1994.

100 *Ibid.*

According to evidence presented in the Jawoyn (Katherine Area) Land Claim, there is a collective responsibility for their lands and sites on the land and, by inference, over economic and other developments on our lands. The first time this collective action was seen was during the proceedings of the land claim over Nitmuluk; it led in 1985 to the establishment of the Jawoyn Association and in 1991 to the establishment of the Association's Secretariat.

According to the records of the Jawoyn Association there are currently about 450 adult Jawoyn people. Most Jawoyn (about 90 per cent) live on or close to Jawoyn traditional lands, the majority in or close to Katherine township, either in 'town camps' such as Rockhole, Mayali-Brumby, Binjari and Jodetluk, or in town housing. Significant Jawoyn populations are also located at Wugularr, Barunga, Manyallaluk, Jilkminggan and Pine Creek. There is also one permanent out-station on Jawoyn traditional land at Werenbun. Smaller groupings of Jawoyn live in northern Kakadu National Park at Patonga, and Kunbarllanjnja in western Arnhem Land. Other Jawoyn people live in Darwin, Alice Springs, Nguiu as well as interstate[101].

The Jawoyn Association believes that economic development is not separate from socio-cultural development[102]. In a regional context, economic and social advancement for the Jawoyn benefits everyone else in the region including the non-Aboriginal population. The Jawoyn 5 Year Plan includes a Commercial Enterprise Plan, a Community-based Enterprise Plan, a Mining Plan, a Cultural Plan, and a Political Plan to ensure that the Jawoyn Association has a strong political voice with which it can promote the interests of Jawoyn and other Aboriginal people. An important element of this Plan is to promote links with industry bodies within and beyond the region.

As traditional owners of the Katherine region, they have sought in the last 15 years to develop economic independence and self-management: they have also sought to improve their relationships with communities of other Aboriginal and non-Aboriginal people in the Katherine region. This has not been an easy task for anyone involved. In the early 1980s Katherine had a national reputation as a 'racist town'; the controversy generated over the Jawoyn Land Claim became a focus of community disharmony and misunderstandings did nothing to enhance the town's image.

Much has changed since that time, and there is little doubt that Katherine is a better place than it was a decade ago. The establishment of the Jawoyn Association as a representative organisation for the Jawoyn community has had much to do with the changes, and the Association has been instrumental in changing attitudes within other communities in the Katherine region. Local government, business, sporting groups and schools all have benefited from these changes.

Over the last 14 years the Jawoyn have had some major achievements including the return of Nitmuluk National Park to Jawoyn traditional owners 1989, followed by immediate lease back to the NT Conservation Commission Land Corporation to be operated by the Conservation Commission of the NT as a national park 'to be shared by all Australians'. Nitmiluk National Park is run by a board of management with Jawoyn majority membership and Jawoyn Chairperson, plus NT and local government nominees. They also successfully argued, in 1991, first to the Resource Assessment Commission and then the Federal Cabinet, that areas of their traditional lands incorporating many of their most important sites in and around Guratba (Coronation Hill) should be protected rather than mined. In 1993 they negotiated and signed the 'Mt Todd Agreement' with the NT and Commonwealth Governments and Zapopan NL in the first native title agreement in the country. In exchange for title to lands, undertakings on jobs and training and community infrastructure, the Jawoyn people undertook to allow the extinguishment of their native title rights to the mine area and the Werenbun-Barnjarn area of land. This allowed the $1.5 billion gold mine to proceed and was the first post-Mabo native title mining agreement[103].

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101 *Ibid.*

102 *Ibid.*

103 Langton, M, Epworth, D, & Shannon, V. *Indigenous Social, Economic and Cultural Issues in Land, Water and Biodiversity Conservation.* CINCRM, Darwin, 1998.

Agreement resulted in an approximately 50 per cent increase in Nitmiluk National Park as a national resource. The Jawoyn Association has also been awarded a Brolga Award for Heritage Tourism (NT) for its Manyallaluk Tours, Eva Valley (1993, 1994, 1995 & 1996), and they took out Australian Tourism Industry Association national award in same category (1993)[104]. They have also entered into a number of joint venture agreements for exploration for diamonds in the Beswick Land Trust area and for exploration in lands to the east and north east of Katherine, known as Margalkmi Joint Venture.

The Jawoyn Association has been a member of NT Chambers of Mines since 1994 and is the first Aboriginal organisation in Australia to join a peak mining industry body. In 1997 a Jawoyn representative was elected to the NT Minerals Council - the first Aboriginal organisation to be represented on a peak mining organisation[105].

The term *Wardaman* can be used to describe the language, the land and the people traditionally associated with an area of land to the south west of what is now Katherine township. The Wardaman language is most closely related to Dagoman and Yangman languages, however, Wardaman is still spoken in Katherine unlike these other related languages. Wardaman land that has always been claimed by Wardaman people includes country from the upper reaches of the Flora River in the north to Scott Creek in the north west, then south along the major waterways towards the Victoria River in the west and to Romula Knob in the east[106]. Nowadays Wardaman people mainly live in and around Katherine, and in areas to the West including their traditional country. Many live at Binjari, located 12 km south west of Katherine on an excision from Manbulloo Station, and at Djarrung at the south west end of the Flora River Nature Park. Innesvale Station is owned and managed by Wardaman people and a small out-station has been established there. Some Wardaman people also reside at Wurrkleni out-station on Wurrkleni Creek, an excision on Willeroo Station, and in Katherine township.
The Flora River Nature Park, managed by the Parks and Wildlife Commission of the NT, is located on Wardaman land about 80 km south-west of Katherine. The 1,824 hectare park consists of a strip of land along the Flora River that encompasses some of the important natural, cultural and recreational features of the area. Some sections of the park, including Kathleen Falls, have been listed on an interim register of the National Estate of the Australian Heritage Commission, and some are also listed by the National Trust of the NT. These features are of spiritual significance to the Wardaman[107]. Wardaman country is also managed by the Parks and Wildlife Commission in the north east portion of Gregory National Park.

Kalkarindji and **Dagaragu** (formerly Wave Hill and Wattie Creek respectively) lie near the Buchanan Highway about 400kms south-west of Katherine. They were formed as a result of the Wave Hill strike and walk off in the mid 1960s. Dagaragu is an Aboriginal cattle station of approximately 3,200 sq. kms. The community lies about 15 kms from the main road, has few European residents and many of the basic services are located at Kalkarindji. It does have a store, formerly owned and operated by the Dagaragu Cattle Company but is now privately run. Kalkarindji is an 'open' town (ie. not an Aboriginal community to which entry is restricted). As the main service centre it has a much larger European population than Dagaragu[108].

The **Yarralin** community lies on an area of 230 sq. kms of land on Victoria River Downs Station, about 10kms from the homestead. The Yarralin population is drawn from families who, after initially abandoning the area to form the Wattie Creek community later decided to return to their own traditional country. Since the Wave Hill protest they have not worked in the Victoria River Downs stock camp, although many men would have done so in the past[109]. They now have their own cattle company, primarily a killer herd. The Yarralin community today remains highly dependent on Victoria River Downs for services. It has its own school and store.

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104 Jawoyn Association *Op. Cit.*, 1994.
105 *Ibid.*
106 Raymond, E *Wardaman Ethno-biology.* CINCRM & Parks & Wildlife Commission of the NT, NTU, Darwin, 1999.
107 Raymond, E *Op. Cit.*, 1999.
108 McGrath, A, *Op. Cit.*, 1987.
109 *Ibid.*

In the **Victoria River district** in the west of the Garrak Jarru Region, language groups were roughly distributed over pastoral stations according to their land ownership. On Victoria River Downs seven different language groups worked, residing mainly at out-stations where they had traditionally camped. Montejinni and Pigeon Hole were predominantly Mudbura, and on the head station Heinman and Ngaliwurru, while Mt Sanford was worked by the Billynarra. The local landowners composed the main labour supply for each out-station[110].

In a few cases whole groups had migrated away from their traditional territory to settle on stations. In 1928, the Warlpiri first moved to Kalkarindji or Wave Hill, and although 'peace ceremonies' were held, friction still exists between them and the local Gurindji[111]. The latter emphasise their greater sophistication in the ways of the cattle industry. The Warlpiri developed spiritual relationships with their relatively new locale, learnt its totemic meanings, and gained further ties through conception dreamings, birthplaces and mortuary rituals.

The NLC has assisted traditional owners in the **Borroloola** region with research into edible oyster, clam and red claw aqua-culture around Borroloola and has held discussions with Thai-Filipino aqua-culture interests. Ashton Mining Ltd has applied to negotiate a native title agreement for the Merlin Diamond Mine in the Borroloola area. The application was only the second native title negotiation relating to a mining operation attempted in Australia. In 1997 a joint Numburindi/ Wurrahaliba Fisheries Committee met in Borroloola to talk about issues relating to seas, such as dugong protection, marine environment, commercial fishing licences, and aqua-culture ventures from the Walker River to the Queensland border. Following meetings with the NT Fisheries Division, it was finally decided to close the waters in the southern Gulf of Carpentaria to commercial barramundi fishing to protect dugong. This meeting agreed to put into effect the Barramundi Fishery Management Plan - ratified by the Aboriginal run Wurrhaliba Fisheries Committee by the start of 1999[112].

At **Hodgson Downs (Miniyeri)** the local CDEP team has been working hard in a bid to re-establish a viable cattle station south east of Katherine. They've been breaking in horses, building fences and stockyards and droving cattle from the adjoining Elsey station. Learning skills from elders who grew up on Nutwood Downs cattle station. The old men were raised as stockmen. They remember visiting Vincent Lingiari and his people when they walked off Wave Hill station. They also remember the old tracks and water soaks throughout the region. The Miniyeri people want a successful cattle business because it will give them a strong economic base, and employment for their children[113].

At **Ngukurr** in the Roper River area the Aboriginal people, through the NLC, negotiated the Walgundu Agreement that saw the issuing of a mineral exploration licence with some benefits going to the local community. The exploration area is on part of the old St Vidgeons pastoral lease and is covered by the Wandarang Mara Alawa Ngalakan Native Title application. Under the agreement, mining company CRA agreed that it would not oppose the claim[114].

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110 *Ibid.*
111 McGrath, A, *Op. Cit.*, 1987.
112 NLC, *Op. Cit.*, 1998.
113 *ATSIC NT News,* 2nd Ed. September, 1999.
114 Raymond E. *Op. Cit.*, 1999.

CHAPTER 6 - OVERVIEW OF THE DETERMINANTS OF HEALTH

Before looking at models of PHC service delivery, gaps in services, and HSZs, it is important to consider the health status of Aboriginal people and why people are sick.

Aboriginal Health Status

We do not think it appropriate to go into great detail about Aboriginal health status here because it has been well documented elsewhere. However, it is important to appreciate that health status has changed significantly over the past 30 years. Key aspects of this change are:

1. Aboriginal infant mortality has declined from around 8 times the Australian average to just 3 times.
2. The young adult mortality has increased, however, over this same time period. This is due largely to conditions not readily addressed by medical interventions.
3. Premature mortality from chronic disease (diabetes, heart disease) has increased in the adult population.
4. The gap between the average Australian life expectance and Indigenous life expectancy remains around 20 years[1].

Why are Aboriginal People Sick?

In considering this question we have approached it in a number of ways.

Firstly we have examined the various ways in which Indigenous health has been considered over the years. Some of these perspectives we consider unhelpful except in assisting our understanding about where we have come from. Others are more or less useful and we have tried to outline what they have to offer. Most of these perspectives are not mutually exclusive attempts at explanation.

Secondly, we will explore recent research that challenges, or at least puts some limits on, some of the assumptions that public health has been largely based on over the past few decades. Specifically we apply the 10 messages developed by Marmot et al for the World Health Organisation to the project of improving Aboriginal health.

Thirdly we examine the models of PHC and how well they relate to the directions required to improve Aboriginal health according to the insights provided in the first two sections.

This logically leads into the discussion of how PHC services are currently provided.

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[1] Bhatia, K & Anderson, P *'An Overview of Aboriginal and Torres Strait Islander Health: Present Status and Future Trends.'* Aboriginal & Torres Strait Islander Health Unit, Australian Institute of Health and Welfare, Canberra, 1995.

Ways of Viewing Aboriginal Health[2]

An epidemiological framework examines data on disease and death rates in Aboriginal communities and compares them with non-Aboriginal rates[3]. This framework provides an analysis of illness in populations, a description of the problems, and, through the application of medical knowledge of particular diseases, it is possible to deduce some sense of underlying factors, eg poor nutrition that may be operating. However, it gives little insight into the underlying social, cultural, economic or political reasons for such a state of affairs.

Comparisons of Aboriginal health status with that of other colonised Indigenous peoples, particularly in Fourth World situations, and to examine factors that might explain documented differences[4]. Comparative studies, such as has been done by Kunitz, allow for speculative analyses of factors and what might have made the difference and suggest policy directions that may be useful.

Comparative studies of Indigenous health have often proceeded on an analysis that has emphasised the similarities of colonial experience. For example, the health situation of countries who were colonised by European powers, but were never numerically dominated by European settlement tend to be characterised by a resource deficit for health advancement, and have emphasised the importance of community based PHC developments as a way forward for better health. By contrast those Indigenous communities who were colonised and dominated numerically by European settlement have tended to be in resource rich environments, but have been marginalised from the main society. In the US and New Zealand, there has been a more simplified bureaucratic arrangement for dealing with Indigenous health. Whilst in Australia there has been a fragmentary bureaucratic approach due to the competing responsibilities of different jurisdictions[5].

A number of workers have looked at these communities that include Australia, New Zealand, North America (USA and Canada), and northern European countries such as Norway. The studies raise further questions, particularly for Australia. The health status of North American Indians, of Inuit and of Maori is significantly better than for Australian Aboriginal peoples and Torres Strait Islanders.

This is illustrated in the Table 7.

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2 Bartlett, B *Origins of Persisting Poor Aboriginal Health: An Historical Exploration of Poor Aboriginal Health and The Continuities of The Colonial Relationship as an Explanation of the Persistence of Poor Aboriginal Health*. MPH Thesis, University of Sydney, 1998.

3 For example, Plant, A, Condon, J and Durling G '*Northern Territory Health Outcomes: Morbidity & Mortality 1979 - 1991.'* NT Department of Health & Community Services, 1995.

4 For example, Kunitz, S.J. *'Disease and Social Diversity: The European Impact on the Health of Non-Europeans.'* Oxford University Press, 1994.

5 Bartlett B, Legge D *'Beyond the Maze: Proposals for a more effective administration of Aboriginal health programs.'* Congress, Alice Springs & ANU, Canberra, NCEPH Working Paper No 34, 1994.

Table 7: Life Expectancy at Birth, Indigenous Peoples, 1920s to 1980s

	Maoris[6]		US Indians[7]		Canadian Indians[8]		Aborigines[9]	
	Male	Female	Male	Female	Male	Female	Male	Female
1920s	47	45	NA	NA	NA	NA	NA	NA
1930s	46	46	NA	NA	NA	NA	NA	NA
1940s	48	54	51.3	51.9	NA	NA	NA	NA
1950s	57	58	58.1	62.2	NA	NA	NA	NA
1960s	61	65	60	65.7	59.6	63.5	50**	NA
1970s	63	67	60.7	71.2	57.8	60.3*	NA	NA
1980s	65	68	67.1	75.1	64	72.8	54	61.6

Source: Kunitz, S.J. 'Disease and Social Diversity: The European Impact on the Health of Non-Europeans.' Oxford University Press, 1994, p24.

* Alberta ** Northern Territory

In Table 7, it can be seen that figures for Australian Aborigines were only available from the 1960s, and then only for the NT, which was still under Commonwealth Government administrative control. These figures show that the life expectancy for Maori and North American Indigenous peoples was about 10 years better than for NT Aborigines (although only male figures were available). However, perhaps the most telling feature of this table is the lack of figures for Australian Aboriginal and Torres Strait Islander peoples. This reflects the lack of attention being given to the issues and the fragmentary bureaucratic responsibilities in relationship to Indigenous health in Australia.

Clearly, the simple analyses that Aboriginal people have been colonised, that they have been numerically dominated by mass European settlement, and are thus marginalised, with traditional health care systems and economic activities destroyed, and living conditions imposed according to the needs of the invading settler society are inadequate explanations. All of these things are important ways of understanding much of the situation Indigenous Australians find themselves. The poverty, and accompanying poor living conditions, poor nutrition and societal fragmentation have all played a major part in the creation of a society where disease and death are so prominent. However, these factors also apply to the other countries under examination in Kunitz's comparative studies. Something else has made a difference to them, but not to Australia.

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6 Pomare EW *'Maori Standards of Health: A Study of the 20 Year Period 1955 - 1975* (Auckland Medical Research Council of NZ, Special Report Series no 7, 1980); E.W. Pomare *Hauora: Maori Standards of Health: A Study of the Years 1970 - 1984* (Auckland Medical Research Council of NZ, Special Report Series no 78, 1988); I. Pool *'Mortality Trends and Differentials'* in *population of NZ (Bangkok: Economic and Social Commission for Asia and the Pacific, 1985).*

7 Indian Health Service *'Trends in Indian Health - 1989. Tables* (Rockville, MD: Division of Program Statistics, Office of Planning, Evaluation and Legislation, Public Health Service, Department of Health and Human Services, 1989.

8 Millar, WJ *'Mortality Patterns in a Canadian Indian Population.'* Canadian Studies in population 9 (1982): 17-31; Ministry of National Health and Welfare *'Health Indicators Derived form Vital Statistics for Status Indians and Canadian Populations, 1978-1986'* Ottawa ministry of National Health and Welfare , September, 1988.; Medical Services, Department of National Health and Welfare *'Life Tables, Registered Canadian Indians, 1960 -64.'* Ottawa: Department of National Health and Welfare, n.d.' The registered Indian population of Alberta is about 12 to 13 percent of all registered Indians.

9 Thomson, NJ *'Inequalities in Aboriginal Health'* (MPH thesis, University of Sydney, 1989) p 39; Gray, A *Discovering Determinants of Australian Aboriginal Population Health'* Working Paper, NCEPH, ANU, 1989, p11.

One factor is that, of the four countries under consideration, only Australia has failed to sign a treaty or other agreement with Indigenous peoples. Until the High Court's Mabo decision of the early 1990s, Australian law formally took the view of *terra nullius* - that is, that the continent was legally empty of people. This obviously false absurdity set the tone for dealing with Aboriginal affairs.

What is the significance of a treaty, and why might this be important to the improvement of a people's health status? Firstly, a treaty implies some sort of sovereignty between two parties. Whilst it is beyond the scope of this report to pursue the notion of sovereignty, we have assumed throughout that Aboriginal peoples are a distinct people who occupied this country for 50,000-140,000 years, and who identify themselves as belonging to this country in ways which those from elsewhere can barely imagine, and that this is a major consideration in how health services are developed and delivered, and how other social determinants of health have been shaped.

In Canada, part of the treaty obligations of the Canadian Government (at least to Treaty Indians) was the provision of health care services. Some of the resistance to current proposals of the Canadian Government to increase community control over health services is related to the fear by some that this will nullify the Canadian Government's Treaty obligations[10].

There are other differences in colonial histories that might help inform us as to why such life expectancy differences persist. In the USA, the Indian Health Service (IHS) was developed over 100 years ago, initially under the auspices of the Federal Indian Affairs Bureau. In the 1970s the IHS became a branch of the US Public Health Service. As a national service it bi-passed the complexity of State/ Territory administrations, and developed into a service agency focused on health service delivery and an objective of being controlled and operated by Native American people, which has largely been achieved.
In New Zealand there are no states, and thus responsibility for Maori health has always rested with the central Government.

However, in Australia, it is the States that are constitutionally responsible for health services, and the Commonwealth Government only became involved in the early 1970s. Thus there is a fragmentary bureaucratic arrangement for the administration and funding of Aboriginal health that is confusing, opaque and allows cost shifting to occur.

A political economy view relates Aboriginal health status to the economic circumstance in which people live[11, 12]. This approach relates people's health status with their socio-economic status in society. A political economy analysis offers more detailed understandings of the underlying factors producing poor health status, and there is little doubt that this analysis is particularly relevant to Aboriginal health. People without economic activity have few options for improving their life condition, and are thrown into a state of dependency by poverty and reliance on welfare. But it is not immediately obvious what the policy ramifications of this analysis are, except to assert that it is a matter of keeping in mind the 'big picture' – that is that improved health status of populations come out of changes to people's socio-economic status. How policy can impact on this needs careful thought. In recent years housing, water and sewerage have become a proxy for socio-economic status in Aboriginal health. It has been the high priority of reports since the 1979 House of Representatives Report. Of course, inadequate housing, poor water and sewerage will create conditions perfect for the proliferation of micro-organisms, and thus infections of the gastro-intestinal tract, skin, eyes, ears and respiratory tract will be common, particularly amongst children living in such conditions. That is only part of the story involved with Aboriginal health. Substance abuse, for instance, is not easily explained by physical living conditions alone.

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10 Scrimgeour, D *'Community Involvement in Health Services for Indigenous Peoples of Canada, Norway and New Zealand.'* Menzies School of Health Research, Alice Springs, 1994, pp5-6.

11 Saggers, S and Gray, D, *op. cit.*

12 National Health Strategy *'Enough to Make You Sick: How Income and Environment Affect Health.'* National Health Strategy, Research Paper 1, Canberra, 1992.

A culturalist view understands Aboriginal health disadvantage as a problem of the clash of cultural assumptions and values[13]. This might also be referred to as *cultural dislocation*, focusing on disruption of Aboriginal culture, and the differences between the dominant culture and Aboriginal culture. The culturalist view offers insights into cultural values, which challenge assumptions of absolute values often made by dominant cultures. The importance of people maintaining their language is an integral part of this view. However, this view runs the risk of seeing culture as a static phenomenon, and has a tendency to look back at what was, rather than confront and embrace what is. Another view is that living cultures change constantly, and that this is a strength of a people, particularly in terms of their capacity to adapt to changing circumstance. Further, culturalist explanations avoid questions of structural inequalities such as economic inequalities, and power inequalities. An appreciation of cultural differences is an inadequate explanation of poor health status.

The health transitions literature has examined overseas experience in order to understand different ways populations have achieved better health status. Caldwell[14] has identified three aspects required to take the so-called low road to health. The high road to health has involved economic development that has enabled the bulk of populations to acquire the health hardware required of good health (shelter, clean water and sewerage) along with a standard of living that enables good nutrition and a generally high degree of control over ones life. The low road is the road to health that has been achieved in some countries such as Sri Lanka and Cuba where the economic developments have not occurred. However life expectancies have increased dramatically and approach that of 'high road' nations. The factors thought to be necessary to this progress towards good health are:

- The education of women;
- Women having independence of agency;
- A free or cheap (ie accessible) PHC system;
- Political fervour, vision.

In Australia, Aboriginal communities are caught in a developmental dilemma. Economic disadvantage and poverty is the norm, whilst the country in which they live is amongst the wealthiest. Educational successes in many communities are limited, and indeed progress towards reasonable levels of literacy appears to have stalled or got worse[15,16].

In some communities, women do have some independency of agency, but not in others. In most communities, there is access to some sort of PHC - probably mostly emergency medical care rather than a more comprehensive style of PHC. However, the political fervour and vision, a feature in the Aboriginal community controlled health service leadership, is frustrated by lack of acceptance and challenge to their legitimacy by government authorities, and some health professionals.

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13 Some health promotion programs in Aboriginal health have emphasised this view. An example is the Healthy Aboriginal Life Team (HALT) which emphasises a return to traditional kinship responsibilities as a way of overcoming petrol sniffing in remote communities.

14 Caldwell, JC & P *'The Cultural, Social and Behavioural Components of Health improvement: The Evidence from Health Transition Studies.'* In Robinson, G (Ed) *'Aboriginal Health: Social & Cultural Transitions'* Proceedings of a conference at the NT University, Darwin, 29-31 September, 1995.

15 Collins, B *Learning Lessons: An independent review of Indigenous education in the Northern Territory* NT Dept. Education, 1999.

16 Boughton, B *What is the Connection between Aboriginal Education and Aboriginal Health?* A Discussion Paper of the CRC ATH Indigenous Health and Education Research Programs, Systematic Review Project (IE0031), November, '99.

A racial inferiority or genetic view focuses on hypothesised genetic differences in anatomical structure and/ or physiological function resulting in an increased susceptibility to disease. Anthropologists of yesteryear were preoccupied with measuring cranial capacities, facial angles, etc. Conclusions were reached as to the significance of these differences in terms of where Aboriginal people were in a notion of linear development of Homo sapiens to the highest form, which was, of course, the Nordic races. Historically, Europeans commonly argued that Aboriginal people were sick because of genetic inferiority and impaired ability to compete, and were doomed to extinction. Darwin's theory of evolution that talked about a biological *survival of the fittest* was applied to social contexts and formed a theory known as Social Darwinism. Whilst this view is no longer widely held in academic or professional circles, it was a widely held view in the past up until the 1950s. It was central to the body of knowledge known as Eugenics[17], which was the ideological underpinning of various projects in the UK, USA, Scandinavia and Australia. It was also the ideological underpinning of the Third Reich in Germany. Eugenics fell into disrepute after the holocaust against Jews, Gipsies, homosexuals, communists and others in Europe.
Eugenics is based broadly on the theory of biological determinism. Few researchers are pursuing work based on this theory. However, the more scientifically grounded field of modern genetics is pursuing some genetic questions relevant to Aboriginal health in some very narrow and specific areas such as alcohol metabolism, and diabetes (eg the thrifty gene theory).
Eugenics is a racist theory and there is little evidence to support it. Further, it is not useful in informing the project of improving Aboriginal health, except that the current circumstance of Aboriginal people has been significantly affected by the widespread acceptance of these views in the past. Clearly assimilationist policies, including the practice of removing children from their families, were largely based on eugenic thinking.

A psychosocial maladaptation view has been proposed as a major cause of Aboriginal ill health. Cawte, a psychiatrist who did work assessing mental health problems in some Aboriginal communities stressed the problems of what he called psychosocial adaptation[18,19].

Saggers and Gray[20] outline a criticism of Cawte's psychosocial maladaptation theory in terms of a probable overestimate of mental illness in Aboriginal communities due to methodological problems, his under-emphases on the influence of poverty and the economic environment in which Aboriginal people live, and his assumption that mental illness amongst Aborigines is a consequence of inappropriate cultural values rather than the injuries of colonisation. Further, a distinction should be made between mental illness as such and mental health or mental stress. A strong argument can be made that a degree of anxiety, and mental distress is a normal response to the high levels of morbidity and mortality Aboriginal people experience in their families and communities, the general living conditions and poverty in which they live, and the effects of dispossession. Emotional responses to these factors are indeed adaptive and part of normal human responses.

A Colonial Relations view recognises that Australia is dominated by people from all over the planet in a continuing process of colonisation that began with the British 212 year ago[21]. The colonisation of Australia was marked by enormous depopulation through disease, massacres and poverty. Despite these histories, the Indigenous population is growing, and more able than ever to engage the dominant society to have Indigenous interests represented.

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17 Tucker, WH '*The Science and Politics of Racial Research.'* University of Illinios Press, Ulbana, 1994.
18 Cawte, JE *'Cruel, Poor and Brutal Nations.'* University Press of Hawaii, Honolulu, 1972.
19 Cawte, JE '*Social and Cultural Influences on Mental Health in Aboriginal Australia: A Summary of Ten Years Research.'* Transcultural Psychiatric Research Review 13, 1976. p28-38.
20 Saggers, S and Gray, D, *'Aboriginal Health and Society: The traditional and contemporary Aboriginal struggle for better health.'* Allen & Unwin, 1991, pp 9-11.
21 Bartlett, B *Op. Cit.* 1998.

For the health sector, it means coming to terms with the fact we are dealing not with the rump end, the disadvantaged and marginalised section of our own society, but with a different people. The former are leaderless, and live as isolated individuals or families. They struggle to survive one day at a time whichever way. They become the regular fodder of our welfare services – social workers, child protection teams, etc. The latter have spiritual and cultural ties that are probably stronger in some respects in the face of their histories than might otherwise be. The are marginalised socially and economically from the dominant society, but have their own social structures, mores, Laws, and customs. And they have a leadership. As within the mainstream, not everyone will follow and support that leadership, but it is nevertheless a feature of contemporary Aboriginal society. The histories have put this society under great strain. The project for improving Aboriginal health is intimately related to the project of reconstruction of Aboriginal society, including strengthening leadership.

None of these frameworks for understanding poor Aboriginal health provide sufficient explanations on their own. Indeed, the racial inferiority and psychosocial maladaptation frameworks are more problematic than useful. The colonial relations framework, I suggest, offers further insights into the question. An historical analysis which emphasises two divergent world views coming together with little shared understandings, and with one side prepared to pursue dominance at all costs, shows the roots of contemporary relationships played out in health service delivery. It helps explain the insistence of Aboriginal people on community control of PHC, their distrust of governments and those working for them. It helps explain why Aboriginal health is persistently poor.

The development of dependency through imposed policies involving food rationing, communal kitchens, restriction of people's movement, reliance on pensions and other social security payments, and removal of children have helped shape the pattern of disease and suffering currently experienced by many Aboriginal people. This is related to Aboriginal people being defeated in Australia's forgotten war. But whilst Aboriginal people were defeated, they have never ceded sovereignty and they continue to resist, albeit in subtle form. The consequence of that defeat, however, is the institutionalisation of Aboriginal society through Government settlements and missions, psychiatric hospitals and gaols. These are not merely the stories of poverty, and socio-economic marginalisation, but are the stories of colonial domination of a people. The continuities of dependency and domination tends to be seen, not only in the high incarceration rates, but in the way that so much of Aboriginal life is controlled through government departments. This applies just as much to health as to any other part of life.

The history of massacres, stolen children and continuing high mortality rates, coupled with marginalisation and discrimination has impacted on people's mental health status with recurrent grief being a dominant feature of Aboriginal lives. Generational and recurrent grief, along with some people's crises of identity (as a consequence of stolen generations and more general societal disruptions), play a role in undermining individual self-esteem and community efforts to improve social and economic conditions of life.

These factors underlying Aboriginal ill health are not amenable to medical interventions, although the process of delivering medical interventions offers opportunities for the strengthening of Aboriginal society. How medical interventions are delivered can either contribute to the long-term solutions required to achieve sustainable improvements in Aboriginal health, or further entrench the dependency and marginalisation that is at the centre of the problem.

Risk Factors and the Social Determinants of Health

Over the past few decades public health has been increasingly focused on the concept of risk factors. The identification of risk factors for particular disease processes has come from the use of epidemiological and statistical methods able to associate particular factors with disease. Thus smoking is related statistically to the occurrence of lung cancer, emphysema, ischaemic heart disease and other cardio-vascular disease. These associations are not actually causes, but the stronger the association the more tempting it is to conclude that a causal relationship is involved. Thus the health industry has increasingly focused on risk factors as a way of trying to prevent particular illnesses.

Risk Factors commonly identified as relevant in Aboriginal health include:

- Poor diet, especially high intake of refined carbohydrates and fat;
- Substance misuse - alcohol, solvents, tobacco, marijuana;
- Lack of exercise;
- Obesity;
- High blood pressure;
- High serum cholesterol levels;
- Inadequate fluid intake;
- Unhygienic living conditions;
- Sick dogs;
- Unprotected sex.

However, extrapolating risk factors derived from population data to individual client risks is somewhat reductionist and have questionable validity. Looking for high cholesterol levels, and treating them is dealing with risk factors as if they were a disease. Some have suggested that this can actually be self-fulfilling. Someone being told that they have high cholesterol levels that can increase their chance of heart disease commonly causes a physiological reaction that can add to the risk of heart disease. Of course, it may also prompt a change in behaviour that can reduce the risk. However the ability to change behaviour is related to broader social questions and where the individual sits within social strata. Thus someone of high socio-economic status and high self esteem is more likely to be able to change their behaviour, whereas people living in poverty and who feel bad about themselves are unlikely to reduce their risk of disease through behaviour change. For Aboriginal people, most of the risk factors listed above are largely related to marginalisation and poverty.

Marmot and others[22,23] have written extensively in recent years about this other effect - an effect related to social hierarchy and individual self-esteem; about how the width of the gap between rich and poor is an important determinant of the life expectancy in a society; that it is not just to do with absolute poverty levels. They point out that these are large effects, not just minuscule statistical findings. They estimate that only around 30% of disease is accounted for by risk factors. Thus to some extent risk factors may be determining which disease process is activated rather than whether a disease is activated or not.

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[22] Evans RG, Barere ML, Marmor TR *Why are Some People Healthy and Others Not? The Determinants of Health of Populations.* Aldine de Gruyter, NY, 1994.

[23] Marmot M & Wilkinson RG *Social Determinants of Health.* Oxford University Press, Oxford, 1999.

The World Health Organisation (WHO) asked Marmot to put together 10 key messages for better health based on this new work. They came up with the following:

1. ***The Social Gradient*** - people's social and economic circumstances strongly affect their health throughout life. One implication of this is that health policy should not be confined to Departments of Health, but need to run across the whole of society. Aboriginal society has increasingly been pushed to the margins by the dominant colonial society. Even in remote communities the dominant day-to-day influence tends to be in the realm of non-Aboriginal priorities. Thus this factor is a major factor for Aboriginal society.
2. ***Stress is harmful***, particularly chronic, unresolved stress. We mentioned above how the width of the gap between rich and poor is a major determinant of health. For Aboriginal people, they are surrounded by the physical wealth and power of white fellas. This is a stressful circumstance. It is difficult for people to break out of a life that is marked by stress as a consequence of high levels of substance misuse, poor educational and employment opportunities, and surrounded by a lifestyles of another people that cannot be attained. This is an example of chronic, unresolved stress.
3. ***The effects of early life last a life time***, which means their need to be stronger support for mothers and children. Whilst the development of child and maternal programs can help in this area, the main focus tends to be on the physical welfare of the mother and child that does not really go to the heart of the matter. It may improve people's self esteem and confidence much more if Aboriginal women are seen doing this for themselves, rather than the 'experts' and the best paid health staff always being non-Aboriginal.
4. ***Social exclusion*** is harmful. This relates to poverty, and is particularly relevant for marginalised groups in society. Aboriginal society has been excluded from the dominant society from the time of the missions and government settlements to the settlements on the outskirts of towns, incarceration in gaols and psychiatric wards, and the general discrimination that limits access to jobs, and opportunities in the mainstream.
5. ***Stress in the workplace*** increases the risk of disease. This is not referring to the busy executive, but those who lack control in the workplace. Where Aboriginal people do have work, it is often in the lower levels of the organisation, where they can exert little influence over their needs.
6. ***Unemployment and job insecurity*** increase the risk of disease. Aboriginal society suffers a high level of unemployment, so this too is relevant.
7. ***Strong social support*** can prevent disease. This refers to friendships, supportive networks, and good social relationships at home, work and in the community. Aboriginal society has tended to form strong networks as a means of survival. These networks are a positive feature that can be strengthened and nurtured, or weakened by government interventions. Community controlled health services are based on these networks and work to strengthen them. Control of services outside those networks can be potentially damaging to them by creating division within communities.
8. ***Addictions***. Misuse of alcohol, tobacco and other drugs are damaging to health. However, the use of these drugs is influenced by the social gradient with the lowest socio-economic group having the highest rates of misuse. Thus the social position and poverty are themselves are determinant of addictive behaviours. Clearly this is a major issue in Aboriginal society.
9. ***The provision of high quality food***, including the recognition of this as a political matter, not just of individuals choosing to eat good food. This can be seen particularly in some remote communities where the quality of food provided in the store is very poor, and very expensive.
10. ***Transport*** also relates to health. Using forms of transport that encourage exercise - walking, bicycles, etc. has a positive impact where continuing reliance on motor vehicles not only does not involve exercise, but also contributes to pollution, greenhouse effect, etc. However, for Aboriginal people in communities outside major centres, transport is critical to health in many other ways - catching food, getting into town for shopping, education, health care, etc. Thus there are two sides to this question for Aboriginal society.

There are a few common factors that emerge from this list:

- Stress and powerlessness.
- Poverty.
- Social relationships.

Clearly the health sector cannot address all of these issues directly. However, how services are delivered and who controls them are critical factors in terms of a health service moving beyond just treating sick people (as important as that is) or telling people what they should do.

Significance for Aboriginal Primary Health Care.

Sanders and Werner have written about the problems that comprehensive PHC has faced since that practice was acknowledged and enshrined in the WHO Alma Ata Declaration in 1978[24]. Comprehensive PHC was community driven and based – that is it was a horizontal process with priorities and directions being driven from the community. At their best Aboriginal community controlled health services work this way to great effect. However over the years many agencies including the WHO, UNICEF and the World Bank, along with national governments and professional bodies have opted for selective rather than comprehensive PHC.

Werner[25] has described three major obstacles in implementing comprehensive PHC:

1. Selective PHC that was introduced on a broad scale in the early 1980s.
2. Structural Adjustment policies including cost recovery or user-financed health services. This has particularly been imposed on poor debt laden countries by the World Bank, but has also been a persisting political influence in health service development in Australia.
3. The takeover of Third World health policy by the World Bank marked by its 1993 Report *Investing in Health.*

Some examples of selective PHC are seen in immunisation programs organised from central agencies (ie vertical programs). Sanders and Warner document the negative impact of packaged and marketed Oral Rehydration Salts (ORS) that have in some places increased the dependency of people on a supply system for dealing with diarrhoea, rather than maintaining knowledge about the effective use of locally available and cheap alternatives[26].
The World Bank in its 1993 Report took an approach using economic rationalist language (eg *best buys*). This report essentially recognised that poor, marginalised populations were not useful to the world economy, and that providing support, albeit targeted and selective according to the estimated 'worth' of the individual using a measure of Disability Adjusted Life Years (DALYs), was an *investment* in economic terms[27].

These obstacles that undermine the functioning and further development of comprehensive PHC is driven by a range of influences, but at the centre is an economic system that makes profit out of ill health. Thus commercial interests (the market place) are more interested in developing products that can be marketed rather than support for a self-reliant alternative. This encourages a focus on technical fixes, rather than people led solutions.

The recent evidence in regard to the determinants of health as outlined above suggest that comprehensive PHC may have the capacity to impact on a range of these determinants linked to power and self esteem which selective interventions from outside the community actually exacerbate.

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[24] Werner, D & Sanders, D *Questioning the Solution: The Politics of Primary Health Care and Child Survival, with an in-depth critique of Oral Rehydration Therapy.* HealthWrights, Palo Alto CA, 1997.
[25] Werner D *Globalisation and Primary Health Care* Keynote Address, PHA Conference, Darwin, 1999.
[26] Werner, D & Sanders, D *Op. Cit.*, 1997.
[27] World Bank *World Development Report 1993: Investing in Health.* Oxford University Press, NY, 1993.

This is relevant to Aboriginal communities. More Aboriginal people delivering services may be more important than precisely which services are delivered. Comprehensive PHC services have the potential to be a vehicle for community action in regard to problems they perceive, and in the wider sense assist the reconstruction of Aboriginal society.

These issues make community control not just a slogan and rhetoric but a *key determinant for improved health* in the longer term.

CHAPTER 7 - CURRENT SERVICE PROVISION

This section provides an overview of how PHC and support services are currently provided in the Top End of the NT. Details about each community are included in the Appendix 7, Community Profiles with overviews in the section of HSZs in Chapter 9.

A. Primary Health Care

PHC to the Aboriginal communities in the Top End of the NT is delivered in a number ways:

1. directly by THS;
2. by community controlled health services (mostly OATSIH funded);
3. through THS SAs with Community Councils or other non-government organisation (eg Resource Centres).
4. CCTs;
5. a combination of the above models, including private general practitioners (GPs).

An analysis of the numbers of people accessing the different types of PHC service in the Top End reveals a high number of situations involving more than one type of service (designated *Combined*). This complexity of PHC service delivery is a source of confusion for the community and sometimes creates competition amongst providers. In some communities this has tended to undermine teamwork, which is a hallmark of best practice in PHC. In an environment of scarce physical and human resources these dynamics undermine efficiency and effectiveness, as well as reducing the opportunities for communities to take more control. Simplified arrangements would be more practical, encourage teamwork amongst health service staff, reduce the amount of resource expended on administration and would give communities greater opportunities to take some level of control over the health services provided.

Figure 14: Top End Aboriginal population estimates that receive PHC Services through various models of service delivery.

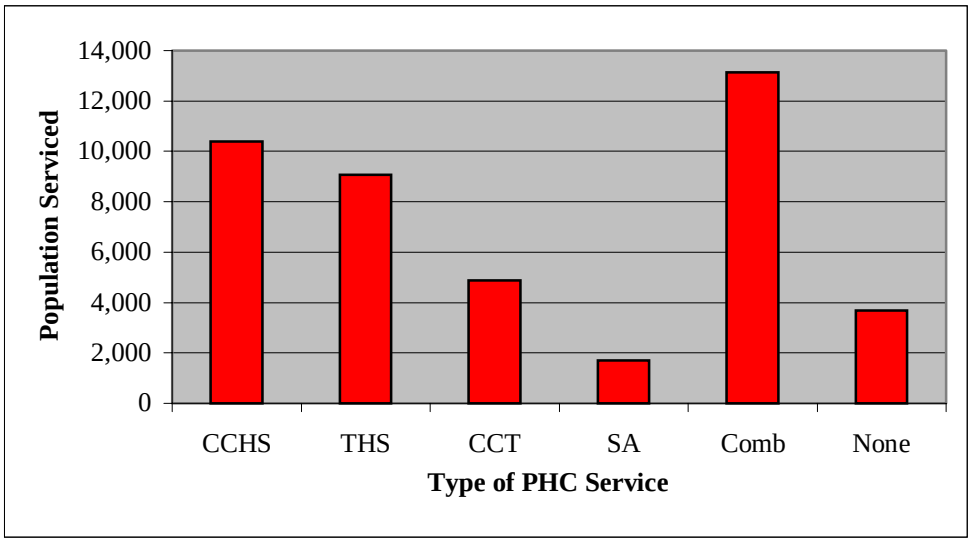

Table 8: Number and Percentage of Population by Type of Service Accessed.

Type of Service	Population Serviced (Number)	Population Serviced (%)
Community Controlled	10,395	24.3
THS	9,070	21.2
CCT	4,885	11.4
SAs/ Community Councils	1,695	4.0
Combination	13,130	30.6
None	3,690	8.6
TOTAL	**42,815**	**100**

Figure 14 and Table 8 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 five 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 Danila Dilba in Darwin and Wurli Wurlinjang in Katherine. It also does not take into account the greater choice that town-based people have (eg accessing hospital, community health centres 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. We have included all population groups who have organised access to one of the five types in the appropriate category. Those out-stations and homelands that have no organised access (either resident health service staff, or organised visits, no matter how frequent) have been designated as having no service.

A feature of these results is the large number of people (13,130) who have access to a combination of services. This reflects a growing complexity in service delivery that we view with some concern, as this complexity complicates staff relationships and reduces the opportunities for community control of PHC.

The 3,690 people, who were designated as having no service, are people living on communities/ homelands/ out-stations that have no resident PHC service staff, get no visiting service, 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 many of those who have been counted as receiving a service of one of the five types have been included because they receive a visiting service that is sometimes very infrequent and cannot be considered adequate. Others receive quite frequent visits, but are large enough to warrant a resident service.

1. THS Delivered PHC Services.

The following communities receive their PHC service solely through THS:

Alyangula
Angurugu
Barunga
Wugularr
Bulman
Jilkminggan
Mataranka
Milingimbi
Milyakburra
Miniyeri
Ngukurr
Umbakumba
Woodycupaldiya
Wadeye (Port Keats)
Yirrkala

Whilst Alyangula has a private GP who largely services the non-Aboriginal population and the mine, we have not counted the non-Aboriginal population or that GP. The only services we have included in our analysis are controlled by THS.

Miniyeri, Angurugu, Milyakburra, and Umbakumba were identified as RCI sites in the first round announced in 1997, though no health service resources from this have been implemented at the time of writing.

Jilkminggan, Barunga, Bulman, Beswick and Ngukurr were identified in the Interim Report of the Top End Planning Study as areas of need according to our staff: population ratio analysis. However, the interim analysis was based on unverified data, and the final analysis in this report is a more accurate assessment of relative need.

Whilst the development of health councils or boards has been attempted in many communities for a number of years, none of these communities have a currently functioning health board/ committee/ council.

The Jawoyn Association are proposing the development of a new CCT involving Barunga, Wugularr (Beswick), Gullin Gullin (Bulman), Weemoll, Manyallaluk (Eva Valley), Banatjarl, Werenbun, Gimbat, Jilkminggan, Mataranka, Mainoru, Mountain Valley and Conway Stations..

The dominant services provided 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, the number of 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.

None of the PHC services delivered through THS have resident doctors, but receive medical officer visits at varying intervals. Batchelor has a resident private GP who also visits Adelaide River. Otherwise, District Medical Officers (DMOs) are employed centrally in Darwin and Katherine, and spend significant amounts of time in the central location and travelling. It is widely recognised that doctors are better able to provide general practice services, as well as some public health support when resident in the community(s) being serviced. The NTRHWFA has assisted in operationalising doctor positions in communities.

Nurses and AHWs have generally 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[1].

2. THS Funded Health Services through Service Agreements

THS funded SA services include:

- Belyuen
- Daly River (Nauiyu Nambiyu)
- Minjilang
- Peppimenarti
- Warruwi

These services are funded through a SA between THS and the Community Councils or Homelands/ Out-station Resource Centres. The Agreement is for the delivery of clinic based PHC 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 nurses and AHWs.

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. Generally, administrative and other support is not funded.

[1] Tregenza, J & Abbott, K *'Rhetoric and Reality: Perceptions of the roles of Aboriginal Health Workers in Central Australia.'* Central Australian Aboriginal Congress, Alice Springs, 1995.

The model of PHC service developed through the '*SA'* (previously known as *Grant In Aid*) arrangements has been the subject of strong debate as to whether they offer any real possibility of community control, and whether these arrangements hand responsibility for PHC services to Community Councils without adequate resources, and specifically health service administration. There is evidence that these services have been under resourced[2]. Since that report difficulties have continued at Palumpa and the Council has recently handed back responsibility for the running of its health service to THS. Difficulties relate to the lack of opportunities for in-service training, relief staff, and administration/ management support. Some of these issues are further discussed in the section on Community Control in the *Proposed Model of PHC service Delivery* (Chapter 8). Resources for health service management are necessary for these services to better develop the *means* of control. A lack of these resources has resulted in services becoming isolated from regional health service supports, and other PHC networks.

Potentially, this SA model could be reformed into a comprehensive PHC model under community control.

3. OATSIH Funded Community Controlled Health Services.

These are:

- Danila Dilba Biluru Butji Binnilutlum Medical Service (Danila Dilba), Darwin
- Wurli Wurlinjang, Katherine
- Miwatj Health, Nhulunbuy

All OATSIH funded services have medical officers employed and (except in the case of Miwatj) resident in the community where the service is delivered. All have nursing staff employed, although nurses employed at Danila Dilba and Wurli Wurlinjang mostly have roles other than clinical. Such roles include public health, health education, AHW education, and clinical support. They also have administrators, and managers employed, as well resources provided for cleaning, transport and maintenance activities.

Whilst Miwatj Health are included here, they operate somewhat differently to the other services in this category. They provide services to a number of communities in the North East Arnhem Zone, and tend to supplement services controlled by other providers. Thus in our analysis of how communities are services, many Miwatj serviced communities are included in the Combined category.

These services are clear about the model of service delivery they aspire to – community controlled comprehensive PHC. This includes general practice clinical services (sickness services, clinical public health programs - immunisations, communicable disease control, child health & maternal health, Pap smear programs, etc,) as well as community based programs aimed at addressing underlying causes of ill health. These are described in more detail in the section on *Proposed Model of PHC Service Delivery.*

These services provide clinic based as well as outreach services to associated population groups (town camps and out-stations).

Danila Dilba and Wurli Wurlinjang are developing Social and Emotional well-being programs which complement the psychiatric services provided through their clinics. These programs are not directed at psychiatric illness as such, but rather the emotional distress many community members experience as a consequence of the histories of dispossession (including the stolen generations) and of poverty and marginalisation. These services offer counselling support to people and families. However, there is a larger vision that these programs will develop innovative ways of assisting the community as a collection of people with some shared experience (rather than individuals) to deal with the suppressed grief and anger evidenced by continuing violence and substance abuse within the community.

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[2] Scrimgeour, D *Report of Review of Nganmarriyanga Community Health Service* Menzies School of Health Research, Darwin, 1992.

These OATSIHS funded services are the ones that have claimed to be the fully Aboriginal community controlled health services. In the Top End they are all larger services compared to the situation in Central Australia where there are a number of small stand alone services. Scrimgeour[3] has pointed out the difficulty of people in these smaller communities taking complete control. Issues of health service management, financial management, health program development, implementation of public health programs, managing professional staff, etc are complex and sophisticated matters that are performed within the mainstream by highly qualified professionals. In many bush communities education levels are low, and people's experience of a health service extremely limited. Thus in these smaller services non-Aboriginal administrators and other staff appear to be the ones actually in control. However, the health committee or councils in these small services have frequently asserted their control when they have felt it necessary eg when a doctor or nurse has been working contrary to the perceived needs of the community.

There have been times of instability in OATSIHS funded health services, but no more than in communities serviced in other ways. Such instability is a product of the dynamics within the particular community, not the model of PHC service delivery.

The advantages of community controlled health services are:

- Access to decision making by community members, at least when they perceive it necessary;
- Responsiveness of the health service to local issues;
- Not constrained by bureaucratic requirements in decision making apart from constraints imposed on funding.

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. Centrally controlled services, on the other hand, are often constrained by the clerical demands of the bureaucracy and cumbersome and often inflexible hierarchal decision making processes.

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. These are issues that need to be addressed through collaborative planning processes.

4. Coordinated Care Trials

CCTs were established as part of a Council of Australian Governments (COAG) review of possible funding options. Coordinated Care was specifically directed at addressing the needs of people with chronic illness and disabilities. However, a number of Aboriginal CCTs were established as a means of funding all PHC needs of the defined population. Both the DHAC and THS have pursued this option with a great deal of commitment, and allocated significant resources to help establish the trials. In the NT there are two CCT sites:

1. Tiwi
2. Katherine West

Key strategies of the NT Trials were:

- A flexible funding pool;
- Care Coordination;
- Community control.

Health Boards were established in these areas representative of the client communities. The funding arrangements were based on THS providing the funds that they had previously spent in the designated areas to the respective Health Board, and the Commonwealth contributing the average per capita Australian utilisation of MBS and PBS on the basis of imputed populations for the CCT areas, with an increase later in the trial if enrolments exceeded 90%.

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[3] Scrimgeour, D *Rethinking Community Control: A Core Services Approach to Health Care in Remote Aboriginal Communities.* Paper presented to Rural Health Conference, Perth, 1997.

The HIC use Standard Weighted Patient Equivalents (SWPE) in various formulas used for calculating various funding arrangements including the funding of Divisions of General Practice, Practice Incentive Program, Immunisation Incentive Program, and GP Rural Retention Grants. These funding arrangements were not clear at the time the conditions for the Trials were established. For the Tiwi Health Board (THB), by not bulk billing they estimate that 2,000 SWPE are lost. This is around 1% of the NT population. The potential loss of income is significant and has had to be weighed against the disadvantage of bulk billing clients and the administrative work load that entails.

The Tiwi CCT found it necessary to bulk bill all children under 7yrs of age in order to take advantage of the funds from the immunisation incentive's program which requires identification of which children are clients of particular practices, as well as their immunisation status. The level of funding is determined by Health Insurance Commission (HIC) data generated from Medicare billing practices. For any clients enrolled in the Trial and are bulk-billed, the following occurs: the bulkbilled service is paid by the HIC to the GP and the cheques forwarded to the THB. At the same time a bill is generated for that trail patient by the HIC to the DHAC, and then to the THB who pay this bill monthly. For patients who are not Trial clients, the HIC pay the THB (via the GP) but do not generate a bill to DHAC and THB. These non-Trail patients are the source of a small amount of extra funds.

The complexity of this system is one of the problems of the CCTs. Some of the increased administrative burden relates to the requirements of the evaluation process needing to access HIC data. Other aspects, however, are not so easy to overcome without a change in the way some program areas are funded (eg client sign up). These experiences are important to consider in the light of the development of the PHC Access Program that has some similarities to the CCTs. Although extra funding was provided for some of these extra functions, it is still an additional overall burden that contributes to making PHC service delivery difficult.

The Boards initially operated as purchasers of health services from providers, but this eventually changed so that now the THB is actually the provider of PHC services, and the Katherine West Health Board (KWHB) is providing services to 4 of its communities, and purchasing services from THS for the remainder.

The theoretical weakness of applying the funder-purchaser-provider split to the NT is that there are a limited number of providers available, so that the cost-effectiveness and efficiencies generated by the assumed competition of providers is not operative. Indeed in the two CCT areas there was only one provider, THS. Thus, the Boards determined that it was better to deliver services that they controlled.

The THB provides PHC services to:

1. Nguiu;
2. Pirlangimpi (Garden Point); and
3. Milikapiti (Snake Bay)

The KWHB is responsible for services to:

1. Dagaragu (Wattie Creek) – services provided by Health Board.
2. Kalkarindji – services provided by Health Board.
3. Lajamanu – services purchased from THS.
4. Timber Creek – services purchased from THS.
5. Yarralin – services provided by Health Board.
6. Bulla - services purchased from THS.
7. Pigeon Hole - services purchased from THS.

A clinic operates without resident health service staff at Mialuni (Amanbidji),

The CCT were established as a Trail for a set period of 18 months and included an evaluation requiring participants to give consent to the evaluators accessing client information from the HIC normally not available. Thus individual consent had to be obtained in order for people to be included in the trial. The complexity of this was particularly problematic for Katherine West due to the vast area covered by the Board, and the diversity of communities within the area. Tiwi, on the other hand, found this process, whilst no doubt tedious and a waste of resources, much easier to achieve.

Care coordination for the Trials is based on Standard Care Plans for the whole population and for specific prevalent conditions. Guidelines Standards and Audit Team (GSAT) standards have been installed into the new computer information system, Coordinated Care Trial Information System (CCTIS). There have been concerns expressed in the KWHB Evaluation[4] that the CCTIS has increased the workload of staff, does not function optimally as an effective tool in health service delivery, and is dependent on communications technology in health centres that is not always present.

The benefits of the CCTs are:

- Increased funds into the designated areas;
- Increased community involvement and control through the Health Boards;
- Increased health services implemented.

The disadvantages of the CCTs have been:

- The enrolment process has consumed resources for little gain;
- Administrative requirements have been complex;
- The evaluation process has been onerous on the Health Boards;
- As the cash out of MBS/ PBS entitlements involve a cap on funds, this could disadvantage communities in the future.

5. Combination of Health Service Models

The way these services are delivered are varied. The combinations are briefly described in the following list:

- Adelaide River – THS delivered service, plus a private GP.
- Bagot – THS SA plus private GP.
- Batchelor – THS delivered service, plus a private GP.
- Binjari - THS SA plus private GP.
- Borroloola - THS delivered service plus private GP.
- Jabiru – THS delivered service, THS SA and NTRHWFA grant to Djabulukgu Association.
- Galiwin'ku – THS SA and NTRHWFA grant to Council plus a part time Miwatj doctor.
- Gapuwiyak – THS delivered service, OATSIH fund a homelands nurse and AHW, plus Miwatj doctor.
- Gunyangara – THS and OATSIH SA plus a Miwatj doctor.
- Laynhapuy Homelands - THS and OATSIH SA plus a Miwatj doctor.
- Maningrida – THS delivered service and Resource Centre employed doctors.
- Numbulwar - THS delivered service, and THS SA with the council for AHWs.
- Oenpelli (Kunbarllanjnja) – THS delivered service, OATSIH SA with Demed Association who contracts THS to service out-stations, and a doctor employed by Kunbarllanjnja Council.
- Palumpa – THS delivered service, and OATSIH SA with Council for employment of AHWs.
- Pine Creek - THS delivered service, plus a private GP.
- Ramingining – THS delivered service, OATSIH SA with Resource Centre who contracts THS for the employment of an Homelands nurse.
- Robinson River – THS delivered service plus private GP.

Adelaide River and Pine Creek have mostly non-Aboriginal populations.

In addition to the above services primarily for Aboriginal people, in Darwin, Katherine, Alyangula, Jabiru and Nhulunbuy there are private GPs or GPs employed by mining companies who whilst providing some service to Aboriginal people, are predominantly servicing the majority non-Aboriginal community. Many of these GPs, however, operate from THS provided facilities.

[4] d'Abbs, P *Katherine West Coordinated Care Trial: Local Evaluation – Mid-Term Report* Menzies School of Health research, Darwin, July, '99, pix.

In Darwin, three Community Care Centres operate from Darwin, Palmerston and Casuarina. These consist of predominantly nursing staff along with allied health professionals. The services provided include some general PHC and some service to Aboriginal people. However, most of the services provided are narrowly focused on particular community needs such as child health, palliative care, early discharge care and domiciliary care. For the purposes of analysis we have included 1 nursing position in the Darwin area as being involved in Comprehensive PHC, along with the only AHW employed in these Centres. However, we have included Darwin as a population serviced by a Community Controlled Health Service, as this is the only arrangement specifically organised to provide PHC services to the Aboriginal and Islander population of Darwin. Bagot has been included separately from this.

In areas with hospitals, some Aboriginal people also access the hospital Accident and Emergency Department. THS, however, are unable to identify how many are genuine PHC practice as compared to legitimate accident and emergency work. We have not included these resources in our analysis.

Other THS Services

THS Management Structure[5]:

We have included this in some detail, although we are aware that THS have been in the process of a re-structure for most of the previous 12 months. We have only selected the areas that are particularly relevant to Aboriginal PHC services. A weakness in THS programs is that some programs (eg women's cancer screening) operate as selective PHC interventions that tend to clash with the Aboriginal health service model of comprehensive PHC.

OPERATIONS NORTH

THS delivers health services through four Districts that are:

- Darwin Urban, based in Darwin.
- Darwin Rural, based in Darwin.
- Katherine, based in Katherine.
- East Arnhem, based in Nhulunbuy.

These Districts make up OPN. The OPN *Regional Director* integrates and coordinates the activities of OPN with other central support Divisions and Operations Central of THS. S/he also participates in intersectoral forums at national and Territory level. *OPN Executive Support* assists with Regional directors' work and coordination of special projects, coordinates the Divisional budget, provides administrative support, customer relations and specialist outreach.

The *Deputy Regional Director* provides regional program support – Family and Children's Services (FACS), mental health, dental, evaluation & policy; manages regional programs and NT Aerial Medical Service (NTAMS) and manages regional support services – workforce planning, recruitment and quality management.

Darwin Rural Health Services

Darwin Rural is administered from Darwin. It provides a range of health and community services to both THS-run and SA health centres and provides support services to staff including:

- FACS
- Aged and Disabled – coordinator, physiotherapist, occupational therapist and speech pathologist
- Mental Health
- DMOs

Darwin Urban Health Services

Darwin Urban, administered from Darwin, has Community Care Centres at Darwin, Palmerston and Casuarina. There are also specialist units in the program areas of:

- *FACS*
- Aged and Disability
- Some PHC services

Palliative Care Program provides education, support and advice to the whole OPN area.

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[5] *Territory Health Services Annual Report 1998-99*, NT Government, Darwin, 1999.

Katherine Health Services/ Katherine Hospital

Katherine District, administered from Katherine, provides health and community services through an urban community health centre, a hospital and remote community health centres. It is sub divided as follows

- Community Services
- FACS
- Aged and Disabled
- Allied Health
- Community Health East/West
- Mental Health
- Rural Medical Officers
- Hospital

East Arnhem Health Services/ Gove Hospital

East Arnhem District, administered from Nhulunbuy, provides health and community services through:

- an urban community health centre
- a hospital
- remote community health centres

The District also provides support services to PHC staff including:

- FACS
- Aged and Disabled - occupational therapist and speech pathologist
- Mental Health
- Hospital Medical Officers
- Hospital - physiotherapist

OPN Regional Programs

These include:

- Children's Services
- Pensioner Concessions
- Non-government Liaison Services

Top End Rural

- NTAMS
- Oral Health Services
- Process Improvement Resource Team

ABORIGINAL & COMMUNITY HEALTH POLICY & CORPORATE SERVICES

Primary Health & Coordinated Care

1. Urban
2. Rural
3. Aboriginal Health
4. Oral Health
5. General Practice

Research Coordination

Program Review

Staff Development Services

Strategic Workforce Planning Unit

Office Services

Employee Relations (Out-posted)

HEALTH PLANNING & SYSTEMS SUPPORT

Aged & Community Care

Disability Services

Acute & Specialist Care

Business Information Management

Epidemiology

Finance & General Services

Health Economics

Hospitals & Development Project

Inter-Government Relations'

IT Services

Office of Senior Territorians

Overseas development Projects

PUBLIC HEALTH, FAMILY & CHILDREN'S SERVICES & CHIEF HEALTH OFFICER

Public Health

- Public Health Strategy Unit & Health Promotion
- Alcohol & Other Drugs (A&OD)
- Centre for Disease Control and Women's Cancer Prevention

This includes communicable disease control (immunisations, TB control, STD/ HIV programs) as well as PAP smear programs and breast cancer screening.

- Environmental Health, Radiation, Pharmacy & Poisons
- Medical Entomology
- FACS

THS & Health Promotion

The Public Health Strategy Unit is administered from Darwin and has the responsibility for pursuing THS Health Promotion strategies. They administer *Health Promotion Incentive Funds* and Top End project's funded in 1998/99 included:

Men's Health

- Kunbarllanjnja Men's Health Project
- Well Men's Checkups - Galiwinku
- "Play It Safe" football carnival

Nutrition

- Nguiu Child Care Centre Nutrition Program
- Healthy Eating - Maningrida
- Dental Health and Nutrition Program

Environmental

- Greening Yameeri and Wathunga
- Dust Suppression - Miniyeri
- Likkaparta Dust Suppression
- Mialuni Dust Control Program
- Galiwinku Scabies Jingle
- Scabies Project - Milingimbi/ Ramingining

Other Projects

- Smoking Project - Numbulwar
- Gapuwiyak Community Education Project
- Beswick Christmas Holiday Program (Prevention of Petrol Sniffing)
- Protective Behaviour (Child Protection)
- Adelaide River/Batchelor School (Heart Health)
- Resource Public Health Training
- Battle Of the Bands – Galiwin'ku (World No Tobacco Day)
- Daly River Healing Concert
- FIG JAM Concert Fringe Festival

Each project receives only around $5,000. The Unit also provides advice and support to District Health Promotion workers, but they have no line management responsibilities for these workers. We have no information about results of evaluation of these projects although we were assured that they had been very successful. We also have no information as to what criteria the Unit uses to select projects for funds. However, in our data collection and verification phases that involved contact with a range of community-based organisations (both health centres, and non-health organisations such as out-station resource centres), these health promotion activities were not mentioned. We were told that part of the Unit's role was to help build community capacity. However, there appeared to be no vision about how they were to do this.

In 1998 THS commissioned a review of its health promotion program[6]. The process of this review was limited to interviews with THS staff, and compared the health promotion strategies of THS with theoretical and international perspectives. There is no analysis in the report of the context in which THS is operating. There is no recognition of the way services are delivered – that is, that not all are delivered through THS but rather through community controlled health services, and some through other organisations such as community councils. Further there is no recognition that the context of improving health status in the NT is overwhelmingly dominated by the question of overcoming poor Aboriginal health status represented by a 20 year deficit in life expectancy compared with non-Aboriginal Territorians. Despite these fairly obvious issues the Review failed to interview anyone outside THS. This is a further example of an external review of THS operations that have been carried out with no inputs from outside the organisation. This is not only poor methodology from an intellectual stance, but fails to provide THS with fresh views. But most importantly it fails to recognise that there actually exists a network of dynamic community health organisations that have provided the main thrust in changing how health services are delivered, and who have provided leadership both locally in the NT and nationally in the struggle to improve Aboriginal health. This leadership is accountable to the community that health promotion professionals are apparently trying to develop or build their capacity. Surely a Review should engage the community politic in its attempt to assess the validity of the THS Health Promotion Strategy.

We believe that these sorts of programs and their reviews need to be brought under the structures of the Framework Agreement, so that important questions such as community capacity are brought under the Aboriginal health leadership rather than being left to the intellectual constructs of non-Aboriginal health professionals.

Strategy 21

Under Strategy Twenty First Century THS are moving into a funder / purchaser / provider split framework. The strategy has three aspects – strategic intent, core business focus and stretch goal areas[7].

Strategic Intent

To create and enhance a Territory-wide network of services which delivers continuing improvement in the health status and well-being of all Territorians.

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[6] King, L & Ritchies, J *Promoting Health in the Northern Territory: A Review.'* WHO Regional Training Centre for Health Development, School of Medical Education, Faculty of Medicine, University of NSW, April 1999.

[7] Strategy Twenty First Century *Strategic Intent* Territory Health Services, 1999.

Strategic Directions are identified as being:

- public health
- primary level care
- acute & specialist care
- community services
- organisation support

The Core Business Focus is stated as:

- policy leader in health for Territorians
- funder/ purchaser of government-approved health services
- NT's lead provider of non-commercial health services
- a catalyst for total health solutions, achieved intersectorally

Stretch Goal Area are identified as:

- strengthening community capacity
- a quantum shift to service delivery by others
- a significant increase in aboriginal involvement in the health workforce
- total health solutions through intersectoral collaboration

There are a number of significant issues included in the strategy that could significantly influence how Aboriginal health services are addressed. Particularly the intent to move towards funder/ purchaser/ provider split provides opportunities to enhance community control of services.

The strengthening of community capacity, however, needs to be brought under the direction of the Aboriginal health leadership as part of the way of further advancing community control as part of the reconstruction process. We have discussed the problematic notion of small communities isolated from the broader Aboriginal politic elsewhere.

Provision of Specialist and Allied Health Services to Communities.

Specialist Services

Specialist services to the regional hospitals and remote communities in the Top End are all coordinated from Darwin but have diverse means of coordination and funding. There are currently three ways in which this occurs:

The *Specialist Outreach Program* is funded jointly by OATSIH and THS. The program employs a coordinator and an Obstetrician/ Gynaecologist who spends 3 days a week providing an outreach service and two days in RDH. Other specialists are permanent employees of THS based at RDH and include Surgeon, ENT and Eye Specialists who are all permanent employees of THS and are based at RDH.

The coordinator organises visits for the gynaecologist, surgeon, ophthalmologist and the ENT specialist. The coordinator also oversees the administration of budget, organises equipment for minor procedures and communicates with PHC services in communities regarding frequency and duration of visits. A medical secretary organises the scheduling of patients to attend clinics, admission to hospital, pathology tests and radiography appointments, typing of letters for each patient seen by a specialist and travel arrangements for specialists. The coordinator travels with the Obstetrician/ Gynaecologist to assist with the mobile colposcopy clinic. The majority of visits to communities involve the Obstetrician/ Gynaecologist and the Eye Specialist.

During the visits any patient requiring review by a specialist is seen, this includes new referrals, reviews of patients recently discharged from hospitals and patients seen during a previous visit. This is organised by the PHC service in the community. If required, minor surgical procedures are performed at the community health centre, or referred to the regional hospital. The gynaecologist carries a portable ultrasound and colposcope that avoids the necessity for many women to travel to larger centres for these services.

The frequency of visits varies and is dependent largely on the size of the population of a community. Nhulunbuy and Katherine receive a visit 8 weekly varying in duration from 2 to 5 days. Visits can vary from 1 per year to 1 per 2nd monthly. Physician visits are based on an assessment of need by the DMOs or GPs working in PHC settings and negotiated with the visiting physician.

The specialists travel mostly by air, either charter or commercial. During the dry season some of the communities are accessed by road. Routine visits to out-stations/ homelands are rarely made. Any out-station residents requiring a specialist consultation are usually brought in to the main community.

Specialists, other than the Obstetrician/ Gynaecologist usually travel to communities alone and rely on assistance from PHC staff, mainly Registered Nurses (RNs) and AHWs. If procedures are to be performed, a nurse will accompany them.

Specialist physician services are coordinated by the THS Community Physician. This position was set up in 1996 specifically to act as a liaison point between hospital staff (esp. medical specialists) and community staff. The specialists' travel and accommodation costs are met from the PATS budgets of the districts to which they travel. Mechanisms of remuneration to the specialists vary: some are salaried and do not bill at all, others bill Medicare, others are given a sessional fee (eg in the CCT communities where Medicare has already been *cashed out*).

Specialist paediatric services are coordinated by the community paediatrician who is based at the Centre for Disease Control in Darwin. S/he also has responsibility for child health public health program policy, development and implementation. S/he visits some communities herself as well as attending ward rounds at the RDH. Visits occur about every 2-3 months and are based on size of community, community PHC service requests and the periodically assessed needs of the community. Both public and private paediatricians are involved in these visits. They organise their own visits. The private paediatricians are paid by THS on a sessional basis. The service is reviewed each year in consultation with the PHC staff in communities and a schedule of visits for the next 12 months developed.

Most specialist visits are day visits except those to regional centres when visits may be for 2-3 days during which the specialist may visit a number of communities as well as conduct outpatient clinics in the regional hospital.

Allied Health Services

A range of allied health services are organised at the THS District level.

Darwin Rural

Allied health services in the Darwin Rural District include:

- Physiotherapist
- Occupational therapist
- Speech therapist
- Disability coordinator

Aged care and disability programs also operate in this District.

Darwin Urban

A wide range of allied health services are available in the Darwin Urban District and are organised into four units:

- Specialist Adult Health Team:
  - Occupational therapist (2)
  - Physiotherapist (2)
  - Psychologist (1)
  - Continence RN (1)
  - Respiratory RN (1)
  - Spinal RN (1)
  - Stomal RN (1)

- Community Care Centres:
  - AHW (1)
  - Community Health Nurses -including after hours. (72.5)
  - Disability Information Officer (3)
  - FACS Worker (7)
  - Family Support Worker (2)
  - Social Worker (1.5)

- Community Health Paediatric Team:
  - Occupational therapist (2)
  - Physiotherapist (1)
  - Speech pathologist (3)

- Sexual Assault Referral Centre:
  - Sexual counsellor (2)
  - Social Worker (1)

There are also aged and disability services based in Darwin Urban. Some of these services (including the specialist RN services and palliative care) offer advice and support to all THS Districts in the Top End.

Katherine

Allied health services in the Katherine District include:

- Occupational therapy
- Physiotherapy.
- Speech therapy (part-time)
- Aged Care Assessment Team (ACAT) – Occupational Therapist

The dental position has been vacant.

All of these positions visit remote communities in both the South East Top End, Katherine East and Katherine West HSZs.

East Arnhem

Allied health services in the East Arnhem District include:

- Occupational therapy
- Physiotherapy
- Speech therapy
- Aged Care Coordinator

The Physiotherapist is based at the Nhulunbuy Hospital and visits to remote communities are restricted.

Allied health services appear to be poorly integrated with community PHC services. This is partly due to the scarcity of allied health professionals available to visit communities.

There are a number of programs operating in the Top End including AACT, Commonwealth Rehabilitation Service (CRS), Northern Rehabilitation Networks, Guide Dogs Association, NT Education Department hearing programs in schools, OATSIH Hearing Programs in the major Community Controlled Health Services, and the National Acoustics Laboratory program.

Community-based aged care and disability services are fairly basic and require more focus and development. A recent report has focused on these issues and advocated the employment of community-based disability workers[8]. We support this proposal and would add that they should be located within the PHC services in communities. Many allied health services are not available to communities, and access is only available if people go to Darwin, or other major centres. These include podiatrists, orthotist/ prosthetist, counselling services, dieticians/ nutritionist, audiology, and dental/ oral health services.

Mental Health Services

The management of mental health service delivery is the responsibility of the Regional Directors. In Darwin there is a mental health program manager for mental health services who has responsibility for both in patient and community based services.

General Adult Inpatient Services
Inpatient services are collocated at the RDH. There is a 12 bed acute ward, a 7 bed low dependency ward and a 9 bed secure ward.

General Adult Community Based Services
There are two community based teams in Darwin Urban that provide assessment, treatment, consultancy and case management services. There is also a non residential rehabilitation program in Darwin for clients with serious mental illness and a mobile, extended hours is also available.

Darwin Rural, Katherine and East Arnhem have resident community health teams that are supported by a visiting psychiatrist. Services include assessment, case management, community education and clinical support to PHC providers. Services are mobile and workers facilitate access to acute inpatient care as appropriate. Whilst priority is given to those with severe and chronic mental illness, this has to be balanced with the community demands for a range of services (eg crisis and counselling interventions) in the absence of alternative providers.

Darwin Rural has a senior Mental health worker based in Darwin supported by two clinical nurse consultants with Aboriginal Mental health workers in some communities. Katherine mental health team is supported by a mental health committee. East Arnhem is supported by Aboriginal Mental health workers employed by Miwatj Health.

Services for Children and Adolescents
The Specialist Child, Adolescent and Family Service in Darwin provides a community based assessment, treatment and consultancy service for children and adolescents with mental disorders up to the age of 18years where effective intervention is not available through other services.

Forensic Psychiatry Services
The Forensic Team in Darwin provides assessment and treatment services for juvenile and adult remandees and sentenced offenders with mental disorders. The team also provides input to the care of forensic inpatients, provides a community based sex offenders treatment program and a consultancy service for criminal justice agencies.

Staff Development/ In-Service Training

In-service education is provided to nursing staff, and relief staff is 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 Aboriginal Cultural Awareness Program (ACAP) is operating in all THS districts. This is an orientation program consisting of four phases.

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[8] Curry R, *Allied Health Therapy Services in Aged and Disability Care in Remote Aboriginal Communities of the Northern Territory: A Framework for Quality Service Provision* Top End Division of General Practice, Darwin, 1999.

Other Service Initiatives

Fly-in, Fly-out Female General Practitioner Service.

This service was funded by the Commonwealth through DHAC in the 1999-'00 Federal Budget. Previously a program run from RDH targeted communities in the Top End that did not have access to a female practitioner and were perceived as having poor access to women's health programs, especially PAP smears, and fertility control information.

The budget announcement was to expand these services to other remote communities. Unfortunately, this occurred without discussion with the community sector involved in the provision of PHC services, or the collaborative planning forums established under the Framework Agreement. Attempts are currently being made to rectify this situation in an attempt to shape this program to be a support for comprehensive PHC rather than remaining a selective PHC program that undermines the former. So far this funding has not been allocated, and the expanded service has not been commenced.

Eye Health Program

OATSIH has funded a program involving the employment of eye AHWs in the Top End to promote and coordinate better eye health services to Aboriginal communities. This program is expected to start in early 2000.

Sexual Health Programs

OATSIH administer the National Indigenous Sexual Health Strategy for the NT. This involves allocating funds to programs aimed at addressing sexual health issues with a particular focus on STD/ HIV control and male health issues.

THS run a sexual health unit which provides practical public health services for the control of STDs/ HIV including assistance to PHC services for treatment and contact tracing.

B. Evacuations

THS provide a 24 hour consultation (by phone or radio) service to remote communities and an emergency retrieval service when indicated. Medical evacuations are carried out in conjunction with St Johns Ambulance and/ or Pearl Aviation (contract and charter aircraft). Evacuations may include a combination of road and air transport and the retrieval team may consist of a doctor and nurse, depending on the physical condition of the patient. The responsibility for the road transport component of evacuations usually falls on the local PHC service that will transport the patient to the air strip, or to meet the St Johns Ambulance half way. The significance of this role for many PHC services is illustrated by the common circumstance where 4 wheel drive vehicles have been converted into community ambulances. The mode of evacuation is determined by a number of factors including distance from the major centre, the presence of an air strip, the condition of the air strip, the time of day and the weather.

The overall responsibility for evacuations comes under the General Manager, Top End Rural. Evacuations are done by district but there are different arrangements within each. THS has a centralised contract with Pearl Aviation that has a plane in each district. A fourth plane is available for backup. If one plane is in use another may be utilised from elsewhere. THS provide the medical staff but different arrangements operate in each district. Nurse escorts are employed by NT Aerial Medical Service (NTAMS). The NTAMS provide an evacuation service to the whole of the Top End, with consultations done by regional DMOs.

Darwin Rural District

Emergency calls are made to the RDH switch which contacts the DMO on call who consult with whom ever is making the call. If a decision is made to evacuate that DMO will arrange the aircraft and an NTAMS nurse. An RDH specialist or anaesthetist provides doctor escorts when indicated.

East Arnhem District
Emergency calls are made to the Gove District Hospital. The hospital doctor on call consults with the caller. If evacuation is indicated, the hospital doctor will arrange the aircraft and an NTAMS nurse. The hospital provides the doctor escort when indicated.

Katherine District
Emergency calls are made to the Katherine District Hospital. The DMO on call consult with the caller. If evacuation is indicated the DMO will arrange the aircraft and an NTAMS nurse. The DMO provides medical escort when required.

The main advantages of these arrangements where the DMO conducts the initial consultation with PHC staff, and hospital doctors provide medical escorts is that it allows the initial decision to be largely made by the doctor working in the PHC sector, but leaves the actual escort work to hospital doctors who are more likely to have the current technical skills required for this task.

Patient Assisted Travel Scheme

The Patient Assisted Travel Scheme (PATS) assists those in remote areas to access specialist treatment including outpatient clinics and diagnostic procedures where such services are not available in the community of residence.

PATS do not provide support for transport where the community of residence is less than 200 kms from where services are to be accessed. This is a major issue for many communities who fall into this category. Not only are they unable to access PATS support, but they are often not given priority for the allocation of transport resources from funding bodies as they are deemed too close to major centres. Thus they lose out both ways. This policy restriction should be reviewed.

C. Substance Misuse Services

Alcohol, tobacco, sniffing and kava continue to be misused in many Aboriginal communities of the Top End, although kava and petrol is a problem only in some communities. However, of growing concern to both community members and service providers is the excessive use (some claim increasing[9]) of gunja (marijuana) and prescription drugs, the appearance of other illicit drugs and poly-drug use.

Drug use is related to mental health problems as well as to youth boredom. Many youth suicides have been related to drug misuse. NT Mandatory Sentencing laws have added to family tensions and appear to have an adverse effect on youth self esteem with jail adding to the problems being experienced by this group.

In the Top End there is one detoxification centre in Darwin and four residential rehabilitation programs – two in Darwin, and one each in Katherine and near Daly River. There are no specific petrol sniffing programs. Sobering up shelters operate in Darwin and Katherine which are referred to as the 'spin-dry' model which provide clients with a meal, a clean bed, washed clothes and a shower.

Funding Sources and Issues

Funding for substance misuse programs is from OATSIH and THS through their A&OD Program and Living With Alcohol Program (LWAP) program. Aboriginal Hostels Limited (AHL) also provides some support for residential aspects of programs. In some residential programs, clients make a financial contribution. All services we spoke with expressed concern at the ongoing difficulties in acquiring adequate resources.

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[9] *Annual Report for the Groote Eylandt and Bickerton Island Substance Misuse Program 1997-98*, Angurugu, 1998.

The LWAP is involved with the following funding programs:

- Alcohol and Other Drugs;
- Community Grants Program;
- National Drug Strategy;
- Wine Cask Levy;
- Criminal Justice Program;
- NT Domestic Violence Strategy;
- Community Education;
- Professional Education and Training Program;
- Remote Aboriginal Program;
- Research and Evaluation Program;
- Sexual Assault Program; and
- Treatment and Care Program.

The LWAP began in 1991 and has funding committed until 30 June 2000. The NT Cabinet is yet to make a decision regarding the future of funding arrangements. Whatever the decision, it is likely that all programs will have to re-justify their programs to attract further funding.

Substance Misuse Service Providers

Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties

Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties (FORWAARD) is an Aboriginal community controlled organisation incorporated in 1978. It evolved from a voluntary service begun in the late 1960s for the "long-grassers" and out of town drinkers. Founding members provided a ‘drying out’ night shelter, using their own resources.

Current services include:

- information on alcohol and related problems;
- running a 12-18 week residential alcohol rehabilitation program for men and women. This is a 16 bed facility
- day care program
- visits to remand prisoners and prisoners due for parole at Darwin prison, including the preparation of court assessment reports;
- women’s prisoner program and Outreach Programs;
- community visits and field trips to Katherine, Ngukurr, Kalkaringi, Timber Creek, Oenpelli, Daly River and Tiwi lslands;
- follow up programs;
- counselling
- family support and referrals;
- telephone information and confidential advice;
- provision of information on Alcoholics Anonymous (AA) program meetings, times and venues;
- in house AA meeting weekly, including provision of transport;
- training of Aboriginal alcohol workers;
- liaison with other providers.

FORWAARD Residential And Day Care Program

The program is a Twelve Step, holistic approach with abstinence as the goal and incorporates the cultural values of the client's family group. Clients may enter the program after they have detoxified and been medically examined by Danila Dilba clinical staff.

FORWAARD strives to achieve a reduction in the incidence of alcohol related problems of Aboriginal and Islander people whose lifestyles are relatively well established within the broad Darwin area, including Bagot, Kulaluk, One Mile Dam, Knuckey's Lagoon, 15 Mile Camp, and Palmerston down to Humpty Doo.

Referrals are also taken by FORWAARD from areas across the NT, including Central Australia. Sources of referral include NTG Departments and Authorities including Correctional Services, the Courts, THS, Aboriginal Legal Aid Services (Darwin, Alice Springs and Katherine) and the Australian Legal Aid Commission in Darwin. AA groups throughout Aboriginal communities in the Top End (as well as non-Aboriginal people) seek the assistance of FORWAARD programs.

FORWAARD currently requires and is seeking funding for new premises on land set aside by NTG.

Aboriginal & Islander Medical Support Service Incorporated

The Aboriginal & Islander Medical Support Service Incorporated (AIMSS) is an Aboriginal organisation that was incorporated in 1979 after a failed attempt by Aboriginal activists in Darwin to establish a community controlled health service[10]. It is controlled by an Aboriginal Management Committee.

AIMSS states its aims as the promotion and advancement of good health and well being of Aboriginal, Islander and non-Aboriginal people from disadvantaged circumstances living within or visiting the Darwin & Palmerston regions.

It is located at Coconut Grove in Darwin and runs the Darwin Sobering Up Shelter, the Darwin & Palmerston Night Patrol as well as a medical transport service and a wheelchair transport service. The transport service is mainly focused on getting people to and from RDH.

The Night Patrol helps people in public places who are drinking or intoxicated, exhibiting anti-social or violent behaviours and youths or small children who are at risk of harm. They may take people to the sobering up shelter, an emergency shelter, get medical help or take them home. Their aim is to reduce anti-social behaviour and minimise harm from such behaviours.

The Council for Aboriginal Alcohol Program Services

The Council for Aboriginal Alcohol Program Services (CAAPS) was founded as a cooperative venture by community development workers from the Anglican, Uniting and Catholic Churches in 1985. CAAPS was given land by the NT Government and developed facilities from which residential services could be provided with Commonwealth funding in 1996/97.

CAAPS provides training[11], treatment, hostel accommodation and community based field work programs to Aboriginal people, families and communities. It is governed by a council elected annually by Association members from the Darwin region and remote Aboriginal communities. The council meets quarterly to determine policy and direction for the organisation in accordance with the aims, objectives, practices and principles of the Association.

Residential Treatment Program

CAAPS run a six week residential program which is based on a Minnesota Family Treatment Model adapted from Holyoake, WA and the Australian Institute on Alcohol and Addictions Program which has been customised by CAAPS for use with Aboriginal and Islander people. Programs provide awareness of the physical, mental, emotional, spiritual, cultural and social effects of alcohol and other drug dependence behaviours within Aboriginal families.

CAAPS acknowledges, encourages and supports the involvement by sober family members and children in the program, as they believe that drug misuse can be treated more effectively by involving the whole family in the recovery process. A core aspect of the program is to address the misuse of Aboriginal kinship obligations or co-dependency aspects of alcohol and other drug dependency.

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[10] Crawshaw, J & Thomas, D *Op. cit.* 1992.

[11] CAAPS is an accredited provider of training in substance misuse programs.

The Dolly Garinyi Hostel and purpose built client accommodation units were opened during 1997. These units provide appropriate supported accommodation in a semi-bush setting for up to 30 clients. The cost of supported accommodation is $120 per week per adult and $60 for children under 16. Clients are provided with food to cook, are expected to keep their units clean and tidy and do their own laundry. The hostel is not staffed or resourced to cater for clients who need 24 hour supervision or expert medical care.

CAAPS Community Based Field Program Team (CCBFPT)

CCBFPT was established in 1991 to provide referral and aftercare support for the residential treatment program to remote Aboriginal communities that it related to in the church mission era. They are Oenpelli, Jabiru, Maningrida, Nguiu, Milikapiti, Daly River, Port Keats, Milingimbi, Ramingining and Groote Eylandt. This concept was gradually expanded to include the Darwin Prison and Juvenile Remand Centre as well as receiving referrals from the court system and RDH.

Present CCBFPT activities include:

- counselling, assessment, referral and follow up services;
- liaison and networking;
- court, prison, and hospital assessment and referrals;
- support for the CAAPS alcohol counsellor in Jabiru.

Aboriginal and Islander Alcohol Awareness and Family Recovery

Aboriginal and Islander Alcohol Awareness and Family Recovery (A&IAAFR) is a program run by the Catholic Church Diocese of Darwin and is funded by the LWAP. It offers programs for Aboriginal families where alcohol and other substance misuse are causing problems. The administration is based in Darwin.

They run:

- an Alcohol Treatment Centre at Five Mile near Daly River which offers a six week residential program for all family members, including specific programs for the alcohol/drug user, partner & children. The programs include education, group sharing, family and couple meetings, hunting, fishing, cultural and recreational activities. The families live in hostel accommodation and take care of their own cooking and household needs.
- community based programs that offer information, support, intervention, education, school programs, referral, follow-up, training and community networking. Local Aboriginal group members volunteer as community workers and offer support and intervention to their own family and/or kinship groups. Community based programs are conducted at the following places:
    - Wadeye;
    - Nguiu;
    - Pirlangimpi; and
    - Milikapiti.
- Some communities conduct an outreach support program to neighbouring communities. These are:
    - Belyuen;
    - Palumpa;
    - Peppimenarti; and
    - Ranku.

Groote Eylandt and Bickerton Island Substance Misuse Program

Angurugu Community Government receives a grant from OATSIH for a substance misuse program that Anglicare manages on the Council's behalf. Both communities on Groote Eylandt and Bickerton Island have been well serviced by the program. A major aim is to promote employment and recreational activities and to be actively encourage more youth to participate in treatment as well as training and employment opportunities within the local substance misuse work.

The program uses the CAAPS training and treatment models and treatment facilities, which are based largely on the notion of co-dependency. They have also developed some local strategies. The program claims considerable successes in reducing petrol-sniffing - a marked decline over the past six years when up to 40 people a month were reported to be sniffing petrol regularly[12]. Recently, however, there has been an apparent increase in excessive marijuana use. Kava is also now available on Groote. The basis of the work is to work with families helping to educate them about the effects of substance misuse thus allowing non-users to become stronger in dealing with users in their own families. There has been an increase in awareness of the mental health and general health issues associated with substance misuse.

Services provided include:

- family and individual counselling service to substance users;
- training with the CAAPS Training Unit;
- continuing awareness and after care program;
- assessments & referral to Darwin residential treatment centres;
- education for families and individuals;
- advocacy for mental health and specialist medical assistance;
- liaison with other services agencies locally and regionally. These include probation and parole, police, employment bodies, youth, sport and recreational bodies and local council and land council and elders.
- recreational activities - fishing, hunting, cultural awareness, camping activities;
- follow up sessions after attendance at residential treatment centre.

Kalano's Rockhole Rehabilitation Centre

The Kalano Community Association manages a residential treatment program at the Rockhole Rehabilitation Centre located at the rear of the Rockhole community approx 15km north of Katherine. It is a 6-week residential program that has been developed locally by Aboriginal people with considerable experience in alcohol programs. It is specifically designed to take into consideration Aboriginal cultural values.

The program includes:

- individual and group counselling;
- education on the effects of alcohol on the body, mind and personal relationships;
- financial and work skills;
- communication skills and stress management;
- education for prevention of STDs & other communicable diseases;
- promotion of recreational activities;
- nutritional education;
- general living skills training; and
- cultural activities.

They also provide an outreach service which regularly visits Aboriginal communities in the Katherine region to help deal with alcohol problems, and includes:

- assessments and referrals;
- support and treatment for co-dependents;
- introduction to AA;
- religious activities (if requested);
- after-care treatment.

[12] *Annual Report for the Groote Eylandt and Bickerton Island Substance Misuse Program 1997-98*, Angurugu, 1998.

As a secondary focus, the service also provides the following general services:

- assistance with welfare support;
- social family support;
- court/correctional services support;
- housing (applications/support);
- social security support;
- cultural support (family contact);
- employment (assistance with applications & training); and
- shopping support (supervision and guidance).

Living With Alcohol Programs

The LWAP, apart from its funding role (see above), directly employ some workers in their Aboriginal Living With Alcohol Team (ALWAT). There are two Aboriginal *community development workers* who cover the whole of the Top End. Their role is to coordinate and facilitate the LWAP within NT remote Aboriginal communities to enable the program objectives to be achieved. These include:

- sharing information on safe and unsafe levels of alcohol consumption;
- developing a supportive environment that enables people to identify their own alcohol related issues and make an informed choices.

An Aboriginal tobacco educator is also employed. A project officer based in Darwin is working on a pilot project delivering interventions involving Borroloola and Kalkarindji. There is one local person in Borroloola and two in Kalkarindji who are receiving top up money to their CDEP wages to help with this work.

LWAP employed workers are based in East Arnhem. Their work is discussed in the Section that examines the detail of services in HSZs.

LWAP also fund and manage an Aboriginal Liaison Officer in the Liquor Commission.

D. Hospital Services

Hospitalisation Rates

Although hospitalisation rates are an imperfect measure of morbidity, they are a commonly used indicator. High rates of hospitalisation may reflect various factors including serious morbidity, inadequate PHC services, and the assumed most convenient way of providing specialist services to people living in remote areas.

There are quite substantial differences between admission rates of Indigenous people between States/Territories and when compared to admission rates of non Indigenous people. Deeble et al[13] report hospitalisation rates of Indigenous people in the NT in 1995/96 to be 516 per 1000 population compared with 163 per 1,000 population for non Indigenous people. Indigenous hospitalisation rates in 1995/96 were highest in the NT (516/1,000), followed by WA with a rate of 506/1000 and SA and Qld had rates of 461 and 413 per 1000 respectively. Rates in NSW and Vic were much lower – 258 in NSW and 266 in Vic – and similar to the non Indigenous rates. However these figures could reflect under reporting of Indigenous status in these States.

[13] Deeble J, Mathers C, Smith L et al. *Expenditures on Health Services for Aboriginal and Torres Strait Islander people,* Commonwealth of Australia, May 1998.

Table 9: Separations from Acute Hospitals by Indigenous status, 1995/96

	Indigenous		Non Indigenous	
State/Territory	Total (000)	per 1000 population	Total (000)	per 1000 population
NSW	27.0	258	1,714.3	283
Vic	6.0	266	1,290.9	287
Qld	45.1	413	936.7	292
WA	27.1	506	424.1	250
SA	9.7	461	453.0	311
Tas	0.3		104.5	
ACT	0.3	106	70.3	230
NT	25.3	516	20.8	163

Source: Deeble et al (1998)

At RDH in 1998/99, 55% of the 30,000+ patients were non Indigenous, 45% were Indigenous. However when renal dialysis patients are excluded, Indigenous patients represent only 30% of RDH's total patients. Most of the non Indigenous patients live in the Darwin urban area, while the Indigenous admissions come from a wider area: 62% live in Darwin urban area, 18% in Darwin rural, 10% in East Arnhem and 8% in Katherine. See Table 10.

Of the nearly 5000 admissions to Katherine Hospital in 1998/99, 62% were Indigenous and 37% were non Indigenous. Of the Indigenous patients, 92% lived in Katherine. Similarly the non Indigenous admissions mostly live in Katherine. See Table 11.

Gove Hospital is smaller with nearly 3000 admissions in 1998/99. Three quarters were Indigenous and mostly lived in the East Arnhem area (Table 12).

Tables 13, 14 and 15 show the 20 most frequent Diagnostic Related groups (DRGs) and the length of stay for those DRGs for Indigenous and non Indigenous patients in RDH, Katherine and Gove hospitals.

At RDH day only admissions for renal dialysis represented a third of total admissions and nearly half of the top 20 admissions. Over three quarters of these renal dialysis cases were Indigenous patients. The remaining most frequent 19 DRGs, which represent 26% of all admissions, were normal deliveries and other obstetric cases, gynaecology, gastroenterology, respiratory infections, bronchitis and asthma, other factors influencing health status, cardiology, dentistry. Average length of stay (ALOS) excluding renal dialysis in 1998/99 was 4.6 days. However ALOS for Indigenous patients was 6.4 days and 3.8 days for non Indigenous patients. Figure 15 compares the ALOS for the most frequent DRGs for both Indigenous and non Indigenous patients. Notable differences in ALOS occur between Indigenous and non Indigenous patients: DRG 350 – Gastroenteritis age < 10 has an ALOS of 6.8 days for Indigenous people and 2 days for non Indigenous people; and DRG 943 Other Factors Influencing Health Status Age <80 w/o cc where the ALOS for Indigenous people is 6.6 days compared to 2.2 days for non Indigenous people.

At Katherine Hospital the ALOS was 4 days: 4.6 days for Indigenous people and 3 days for non Indigenous patients. Katherine Hospital has a similar casemix to RDH (with the exception of renal dialysis) in terms of the top 20 DRGs– other factors influencing health status, normal deliveries, other antenatal admissions, cellulitis, injuries, respiratory infections, gastroenteritis, gastroscopies, colonoscopies, dental work. The most common 20 DRGs account for 51% of all cases. Variations exist in ALOS for Indigenous and non Indigenous people – 9.1 days compared to 1.9 days for gastroenteritis in children; 5.1 days for Indigenous people under 55 with respiratory infections compared with 3.1 days for non Indigenous people.

The ALOS at Gove Hospital was 3.5 days: 4 days for Indigenous people and 2.1 days for non Indigenous people. Twenty most frequent DRGs account for 59% of all patients and include: other factors influencing health status, normal deliveries, gastroenteritis, cellulitis, respiratory infections, gastroscopy, chronic obstructive airways disease, dental extractions, injuries, gynaecological procedures, skin procedures, minor ENT procedures, other dental work.

Table 10: Royal Darwin Hospital: separations and bed days by region of residence and Indigenous status, 1998/99

Region of residence	Indigenous				Non Indigenous				Unknown				Total			
	Separations		Bed Days		Separations		Bed Days		Separations		Bed Days		Separations		Bed Days	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
Alice Springs rural	16	*0.1*	73	*0.1*	33	*0.2*	103	*0.2*		*0.0*		*0.0*	49	*0.2*	176	*0.2*
Alice Springs urban	40	*0.3*	136	*0.3*	22	*0.1*	140	*0.3*	4	*0.3*	8	*0.6*	66	*0.2*	284	*0.3*
Barkly	33	*0.2*	241	*0.5*	17	*0.1*	66	*0.1*	1	*0.1*	20	*1.6*	51	*0.2*	327	*0.3*
Darwin rural	2572	*18.1*	14148	*28.8*	428	*2.7*	1622	*2.9*	399	*31.4*	2021	*158.9*	3399	*10.8*	17791	*16.3*
Darwin urban	8804	*61.8*	17809	*36.3*	14058	*87.6*	45380	*82.1*	740	*58.2*	1948	*153.1*	23602	*74.8*	65137	*59.8*
East Arnhem	1459	*10.2*	7845	*16.0*	223	*1.4*	940	*1.7*	18	*1.4*	116	*9.1*	1700	*5.4*	8901	*8.2*
Katherine	1082	*7.6*	7219	*14.7*	459	*2.9*	3167	*5.7*	20	*1.6*	131	*10.3*	1561	*4.9*	10517	*9.7*
Other	230	*1.6*	1610	*3.3*	814	*5.1*	3845	*7.0*	90	*7.1*	367	*28.9*	1134	*3.6*	5822	*5.3*
Total	**14236**	***100***	**49081**	***100***	**16054**	***100***	**55263**	***100***	**1272**	***100***	**1272**	***100***	**31562**	***100***	**108955**	***100***

Table 11: Katherine Hospital: separations and bed days by region of residence and Indigenous status, 1998/99

Region of residence	Indigenous				Non Indigenous				Unknown				Total			
	Separations		Bed Days		Separations		Bed Days		Separations		Bed Days		Separations		Bed Days	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
Alice Springs rural	16	*0.5*	87	*0.6*	1	*0.1*	1	*0.0*		*0.0*		*0.0*	17	*0.3*	88	*0.4*
Alice Springs urban	10	*0.3*	67	*0.5*	3	*0.2*	9	*0.2*	1	*1.0*	13	*3.7*	14	*0.3*	89	*0.4*
Barkly	31	*1.0*	104	*0.7*	10	*0.6*	32	*0.6*	2	*1.9*	2	*0.6*	43	*0.9*	138	*0.7*
Darwin rural	65	*2.1*	277	*2.0*	4	*0.2*	10	*0.2*	1	*1.0*	2	*0.6*	70	*1.4*	289	*1.5*
Darwin urban	57	*1.9*	147	*1.0*	58	*3.2*	139	*2.6*	3	*2.9*	6	*1.7*	118	*2.4*	292	*1.5*
East Arnhem	22	*0.7*	93	*0.7*	1	*0.1*	1	*0.0*		*0.0*		*0.0*	23	*0.5*	94	*0.5*
Katherine	2781	*91.8*	13149	*93.4*	1559	*86.8*	4754	*88.6*		*0.0*		*0.0*	4430	*89.8*	18207	*91.9*
Other	49	*1.6*	159	*1.1*	160	*8.9*	420	*7.8*	90	*85.7*	304	*85.9*	217	*4.4*	606	*3.1*
Total	**3031**	***100***	**14083**	***100***	**1796**	***100***	**5366**	***100***	**105**	***100***	**354**	***100***	**4932**	***100***	**19803**	***100***

Table 12: Gove Hospital: separations and bed days by region of residence and Indigenous status, 1998/99

Region of residence	Indigenous				Non Indigenous				Unknown				Total			
	Separations		Bed Days		Separations		Bed Days		Separations		Bed Days		Separations		Bed Days	
	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%	no.	%
Alice Springs rural	1	*0.0*	2	*0.0*		*0.0*		*0.0*		*0.0*		*0.0*	1	*0.0*	2	*0.0*
Alice Springs urban		*0.0*		*0.0*	1	*0.1*	2	*0.1*		*0.0*		*0.0*	1	*0.0*	2	*0.0*
Barkly		*0.0*		*0.0*		*0.0*		*0.0*		*0.0*		*0.0*		*0.0*		*0.0*
Darwin rural	17	*0.8*	45	*0.5*		*0.0*		*0.0*		*0.0*		*0.0*	17	*0.6*	45	*0.4*
Darwin urban	12	*0.6*	36	*0.4*	10	*1.5*	29	*2.1*	1	*1.5*	3	*1.5*	23	*0.8*	68	*0.7*
East Arnhem	2077	*96.4*	8405	*97.3*	628	*93.0*	1311	*93.4*	39	*60.0*	123	*62.1*	2744	*94.8*	9839	*96.1*
Katherine	13	*0.6*	59	*0.7*	4	*0.6*	9	*0.6*	2	*3.1*	5	*2.5*	19	*0.7*	73	*0.7*
Other	35	*1.6*	93	*1.1*	32	*4.7*	52	*3.7*	23	*35.4*	67	*33.8*	90	*3.1*	212	*2.1*
Total	**2155**	***100***	**8640**	***100***	**675**	***100***	**1403**	***100***	**65**	***100***	**198**	***100***	**2895**	***100***	**10241**	***100***

Figure 15: Royal Darwin Hospital: Region of Residence of Indigenous Patients, 1998-99.

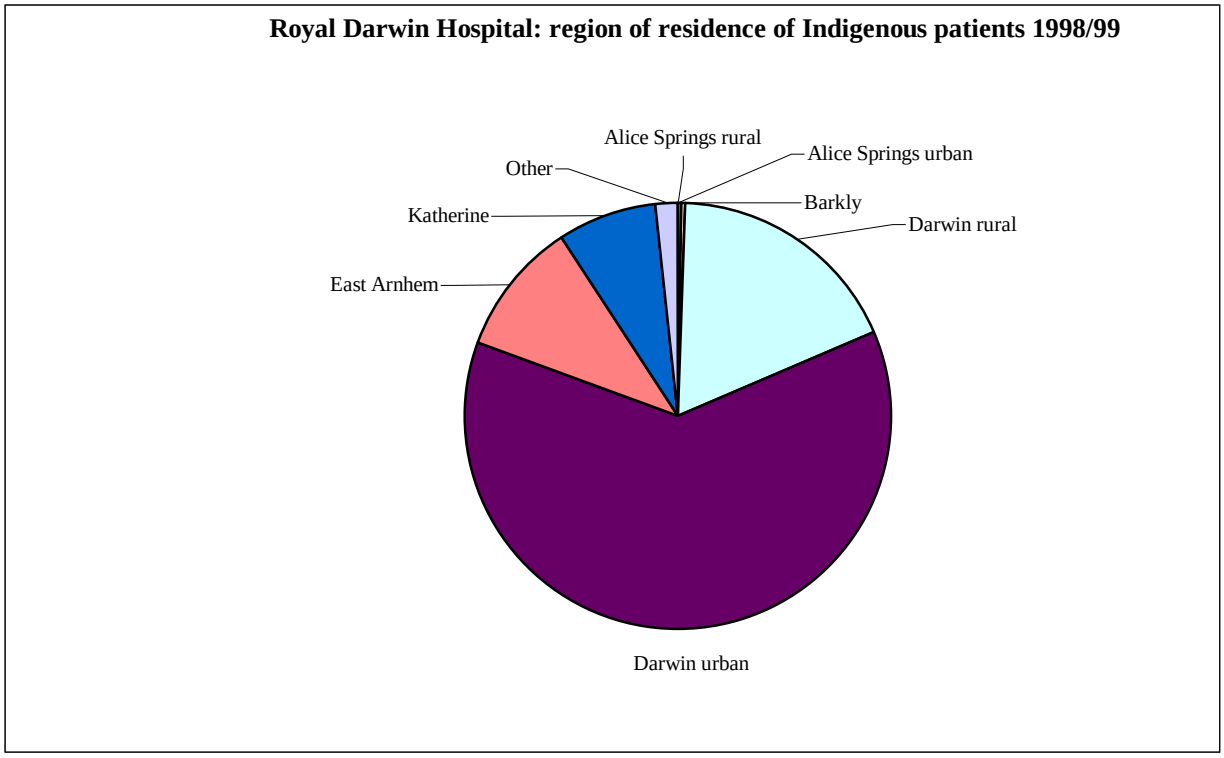


Figure 16: Katherine Hospital: Region of Residence of Indigenous Patients, 1998-99.

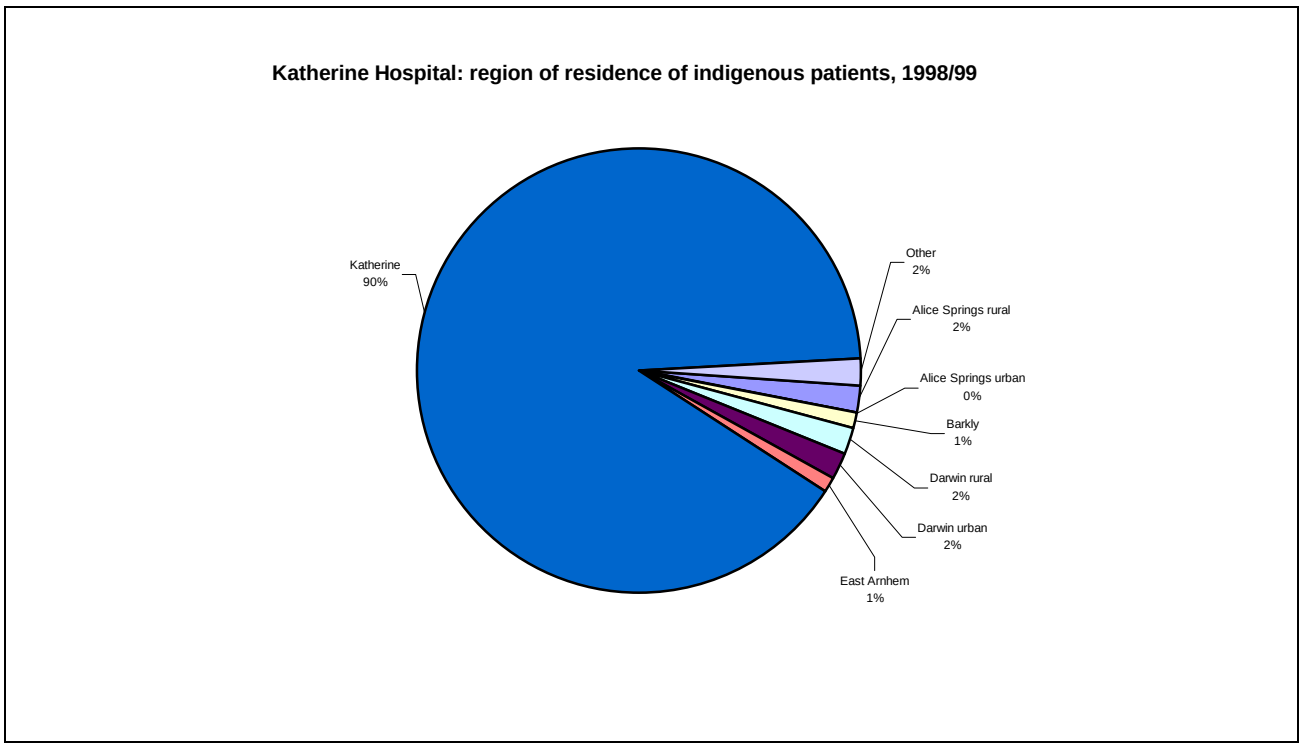


Figure 17: Katherine Hospital: Region of Residence of Indigenous Patients, 1998-99.

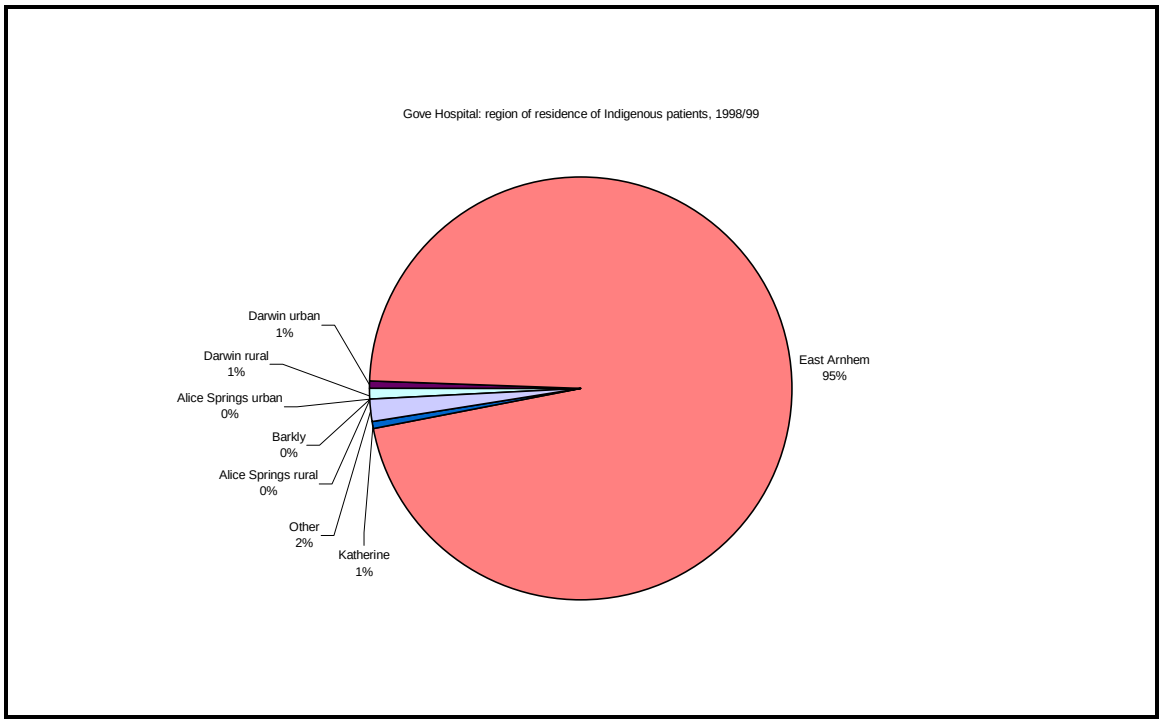
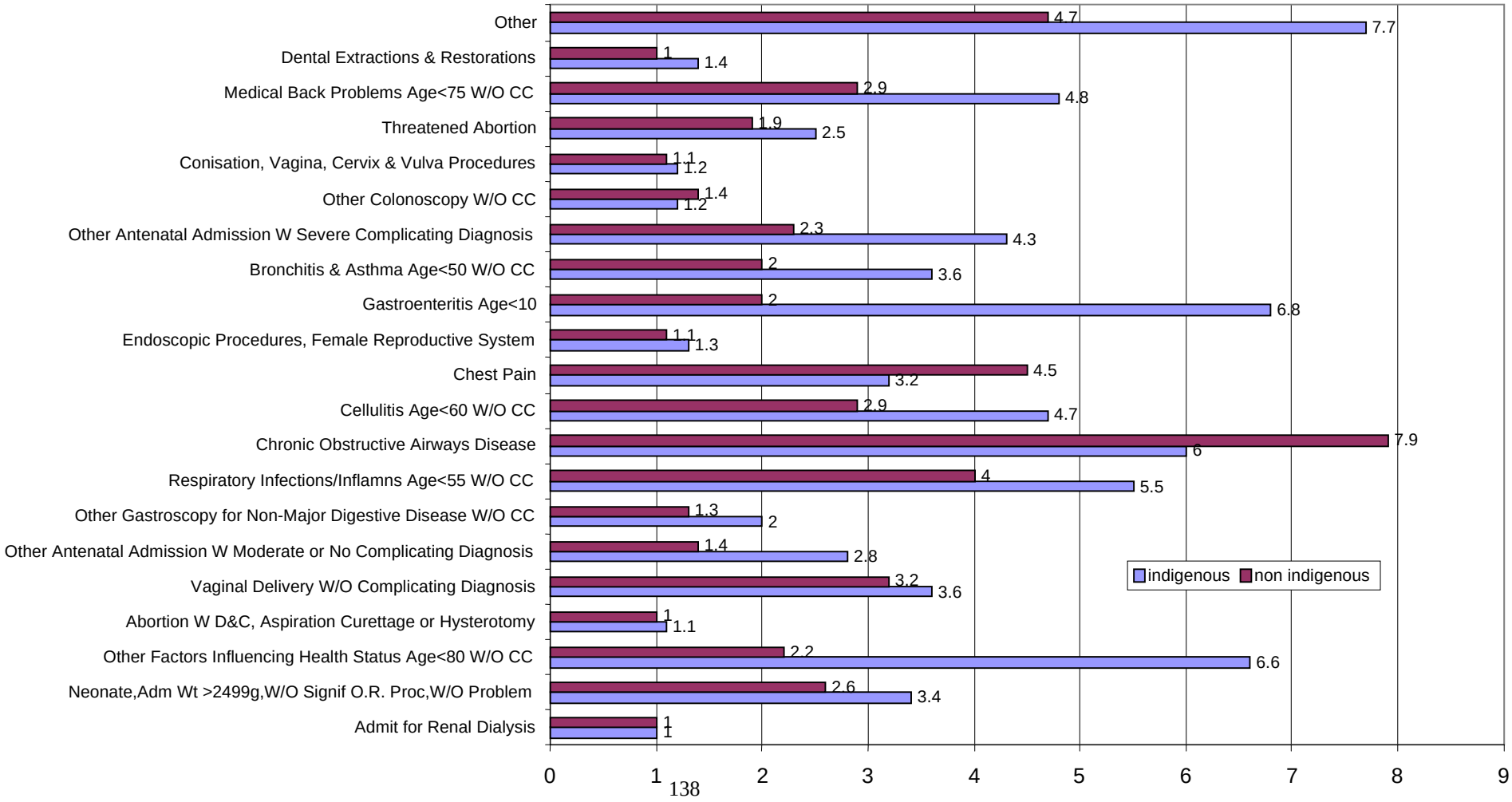


Table 13: RDH: Top 20 DRGs by length of stay and Indigenous status, 1998/99

DRG Code	Description	Indigenous		Non Indigenous		Unknown		Total	
		no of seps	ALOS	no of seps	ALOS	no of seps	ALOS	no of seps	ALOS
572	Admit for Renal Dialysis	7815	1	1890	1	426	1	10131	1
727	Neonate, Adm Wt >2499g,W/O Signif O.R. Proc,W/O Problem	487	3.4	1099	2.6	43	2.7	1629	2.8
943	Other Factors Influencing Health Status Age<80 W/O CC	562	6.6	474	2.2	167	7.5	1203	5
683	Abortion W D&C, Aspiration Curettage or Hysterotomy	173	1.1	735	1	26	1	934	1
674	Vaginal Delivery W/O Complicating Diagnosis	152	3.6	530	3.2	70	3	752	3.2
686	Other Antenatal Admission W Moderate or No Complicating Diagnosis	107	2.8	334	1.4	21	2.2	462	1.8
332	Other Gastroscopy for Non-Major Digestive Disease W/O CC	41	2	342	1.3	11	2	394	1.4
172	Respiratory Infections/Inflamns Age<55 W/O CC	157	5.5	122	4	8	5.4	287	4.9
177	Chronic Obstructive Airways Disease	106	6	137	7.9	5	4.6	248	7
491	Cellulitis Age<60 W/O CC	110	4.7	124	2.9	11	4.4	245	3.7
261	Chest Pain	59	3.2	162	4.5	6	2.7	227	4.1
660	Endoscopic Procedures, Female Reproductive System	48	1.3	167	1.1	4	1	219	1.1
350	Gastroenteritis Age<10	89	6.8	121	2	7	4.6	217	4.1
187	Bronchitis & Asthma Age<50 W/O CC	52	3.6	155	2	7	1.6	214	2.4
685	Other Antenatal Admission W Severe Complicating Diagnosis	78	4.3	121	2.3	6	6.2	205	3.2
335	Other Colonoscopy W/O CC	12	1.2	190	1.4	1	1	203	1.4
659	Conisation, Vagina, Cervix & Vulva Procedures	43	1.2	151	1.1	4	1	198	1.1
681	Threatened Abortion	60	2.5	125	1.9	6	3.2	191	2.2
455	Medical Back Problems Age<75 W/O CC	14	4.8	163	2.9	6	1.7	183	3
128	Dental Extractions & Restorations	50	1.4	128	1	4	1.3	182	1.1
	Other	4025	7.7	8784	4.7	434	5.2	13243	5.6
	Total/ Average	14240	3.4	16054	3.4	1273	3.6	31567	3.5
	Total excl renal dialysis	6425	6.4	14164	3.8	847	5.0	21436	4.6

Figure 18: RDH: 20 Most frequent DRGs: Length of Stay by Indigenous status, 1998-99.



Top End Aboriginal Health Plan
Ben Bartlett & Pip Duncan
PlanHealth Pty Ltd
April 2000

Table 14: Katherine Hospital: Top 20 DRGs by length of stay and Indigenous status, 1998/99

DRG Code	Description	Indigenous		Non Indigenous		Unknown		Total	
		no of seps	ALOS	no of seps	ALOS	no of seps	ALOS	no of seps	ALOS
943	Other Factors Influencing Health Status Age<80 W/O CC	598	4.5	126	3.4	42	3.5	766	4.3
727	Neonate,Adm Wt >2499g,W/O Signif O.R. Proc,W/O Problem	175	4.5	134	3.7			309	4.2
674	Vaginal Delivery W/O Complicating Diagnosis	93	4.4	87	3.5	3	5.3	183	4
172	Respiratory Infections/Inflamns Age<55 W/O CC	114	5.1	29	3.1	7	5.1	150	4.7
491	Cellulitis Age<60 W/O CC	92	4.2	45	3.4	6	4.2	143	4
885	Injuries Age<65	88	2.7	45	2.1	3	1.7	136	2.5
350	Gastroenteritis Age<10	99	9.1	25	1.9			124	7.6
686	Other Antenatal Admission W Moderate or No Complicating Diagnosis	51	2.6	29	2.4	1	1	81	2.5
685	Other Antenatal Admission W Severe Complicating Diagnosis	53	4.1	18	2.8			71	3.8
187	Bronchitis & Asthma Age<50 W/O CC	40	2.8	28	1.7			68	2.4
473	Fx,Sprn,Strn&Disloc of Frarm,Hnd,Ft Age<75 W/O CC	31	2.2	27	1.7	3	2.7	61	2
335	Other Colonoscopy W/O CC	7	1.7	52	1			59	1.1
332	Other Gastroscopy for Non-Major Digestive Disease W/O CC	13	1.5	44	1.3			57	1.4
171	Respiratory Infections/Inflamns (Age>54 W/O CC) or (Age<55 W CC)	52	7.1	4	4.8			56	6.9
52	Minor Head Injury	24	1.1	25	1.1	2	1	51	1.1
99	Lens Procedures W/O Vitrectomy & W/O CC	31	1.1	18	1			49	1
177	Chronic Obstructive Airways Disease	31	6.2	16	6.6			47	6.3
476	Fx,Sprn,Strn&Disloc of Uparm,Lwrleg Age<65 W/O CC	17	2	29	1.8			46	1.9
660	Endoscopic Procedures, Female Reproductive System	20	1.5	23	1			43	1.3
126	Dental & Oral Dis Except Extractions & Restorations	37	3	4	2.8	1	1	42	2.9
	Other	1368	4.9	992	3.2	37	3.1	2397	4.2
	Total/ Average	**3031**	**4.9**	**14083**	**3.2**	**1796**	**3.1**	**2397**	**4.2**

Figure 19: Katherine Hospital: 20 Most frequent DRGs: Length of Stay by Indigenous status, 1998-99.

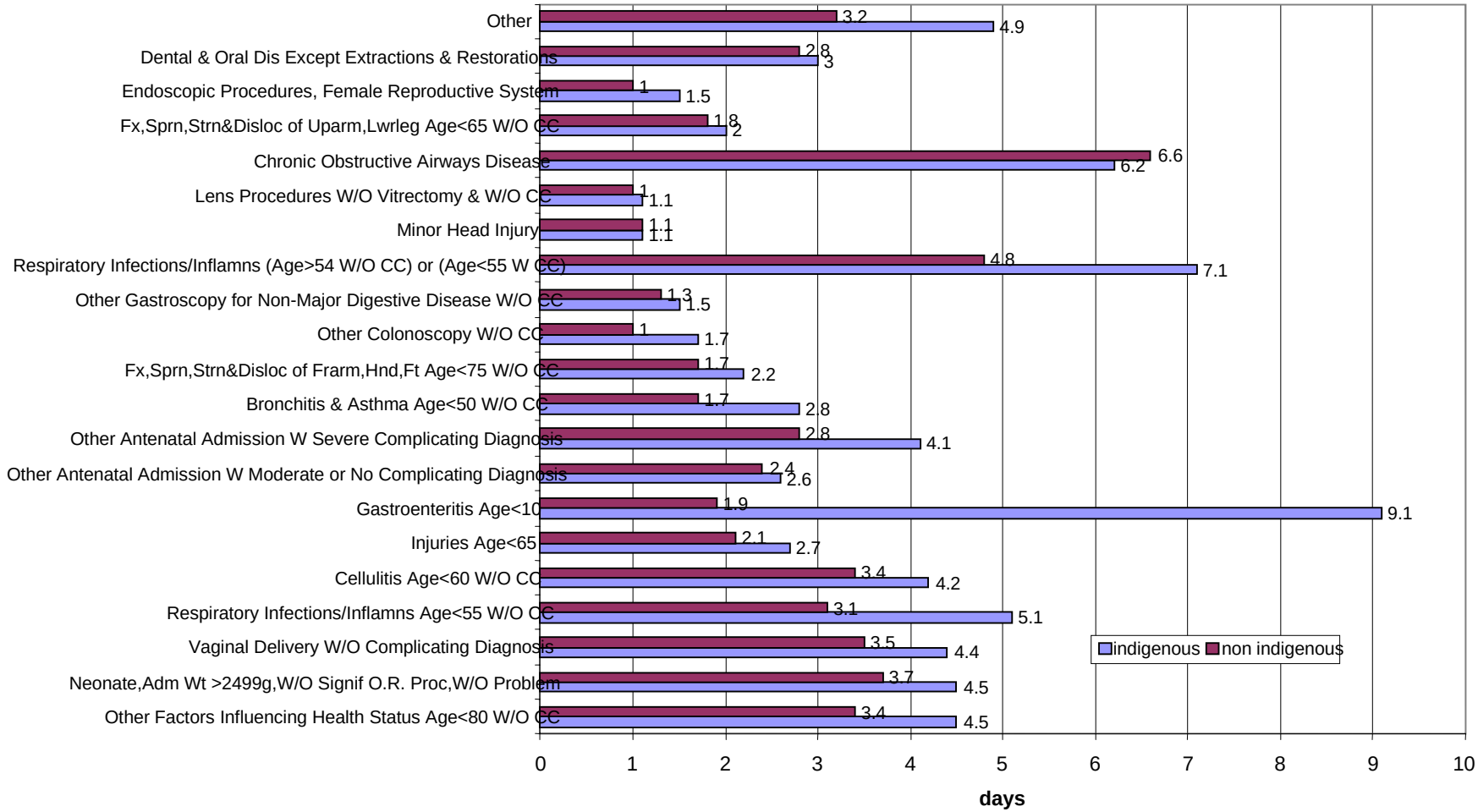
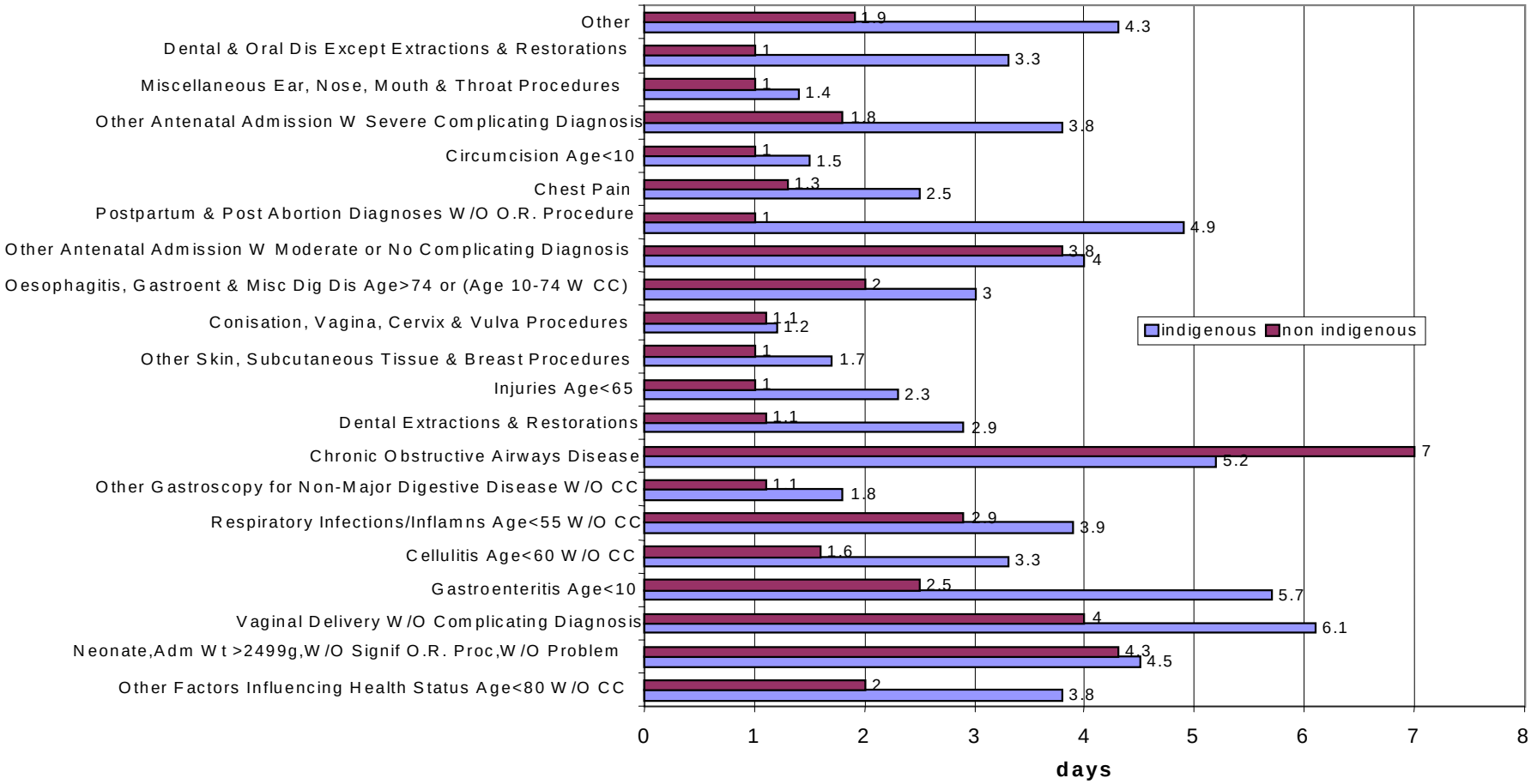


Table 15: Gove Hospital: Top 20 DRGs by length of stay and Indigenous status, 1998/99

DRG Code	Description	*Indigenous*		*Non Indigenous*		*Unknown*		*Total*	
		no of seps	ALOS	no of seps	ALOS	no of seps	ALOS	no of seps	ALOS
943	Other Factors Influencing Health Status Age<80 W/O CC	658	3.8	63	2	62	3.1	783	3.6
727	Neonate,Adm Wt >2499g,W/O Signif O.R. Proc,W/O Problem	125	4.5	41	4.3			166	4.5
674	Vaginal Delivery W/O Complicating Diagnosis	62	6.1	24	4			86	5.5
350	Gastroenteritis Age<10	78	5.7	4	2.5			82	5.5
491	Cellulitis Age<60 W/O CC	48	3.3	17	1.6			65	2.8
172	Respiratory Infections/Inflamns Age<55 W/O CC	49	3.9	15	2.9			64	3.7
332	Other Gastroscopy for Non-Major Digestive Disease W/O CC	17	1.8	28	1.1			45	1.4
177	Chronic Obstructive Airways Disease	40	5.2	3	7			43	5.3
128	Dental Extractions & Restorations	20	2.9	21	1.1	1	1	42	1.9
885	Injuries Age<65	35	2.3	4	1			39	2.2
484	Other Skin, Subcutaneous Tissue & Breast Procedures	19	1.7	18	1			37	1.4
659	Conisation, Vagina, Cervix & Vulva Procedures	25	1.2	9	1.1			34	1.1
349	Oesophagitis, Gastroent & Misc Dig Dis Age>74 or (Age 10-74 W CC)	23	3	9	2			32	2.7
686	Other Antenatal Admission W Moderate or No Complicating Diagnosis	23	4	8	3.8			31	3.9
678	Postpartum & Post Abortion Diagnoses W/O O.R. Procedure	27	4.9	3	1			30	4.5
261	Chest Pain	13	2.5	13	1.3			26	1.9
613	Circumcision Age<10	23	1.5	3	1			26	1.5
685	Other Antenatal Admission W Severe Complicating Diagnosis	22	3.8	4	1.8			26	3.5
117	Miscellaneous Ear, Nose, Mouth & Throat Procedures	20	1.4	4	1			24	1.3
126	Dental & Oral Dis Except Extractions & Restorations	22	3.3	2	1			24	3.1
	Other	806	4.3	382	1.9	2	1.5	1190	3.5
	Total	**2155**	**4**	**675**	**2.1**	**65**	**3**	**2895**	**3.5**

Figure 20: Gove Hospital: 20 Most frequent DRGs: Length of Stay by Indigenous status, 1998-99.



CHAPTER 8 - PROPOSED MODEL OF PHC SERVICE DELIVERY

Overview of Proposed Model of Community Controlled Comprehensive Primary Health Care

The elements of this model as applied to the Top End of the NT are:

A. **Health Service Zones** developed as a planning tool and a means of supplying scarce human resources (eg specialists) to population groups. PHC services will be planned and organised within communities/ population groups within Zones.

B. **Core Functions of PHC** building on previous work and incorporating the Rotem/ Freeman report[1] into a framework that can be operationalised. The framework is as follows:

1. **Clinical services** which all can access through one or more of:
   - **Resident** health care services in the community;
   - **Visiting** professional services;
   - Provision of **medicine kits** to designated holders;
   - Organised access to **medical advice** via phone or radio.

2. **Local & Regional support for PHC:**
   - staff in-service training/ education;
   - management support;
   - program development and evaluation support;
   - provision of specialist and allied health professional services;
   - technical support (maintenance of equipment, IT).

3. **Special Program funding** for preventive programs which require community agency and are directed at addressing the underlying non-medical causes of poor health.

C. Pursue opportunities to increase **community control** (ie to increase the local communities say) of PHC services, and the further development of an Aboriginal health leadership in the NT.

D. **Strengthening Indigenous Health Planning** processes under the Framework Agreement to oversee the development of collaborative planning of health services involving THS, OATSIH, AMSANT and ATSIC

E. Establishment of an **NT Indigenous Health Authority**.

[1] Rotem, A & Freeman, P *Essential Primary Health Care Services – Northern Territory*, THS, 1999.

Funding Arrangements

Funding support for Comprehensive PHC is essential to success of this strategy. It is widely accepted that the resources available for addressing Aboriginal health disadvantage is adequate. However, how funding is organised is also an important question. It is important that funding arrangements reflect and match the core functions of comprehensive PHC (see below).

Recommendation 1

We propose that THS and OATSIH adopt guidelines (acceptable to NTAHF) for funding which strengthen comprehensive PHC service delivery to Aboriginal communities, and reflect the framework of core functions of PHC.

Recommendation 2

We propose that the NTAHF continue to investigate the level of funding required to provide adequate PHC services to people in Top End, and where such funding might come from.

A. Health Service Zones

HSZs are based on:

- language and cultural affiliations;
- current use of health services;
- knowledge of relationships;
- existing administrative/ governance arrangements (eg Homelands Resource Centre coverage);
- how communities currently relate to each other in regard to accessing general services;
- historical associations; and
- geographic proximity and other logistical considerations.

Few of the Zones represent homogenous cultural groups. The majority do not have a clear singular governance structure or process. Thus the Zones are limited in how they should be understood and used.

Table 16: Population and Distribution of Various Sized Communities by HSZ

HEALTH SERVICE ZONES	No of Places	Pop	> 3000	200-2999	800-1199	400-799	250-399	75-249	<75
Tiwi	6	2,250	-	1 = 1,300	-	1 = 480	1 = 350	1 = 100	2=20
Darwin	19	10,750	1 = 8,420	-	1=850	-	2 =630	4 =535	11=315
Top End West	46	4,480	-	1 = 2,200	-	2 = 950	2 = 600	1 = 100	37=630
West Arnhem	65	2,535	-	-	1 = 1,000	-	2 = 590	2 = 160	52=785
Maningrida	43	2,085	-	-	1 = 1,270	-	-	-	34=815
North East Arnhem	104	7,020	-	1 = 1,400	3 = 2,550	1 = 750	1 = 300	4 = 430	83=1,590
South East Arnhem	33	2,845	-	-	2 = 1,700	1 = 450	-	2 = 320	24=375
Katherine East	57	5,795	-	-	2 = 2,040	2 = 1,130	3 = 940	8 = 1,075	34=610
Katherine Wes	50	3,300	-	-	1 = 800	2 = 960	2 = 550	3 = 295	34=695
SE Top End	37	1,805	-	-	1 = 800	-	-	3 = 500	28=505
TOTAL	460	42,865	1 = 8,420	3 = 4,900	12 = 11,010	9 = 4,720	13 = 3,960	28 = 3,515	339=6,340

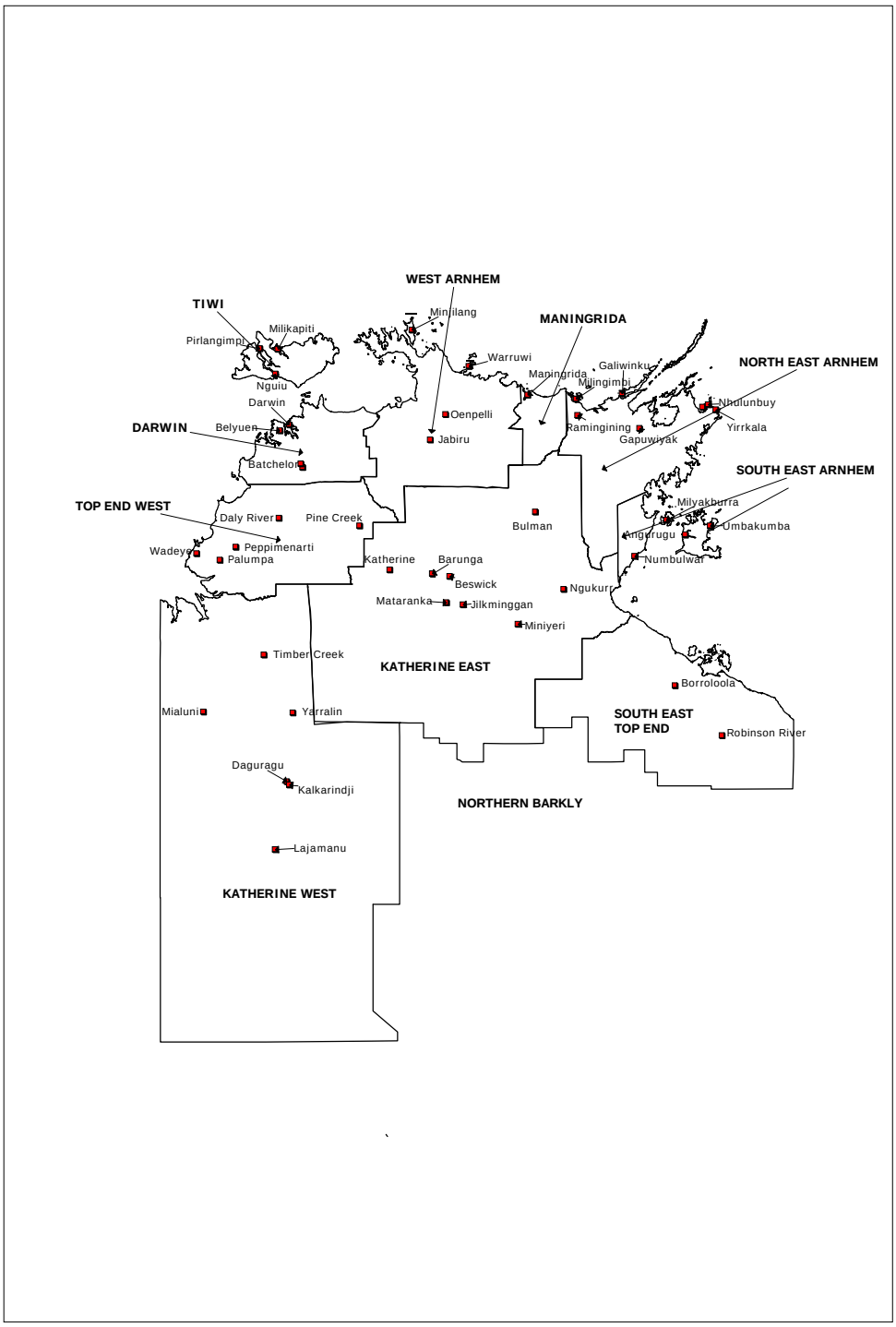
Table 16 shows the proposed HSZs with their approximate population estimates. The last 7 columns show the number of communities of various population sizes in each Zone. This illustrates something of the population density and distribution within these Zones. The *Number of Places* column shows the total number of out-stations and communities that we have information about. It can be assumed that figure, less the number of out-stations/ 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 Darwin, Katherine, Jabiru, Nhulunbuy, and Alyangula because there are other services in these towns that are largely used by the non-Aboriginal population. However, in other communities (such as Timber Creek) we have included the total population regardless of racial origin, because all will be utilising the same health service (see Chapter 2).

One of the main issues for service delivery in the Top End is the dispersion of small groups of people across vast areas of the region. In our work, we have identified groups that have no organised access to health services. The task of an Aboriginal health care system is to address the health service needs of these people, along with the larger population groups. This is one of the main findings of our work across the whole of the NT, and presents a challenge to PHC 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. However, there are services which do provide services to small out-stations/ homelands and these show the way in terms of what can be achieved.

Funding bodies 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. This, of course, is essential to access some communities in the Top End in the wet.

The boundaries of the proposed Zones are shown in the Map in Figure 21.

Figure 21: Map of the Top End of the NT showing Boundaries of HSZs.



Purpose of Health Service Zones

Suggested uses of HSZs have ranged from a simple planning tool to a template for health service governance (eg suggested appointment of Zone Managers), and population groups for funding formulae.

We consider that the relevance of Zones will vary enormously depending on, among other things, historical migration patterns, degree of cultural homogeneity, and historical relationships between communities in Zones. Thus neat, symmetrical and centralised assumptions about the use of Zones should be resisted.

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 (other than that operating within communities) have not become part of the way people think about issues. 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 Zones where some form of Zone-wide arrangement is established, is that it will continue to be necessary to identify resources that belong to particular communities within that Zone.

Thus, for example, in the Top End West Zone, there is a history of difficulty in the provision of services. Daly River and Peppimenarti are funded through THS SAs. Palumpa also has a SA with THS but have requested that THS resume the direct management of the health service. Wadeye and Woodycupaldiya are directly serviced by THS. Historically Palumpa and Wadeye have close affiliations, whilst Peppimenarti was established as a move away from Daly River. There is conflicting and confusing information about which communities could comfortably share health service resources. Palumpa has been under resourced for many years[2]. Thus improved service delivery must take into account these difficulties and relationships, and part of this is developing a system within which all population groups in a Zone feel they have some ownership.

On the other hand the communities represented through the Jawoyn Association (Gullin Gullin-Weemoll, Wugularr, Barunga, Manyallaluk and associated out-stations) present opportunities for a form of regional governance of health services.

Even more the Tiwi Islands are a highly homogenous group who have developed a regional governance of their health service the area of which coincides with our Health Service Zone.

These examples illustrate the great diversity of situations which demand flexible arrangements which fit the reality on the ground.

The complexity of social, cultural, economic and political dynamics within Aboriginal society demands a circumspect approach. A key aspect of health development in the light of new evidence (see Chapter 6) is the reconstruction of Aboriginal society in the wake of the destructive colonial processes of the last 130 years or so. Health sector policies and programs that result in further divisions within communities need to be avoided. The health sector needs to develop a much more sophisticated understanding of the environment within which we operate and be prepared to take direction from the Aboriginal health leadership.

We do not consider Zones to be able to be used in a consistent way in regard to Zone-wide PHC service management, or Zone fund holding bodies for per capita funding arrangements.

Recommendation 3

We propose that the Top End (incorporating the 4 ATSIC Regions of Yilli-Rreung, Jabiru, Miwatj and Garrak-Jarru and the THS Districts of Darin Urban, Darwin Rural, East Arnhem, and Katherine) be divided into 10 HSZs for the purpose of PHC service development.

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[2] Scrimgeour, D *Report of Review of Nganmarriyanga Community Health Service* Menzies School of Health Research, 1992.

Recommendation 4

We recommend that the concept of Zones be used flexibly, and not as a model across the Top End. Specifically, whilst some Zones will lend themselves to the management of health services on a Zone-wide basis (eg Tiwi), this will not be the case in all Zones.

B. Primary Health Care Services

Core Functions of PHC

Background to the Concept:

The notion of core functions of PHC has been around since at least early 1994 when the Commonwealth Health Department sponsored a meeting of representatives of community controlled health services and a number of health bureaucrats in Sydney. This meeting was called in anticipation of Commonwealth Health gaining responsibility for the funding of AMSs. This in fact did not happen until 1995. However, the community controlled health services were keen to have some notion of core functions included in the Health Departments arrangements for funding so that there would be clarity of what Aboriginal health services were.
Later, there were moves to ensure that core functions of PHC were included in the Framework Agreements between the State/ Territories and the Commonwealth on how Aboriginal health issues would be pursued. Whilst this was not accepted, the Australian Health Ministers Advisory Council (AHMAC) sent the issue back to the States/ Territories for further consideration and development. Thus the NT developed a local process to look at this. This culminated in the presentation of the Rotem/ Freeman Report in 1999.

When Minister Wooldridge established the National Aboriginal and Torres Strait Islander Health Council, there were three sub-committees established by the Council – Workforce Issues Sub-Committee, Substance Abuse Issues Sub-Committee, and Remote Area Issues Sub-Committee. The Remote Area Issues Sub-Committee took on the task of developing a definition of core functions.

The core functions of PHC according to a circulated paper[3] restricted the notion of core functions to the provision of sick care and the medically derived preventive/ public health measures such as immunisations, and various screenings. Whilst recognising the wider functions of comprehensive PHC, it did not see these functions as 'core'.

Such a limited notion of core functions does not fit well with Aboriginal notions of 'health' or with the dominant causes of mortality in the Aboriginal community. Many saw it as predictable that such a notion would result in the limited funds available for Aboriginal health being totally consumed by medical programs, with programs aimed at addressing social issues involved in substance abuse, youth suicide, domestic violence, and the like, not attracting resources because they are not considered 'core'. This proposal was never formally adopted.

[3] *'Health Service Delivery for Remote Aboriginal Communities: Position paper of the Remote Areas Issues Sub-Committee of the Aboriginal and Torres Strait Islander Health Council.'* April, 1997.

A PHC service that only provides sick care from a medical and public health point of view fits better the definitions of *selective* PHC rather than *comprehensive* PHC as discussed above. On the other hand, attempts to define core functions in detail for the non-medical health activities assumes that outcomes can be achieved in a way that mirrors the medical. That is the determination of strategies outside the community politic/ dynamic followed by implementation strategies that are imposed on the 'target' community. This is not the case. Whilst medical care and public health interventions of the medical type can successfully deliver specific (but narrow) outcomes to passive recipients, this does not apply to other issues such as nutrition (heart diseases, diabetes), substance abuse, violence, and the like. Attempts to specify detail about what these programs should be fails to take account of the common factor that holds them together. That is, they all require community initiative and action for there to be any chance of positive change.

The debates around these strategic questions again reflect the colonial relationships involved between Aboriginal communities and government and professional agencies. The battles that occur in the mainstream between sickness services and public health, and in more recent decades between these interests and health promotion, as well as the professional jealousies embedded in those relationships, are imposed on the strategies for better Aboriginal health. This dynamic tends to push PHC towards a selective rather than a comprehensive approach. A move towards agreed core functions of PHC for community controlled health services would help prevent this tendency of fragmentation of PHC towards selective programs.

A further purpose of a core functions approach is to provide a template for funding bodies so that their funding lines are clear and have a reasonable chance of supporting the development of effective and comprehensive community PHC. It would help identify gaps that particular services have in achieving a comprehensive approach, and allow a measure of government performance.

The history of conflict between government and community run PHC services can be lessened if governments are able to move away from defining their primary role as a *deliverer of PHC* towards their role as a *funder of PHC.* This could become the key focus for a collaborative partnership approach between the government and community sectors. THS is intending to find ways to move out of PHC service delivery.

Recommendation 5

That the NTAHF adopt the expanded Core Functions of PHC as the basis for implementation of PHC services in Aboriginal communities.

Overview of Core Functions of PHC

PHC Services that people should have access to are based on the Core Functions of PHC from the Central Australian Health Planning Study and are illustrated in Table 17. The discussion that follows incorporates detail of essential components of PHC expanded from the Freeman, Rotem Report.

Table 17: Core Functions of PHC

Core Function	Programs
Clinical Services	Sick care services Screening programs Public health programs (eg immunisations)
PHC Support	Management Program development & evaluation support Education and training Specialist/ allied health support
Special Programs	Preventive programs requiring community 'agency' (eg substance abuse, youth suicide, domestic violence)

i. Clinical Services.

These services include sick care services and medical public health or preventive services.
Clinical care includes:

- Sick Care
  - First contact treatment of illness and injury;
  - 24 hour emergency care;
  - 24 hour access to medical advice;
  - Psychiatric care;
  - Social & Emotional Health including counselling and outreach services;
  - Dental/ oral care;
  - Early Detection & Management of chronic conditions (including dietary advice);
  - Care for the frail aged and disabled;
  - Provision of essential drugs and other therapeutic methods;
- Opportunistic Screening Programs
  - Chronic Disease – diabetes, hypertension, renal disease, heart disease.
  - Sexually transmitted disease;
  - Well Men's and Women's health checks;
  - Annual health assessments for adults aged more than 55yrs.
- Public Health
  - Antenatal care, child birth support, and postnatal care;
  - Child health programs with emphases on growth promotion and support for parenting;
  - Participation with local communicable disease control strategies (eg TB, measles) as required;
  - Provision of immunisations according to recommended schedules;
  - Cervical and Breast Cancer screening programs.

Issues such as environmental health issues, nutrition, substance abuse, violence, etc cannot be dealt with appropriately through clinical services. These issues require intersectoral action involving other community agencies eg the store, community council. However, the interactions that occur in the clinical situation present opportunities to provide information and advice to people as brief interventions[4].

ii. 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, support to maintain equipment, buildings, and vehicles, program development and evaluation, staff development support. Other support needs to be provided at the Regional level – that is either in Darwin, Katherine or Nhulunbuy.

[4] There are times when these brief interventions can be more like victim blaming occasions with health service staff lecturing people about their weight, tobacco/ alcohol use, etc. This can further damage people's self-esteem which can aggravate their health status. Thus clinical staff should be encouraged to make sensitive judgements about when and how such brief interventions should be made, rather than these being prescribed by chronic disease protocols, or by computer programs.

AMS Hub Centres

A developing concept in recent times has been that the larger Aboriginal community controlled health services in the NT (Danila Dilba in Darwin, Wurli Wurlinjang in Katherine, Miwatj Health in Nhulunbuy, Anyinginyi Congress in Tennant Creek, and Congress in Alice Springs) function as regional PHC development and support centres. Many of the regional support roles (management - especially middle management, program development and evaluation, staff development, IT support, and Special Preventive Programs development) discussed above are roles that fit logically into this concept.

In order for this to be advanced a number of factors need to be addressed. It must be recognised that in order for this Hub-Spoke model to work, the existing regional AMSs need to be adequately resourced to deliver PHC service to their local populations and regional visitors that is their primary role. Services are likely to suffer from community backlash if they are seen to be providing inadequate health services to their community whilst being involved in a range of regional activities, which people do not necessarily understand.

There is a current issue that is steadily becoming more acute in regard to this. There appears to be no mechanism within OATSIH or THS for the basic funding arrangements of existing AMSs to be reviewed and adjusted according to current real needs. We are aware of this being an issue for all of the community controlled health services in the Top End.

The other fundamental factor is the need to have clear understandings of the regional roles that are expected of the Hub Centres, both from the funding bodies point of view, and from the remote (or spoke) PHC service point of view. Obviously, adequate resources will need to be made available to fulfil these expected roles.

Nevertheless, the development of a Hub-Spoke model is potentially a very powerful means of further strengthening an Aboriginal health leadership and Aboriginal management, and fits well into the reconstructive aspect of the project of improving Aboriginal health.

Recommendation 6

That funding bodies develop appropriate mechanisms for reviewing the funding base of existing Aboriginal community controlled health services to ensure that they are adequately funded to provide PHC service to their local population as well as provide regional support to PHC service in their region.

Recommendation 7

That the Hub-Spoke Model for the provision of regional support to PHC services be pursued by developing some shared understandings of the roles to be undertaken and that funding arrangements be developed for both AMSANT and the Hub Centres to facilitate this development.

Many of the regional support functions for PHC services discussed below logically sit with the AMS Hub Centres. This does not imply a monopoly provider, but rather that these centres take responsibility for ensuring that the supports relevant to their region are in place, whether provided directly by the Centres themselves, or contracted to other providers.

Administrative Support

i. LOCAL SUPPORT

We propose that each PHC service in communities of more than 400 people have at least 1 administrator. Those with populations of between 200-400 need a part time administrator. In some places this has been achieved through the employment of a senior nurse whose time is split between clinical work and administrative tasks. The administrator should not be designated a manager or the 'boss' in an hierarchy of power[5], but rather they should have their administrative responsibilities detailed, and encouraged to work harmoniously with other PHC staff as part of the PHC team.

Administrators should be resident in the community they serve.

Transport is a major issue for people in communities. Sometimes being more remote actually makes things easier as arrangements (either aircraft or 4WD) are automatically made, whereas being close to a main centre can mean that transport resources are denied. For instance, PATS is unavailable if community of residence is less than 200kms from the regional centre. In these situations, the provision of vehicles and driver resources as part of PHC service budgets would help overcome the problem.

Other local support should include:

a) Drivers;
b) Cleaners;
c) Yardman – maintenance of buildings, gardens and vehicles.

ii. REGIONAL SUPPORT

One of the lessons to be learned from PHC service development in the NT, with the development of autonomous PHC 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, these supports should be operationalised within a collaborative framework that helps ensure the support of all agencies with major responsibilities for Aboriginal health service development (THS, OATSIH and AMSANT), and ensures that the roles and responsibilities of different agencies are defined. The currently operating collaborative forums – CARIHPC, TERIHPC, and most importantly the NTAHF are vehicles for the development of agreed roles and responsibilities.

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[5] There have been suggestions that each Health Service Zone should have a Manager appointed by THS to take responsibility for both the management of PHC services in that Zone, as well as fostering community control of services. If PHC is best delivered through a 'team' approach, then an hierarchy of power is inappropriate. In most remote services the numbers of staff are going to be small. A devolved management structure still firmly set in the central hierarchy is likely to be disruptive to health service delivery. 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.

a) 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. There is a serious shortage of competent middle managers in Australia, and this problem is even more of an issue in Aboriginal organisations where educational disadvantage results in makes recruitment of competent Aboriginal managers even more difficult.

➢ **Administrative**

Regional management support to PHC is important so that those in the community can concentrate on community issues and the delivery of appropriate services. 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. Whilst 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 yeas 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 descriptions, selection criteria and processes with the PHC staff or community members. The process should include advertising the job, police checks, previous employer checks, short listing of applicants, organising interviews with selection panel, and informing 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 could incorporate this process into funding agreements. An example of how this can work is the work of the NTRHWFA that provides solid support to PHC services for the recruitment of doctors. OATSIH has funded AMSANT to employ a Workforce Issues Project Officer. Whilst recruitment was part of this proposal, this position has concentrated mainly on issues effecting AHWs, and recruitment issues here are quite different to other health professionals.
- Financial management. Regional support in financial management, including how to access funds, accountability requirements, and how to utilise resources to achieve outcomes are 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. Some resources already exist, such as the computer program, *Money Story*, which has been used by some community organisations. This program provides simple and user friendly reporting using icons as well as words.
- 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 eg. Vehicles, office and medical equipment – asset register, maintenance protocols, depreciation protocols. Guidelines and computerised systems could be developed at a regional level. The calibration of medical equipment is a special technical skill that is best provided from 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.
- IT Support is an increasingly important area. Many health services have reported that whilst they have received funds to purchase hardware and software for clinical management, there is no ongoing support for upgrading the hardware or software. This is an urgent issue that needs addressing. Further small services cannot have on-site IT support people and are dependant on regional support. This could be incorporated into the role for PHC Hub Centres.
- 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. This could be located in the proposed Regional PHC Hub Centres. It should be stressed that this unit would not determine the policies for community services, but would ensure that policies sit within legal responsibilities, and would facilitate the community PHC service to incorporate 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[6] provides a framework for considering policy issues in terms of the objectives of the service. They have also produced a manual[7] for small rural and remote PHC services and, with Nganampa Health Council and Menzies School of Health Research developed a manual[8] modified for use in Aboriginal health services. A regional approach would build on work already done, and develop draft policies to be made available to smaller PHC services. AMSANT and the NTRHWFA are currently embarking on a joint project to develop a PHC Service Management Manual that is expected to be a resource (both hardcopy and electronic) that would address some of these issues. It is intended that this will include workshops with PHC service administrators that will help facilitate a network of health service administrators and the development of appropriate professional standards.

There is an education and training component to these issues that could be part of orientation and in-servicing programs for health service administrators and managers.

A component of these support strategies should be directed at the needs of Health Boards. People elected to Boards of Management or of community controlled health services, or community health boards/ committees, 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.

Relief Staff

Getting relief staff when needed for staff development or annual and other leave is difficult for small services, and can be expensive. A regional workforce unit that could facilitate access to relief staff would be of great support to PHC services. The NTRHWFA provides this service for doctors, and this should continue.

Recommendation 8

We propose that a PHC service workforce unit be established with Top End and Central Australian arms to provide support for recruitment of staff including relief staff. Consideration should be given to utilising the infrastructure of the NTRHWFA to provide this function.

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

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

8 CHASP, Nganampa, Menzies *'Manual of Standards for Rural and Remote Aboriginal Health Services.'* 1993.

- **Health Program Development & Evaluation**

Public health programs such as immunisations, STD control, and other communicable disease control, as well as well women's and men's programs, chronic disease management and child health programs require systems to be put in place so that health service staff can efficiently follow up people 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 to be possible to have a regional approach that 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[9] 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 centres 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. Further, negotiations need to take place with funding bodies to ensure a seamless process between internal evaluation processes and accountability requirements to funding bodies.
- Community participation issues/ consumer input – this relates to specific program issues such as involvement of carers of children in growth promotion programs, and should not be confused with issues of health service control.

All of these programs will require evaluation strategies. 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. Historically in Central Australia the Menzies School of Health Research have provided this type of support to a range of health services and community development programs. This does not appear to have been such a focus of the Menzies School in the Top End. This capacity could be developed as part of the PHC Hub Centre concept. Likewise public health monitoring processes, including Quality Assurance programs could be developed through the Hub Centres to assist smaller services.

ii. 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 could be delivered by regional in-service training programs. For doctors, Divisions of General Practice and the NTRHWFA provide resources for continuing medical education (CME). Opportunities for these doctor-centric programs to become more appropriate to the multi-disciplinary approach to PHC service delivery need to be recognised and made available to non-doctor staff.

In-service training or staff development is logically located within PHC services. However, smaller services are unable to maintain these functions, and many staff employed in small community controlled services or 'SA' services receive inadequate, if any, regular in-service training. This function could optimally be incorporated into the regional support functions of the PHC Hub Centres.

[9] Central Australian Rural Practitioners Association

It is important that the need of the PHC sector drive the in-service education program, regardless of who actually delivers the program.

The issue of AHW education requires different processes through accredited education facilities such as Danila Dilba and Batchelor College.

Orientation of Staff. New staff, whether Aboriginal or non-Aboriginal require orientation to their new work. Both Aboriginal and non-Aboriginal orientation will need to be focused on how the health care system works, what their expected role in it is, what community services are available for people in need, demographics of the region, cultural issues, and the nature of Aboriginal organisations and communities. Some components of this is best organised at the regional level, whilst specifics about the community needs to be delivered locally.

Staff education and training support is a fundamental aspect of support to PHC. This support needs to be organised at a regional level and coordinated with the staff relief agency. This could be developed as part of the Hub Centre role, or through an in-service facility for the Top End based at Danila Dilba. It is important that wherever this facility is actually located, that it be firmly located within the PHC sector. This is to ensure that the *felt needs* of the PHC service providers are the drivers of the programs delivered. Currently too much of the in-service training tends to be driven by education provider agendas, and assumptions remote from the PHC service culture. This does not preclude this coordinating facility from purchasing training from other agencies.

Recommendation 9

We propose that an in-service educational unit be established to be responsible for the provision of orientation and in-service programs to all PHC service staff including AHWs, nurse, doctors, and administrators.

Health Committees/ Boards of Management. Community members elected to these bodies often have poorly developed ideas about legal roles and responsibilities of their position. Well-timed workshops organised by AMSANT 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. Whilst other agencies have been providing some training to Aboriginal bodies in governance, these have no experience in the specific issues relating to PHC service governance. We have received numerous stories which relate specifically to standards and values relevant to other sectors being imposed on the health sector with negative consequences. Thus this role should be firmly placed within the community PHC sector. This relates to the major strategic goal of supporting and developing the community health leadership and the reconstruction of Aboriginal society as a means of addressing poor Aboriginal health status.

The role of Health Boards/ Committees is crucial to the prospects of expanding community control of health services. AMSANT and some of its member Board members have a unique role to offer training programs for new and developing Health Boards. Generic providers of governance training are unable to deliver the specific training needs of Health Boards. These should be run through the Aboriginal community health sector as part of the strategy of reconstructing Aboriginal society. This does not preclude other providers offering their training programs to Health Boards/ Committees.

Recommendation 10

We propose that a program for the training of members of Health Boards/ Committees be established and run through the community-controlled sector, specifically AMSANT and that long standing Board Members of established services be utilised in this training.

AHW Education. Basic AHW education is beyond the scope of most individual service providers. The only service providers in the Top End that offer basic qualifications for AHWs are Danila Dilba, Miwatj Health and Batchelor Institute. There has been ongoing criticism of the education and other supports for AHWs.

A national review of AHW issues is currently being undertaken by OATSIH. The NTAHF decided that, in the NT, this should be restricted to a review of previous reports because it was felt that the situation had already been well documented. OATSIH see the review as a way of comprehensively documenting the issues and developing strategies for attracting further resources to address the problems.

AHWs have recently been employed under a new AHW Career Structure that links AHW competencies with salary rates. This was initially developed within THS and implemented for THS employed AHWs in October 1997. For other health services the implementation occurred after this date. AMSANT negotiated with OATSIH for the implementations of the new Career Structure within their member services that was attached to a Best Practice program for AHWs. After a negotiation process involving AMSANT and OATSIH the new career structure was implemented in the community controlled services in mid 1999 backdated to July 1998.

Despite these improvements in salary levels, there is little doubt that AHWs are poorly supported in all areas – basic education courses, in-service training, general support to practice in a crisis environment, the development of peer support, etc. These reflect major issues that have been addressed in a number of previous reports, but not acted on. This has meant that many AHWs have given up. The number of AHWs living in communities but no longer working as AHWs is well documented[10]. Whilst this report was conducted around 5 years ago, the situation appears not to have changed and urgent action is required. In the Katherine West CCT where more support has been provided than previously they have had some success in attracting old AHWs back into service. However, there are still many communities with no or grossly inadequate numbers of AHWs. The training of new AHWs continues to occur without consideration of particular community's needs. It is clear that there are still inadequate resources allocated to support AHW education, professional practice and continuing education.

It should be noted in this regard the different situation that operates for AHWs as a professional group compared with nurses, doctors, and allied health professionals. All of these latter groups have professional associations who actually control the maintenance of professional standards. Thus it is the professional groups themselves who take responsibility for these matters. For AHWs, there is no professional association, except the Central Australian and Barkly AHW Association operating in Central Australia. However, this group has not taken up responsibility for these issues, and it has been the employers of AHWs (the community controlled services and THS) who have tried to perform these roles.

Recommendation 11
We urge funding bodies (OATSIH & THS) and the major employers of AHWs (THS and AMSANT members) to take immediate action to ensure that adequate professional support is provided to AHWs. We suggest that the NTAHF oversee the development of collaborative strategies to achieve this.

Recommendation 12
We recommend that the NTAHF enter into discussions with AHW education providers (especially Batchelor College) to develop ways that entry requirements for AHW students can take account of particular community's needs.

[10] Tregenza, J & Abbott, K *'Rhetoric and Reality: Perceptions of the roles of Aboriginal Health Workers in Central Australia.'* Central Australian Aboriginal Congress, Alice Springs, 1995.

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. As mentioned above, AMSANT and the NTRHWFA have been working together to provide better support, including the development of a management manual for PHC services, and this should include ongoing workshops, and other educational events.

iii. Provision of Specialist and Allied Health Services

Rare health service resources will need to be delivered through regionally organised schedules of visits. These services include both medical specialist services, and allied health professional services. These visits are best organised and coordinated at a regional level. THS is the main employer of these professional groups, and this organising and coordinating function is best located within THS. However, work needs to be done to ensure better equity of coverage, and to facilitate multi-disciplinary community visits enabling particularly better chronic disease management.

The medical specialist services that are currently of highest priority include:

- Paediatrician.
- General Physician.
- Ophthalmologist or Optometrist.
- General Surgeon.
- Renal Physician.
- 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.

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. This could facilitate a service-oriented Chronic Disease Strategy within PHC service by organising a range of visits at the one time to cover the types of services required. For example, the Physician, Ophthalmologist, Podiatrist, and Dietician along with PHC staff - AHWs and nurses – is likely to improve the care of diabetics in the community.

Regular allied health visits should include:

- Dentist.
- Physiotherapist.
- Occupational therapist.
- Mental Health Service (these should b 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 less frequently.

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

Recommendation 13

We propose that a regional function be developed within THS to employ allied health professionals and to organise medical specialist and allied health visits to communities.

iv. Pharmaceuticals

Since the implementation of the Section 100 arrangements approved by Minister Wooldridge, the cost of pharmaceutical supplies has become less of an issue. However the provision of support for the storage, and dispensing of pharmaceuticals, including the management of dosette boxes for people with chronic illness remains an issue.

Pharmaceutical supply arrangements should include the supply and maintenance of medicine kits to designated holders in out-stations/ homelands, including the monitoring of expiry dates. The community pharmacies that have taken over the supply of pharmaceuticals to community-controlled services have an important role to play here. There is a need to address training issues both for holders of medicine kits, and for PHC staff. This is best organised at the regional level.

Recommendation 14

We propose that Community or Regional Pharmacies involved in the supply of pharmaceuticals to Aboriginal health services under the Section 100 arrangements develop regional supports to PHC services involving training in the maintenance, storage and dispensing of pharmaceuticals to PHC staff and to Medicine Kit holders; and develop systems of management for the supply of dosette boxes, blister packs or other methods of provision of medications to patients with chronic illnesses or disabilities.

v. Technical Support

There are two areas of technical support that are critical to good PHC service delivery. The first is a system of monitoring and calibrating medical equipment. This is mostly outside the skills and capacity of PHC service staff, but hospitals usually employ technicians with these skills. The role of these technicians needs to be made available to PHC services.

Recommendation 15

That technical support for the maintenance and calibration of medical equipment be the responsibility of THS or Hub Centres whether through regional hospital employed technicians, or through contracts.

The other technical area relates to IT. A number of systems are currently being used in PHC service including Communicare, Ferret, CCTIS and THS's Primary Care Information System. How best to use these systems requires some coming together of clinical staff with technical people. Further some sharing of what the different systems can achieve would be useful, particularly given the commercial competition between most of the systems being used.

Whilst effort has been put into the development of IT and even running pilots on tele-medicine, there remains a serious lack of capacity to maintain computer technology and to develop the technology optimally to assist PHC service delivery. Improving this capacity is most logically done through the AMS Hub Centres. Further funding bodies need to address the need to provide funds at regular intervals for the upgrading of both software and hardware. Hardware is depreciated over a three-year period, and this should be used as the bases for hardware replacement. Funding bodies assert that health services should budget for these needs in their financial planning processes. However, there is currently no mechanism for health services to have their base funding reviewed as to its adequacy to provide high quality best practice PHC services within existing budgets. Current budgets tend to pre-date the current level of technological dependency with the need for internet access, etc. Thus these are new needs that health service have that have never been considered by funding bodies.

Recommendation 16

That IT support be provided to PHC services through strengthening the capacity of this function of the AMS Hub Centres.

Recommendation 17

That funding bodies (OATSIH & THS) develop regular funding arrangements to ensure that PHC services have both software and hardware upgraded in a three-year cycle.

Transport

The context of large distances and poverty in Aboriginal communities combines to ensure that vehicles, and other means of transport are always an issue. We have discussed above the difficulty that the 200 Km rule presents for Aboriginal people in this situation. Whilst we appreciate the economic concerns that underlie the implementation of this rule, it nevertheless is a significant barrier to people accessing timely medical investigations and care.

Recommendation 18

That the restrictions on PATS that disallow people access to support if they live less than 200 km from the service provider be reviewed and consideration given to replacing PATS with other forms of transport for the communities affected, or the distance of eligibility be substantially reduced.

iii. Special Preventive Health 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 usually have 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 misuse 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.

It is inappropriate to develop a long list of *Essential Components* that fit into this category of the Core Functions of PHC, as what is appropriate is dependant on community perceptions, the priority of local leaders, and the degree to which community members will drive it.

However the sorts of issues that communities might be interested in addressing are:

- Substance Misuse Programs
  - Availability strategies (eg restricting access by limiting opening times, imposing sales limits, declaring community dry);
  - Development of local AA type support programs;
  - Treatment programs;
  - Support for co-dependants.
- Domestic Violence Programs, Safety options.
- Mothers support programs
- Male support programs
- Parenting programs
- Youth Programs
- Homework Centres
- Store monitoring programs
- Community Hygiene programs

We have avoided using the term *Health Promotion* because of increasing confusion and contention about what this means in the wake of professionalisation of health promotion within governments in Australia. Whilst these professionals promote the Ottawa Charter (see Appendix 5) as their guide, there is an essential contradiction in the way many health promotion programs work. We acknowledge that many have done their best to avoid these contradictions, and have worked strongly with particular communities around perceived health problems. The history of the struggle against HIV/ AIDS illustrates the importance and centrality of *community agency* in achieving successful outcomes. This needs to be better recognised as *the* key factor when attempting to develop programs to address Aboriginal health problems.

With these types 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.

Funding for these programs needs to be directed at strengthening an integrated and comprehensive PHC service in the community, but funding needs to be organised differently to that for clinical services which need to be delivered to all communities in a more or less similar way. Funding bodies need to develop some flexibility in terms of available funds to support community initiatives in a timely manner.

The development of these programs needs to be organised in a way that strengthens the Aboriginal leadership as part of the reconstruction strategy discussed earlier. Thus funding should be made available to enable the Hub Centres and AMSANT to jointly play a role in working with communities on how to develop these Special Preventive Programs.

Recommendation 19

That health promotion strategies, especially attempts at community capacity building and community development be brought under the influence of the NTAHF to enable the Aboriginal health leadership (AMSANT) to better direct how these processes should operate.

Recommendation 20

That funding bodies maintain a pool of fund whose expenditure is overseen by the NTAHF, and which aims to support programs that groups in the particular communities wish to pursue. The development of these programs may involve the hub centres in developing a framework for the program activity and a means of evaluating progress.

Recommendation 21

Existing OATSIH and THS health promotion funds should be pooled to make up this funding line.

Recommendation 22

That this program be directed by the Aboriginal leadership as represented in AMSANT.

Improving Access to PHC

The staff required to deliver these services are mainly AHWs, nursing staff and doctors. Where possible these staff will be resident in the community they serve within the HSZ. In most HSZs, there is more than one large community. Each of these communities should have designated residential staff, with a visiting doctor on a schedule negotiated with the other communities being serviced. The location of the doctors residence in some cases will appear obvious. However, depending on the other political issues between communities such a decision should be made *after* adequate community input. Where communities are unable to provide clear direction, those responsible for PHC service provision should make a decision so that those communities are not put at risk through indecision by providers.

Staff accommodation will have to be addressed in the process of increasing resident staff in communities . It is 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.

PHC 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 each population 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 for delivering clinical PHC services are AHWs, nurses and doctors.

We have used staff: population ratios to measure basic community need scaled according to community size. (See Chapter 2)

Most smaller populations will not have a family member who is an AHW, and it is unlikely that someone not affiliated with a family group could join as their AHW. This will mean for the vast majority of out-stations/ homelands, 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/ homelands living to people's health status it is important that the health care system supports services to out-stations wherever possible. It is assumed that nurses and doctors will provide visiting services to these smaller populations, and will not be resident.
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 services 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 either through a visiting services, medicine kit holders, telephone advice or a mixture of these.

Visiting services – AHW, nurse, and/ or doctor visits organised from neighbouring communities or from Darwin, Katherine or Nhulunbuy. In some cases 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 and be within the capacity of the health service to deliver. Visits to small out-stations may be focused on the maintenance of medicine kits, and providing some general clinical screening, rather than on more regular face to face clinical care. It should be emphasised that a significant number of PHC services already provide some level of visiting service under existing conditions.

Recommendation 23

We recommend that PHC services be resourced adequately to provide regular visiting services to their associated out-stations/ homelands, and that staff be clearly oriented to the expectation that this is a core part of their work.

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, Ascabiol, antiseptics, methyl-salicylate (rubbin' medicine) and oral re-hydration salts ought be fairly readily available. Others such as antibiotics, 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 with regular reviews through the visiting service. The list of drugs provided would need to be modified according to the availability and reliability of refrigeration.

The Health Care Agents Subsidy Scheme is a currently operating program in some parts of 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 should 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 PHC function. Pastoralists could access this new program. 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 a regional pharmaceutical distribution service. This could involve community pharmacists providing drugs to AMSs through the Section 100 scheme, or THS Regional pharmacies;
- Maintain supplies to medicine kits through the pharmaceutical distribution service;
- Liaise with designated PHC services to ensure coordination with nurse and medical officer visits, particularly in regard to medication reviews and dosette supply;
- Organise regular training support.

Table 18: Health Care Agents Subsidy Scheme.

Size of Community	Percentage of Subsidy (%)	Amount of Subsidy ($)
200	100%	20,468.00
160-199	80%	16,374.40
120-159	60%	12,280.80
80-119	40%	8,187.20
40-79	20%	4,093.60

Source: Territory Health Services

Table 18 shows the current subsidies available to unqualified persons who are designated Health Care Agents by size of community in the vicinity of the pastoral lease.

Recommendation 24

We propose that a system be developed to issue designated kit holders in small communities with no resident health service staff, with medicine kits geared to the knowledge and experience of the holder.

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

Development of a telephone health care advice service that people can access during normal working hours will assist people without other resident health care services to access advice when needed. Regional health authorities will need to work with other agencies such as Telstra and out-station resource agencies to ensure that people have access to either telephone or radio so that they can access this service.
There are two levels from which this service could be developed. In some areas the service may be through the community PHC service. Indeed this already occurs to some extent in some services. However for many of the more isolated out-stations/ homelands, it may be more appropriate to access advice through a more central location such as Darwin. 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 medical emergency/ evacuation on call service. The proposed service is primarily for people on out-stations/ homelands who do not have access to resident health professionals. It is a PHC 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 is inappropriate for a medical officer to take on this large work load when most of the issues will be handled competently by AHWs or nurses.

Recommendation 25

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

C. Community Control of PHC Services

Community control of Aboriginal PHC services is one of the most contentious issues faced in developing PHC services in Aboriginal communities. Thus it is necessary to look at this matter in some detail. We have attempted to present the history of community control of health services, as well as some of the philosophical underpinnings. We then discuss in detail the various attempts that have been made to develop community control, and suggest some principles that are relevant to progress the process.

Reflections on the History of Community Health

In 1971 a group of Aboriginal activists and non-Aboriginal supporters established the Redfern Aboriginal Medical Service. Concern about Aboriginal people's access to mainstream services which were racist, discriminatory and expensive were the motivating factors behind this development[11]. In Melbourne a similar group established the Victorian Aboriginal Health Service shortly after, and many Aboriginal communities followed these leads. Aboriginal Legal Services were established in this same period.

Black militancy, to some extent inspired by the Black Power movement in the USA (eg Black Panthers), was part of the drive to establish these Aboriginal controlled organisations. There was a link up of militancy with grass roots community leaders who had been active resources for their communities. The story of *the late* Mum Shirl in Redfern is a celebrated example.

[11] Foley, G *'Aboriginal community controlled health services: A short history.'* Aboriginal Health Information Bulletin, No 2, 1982, pp13-14.

On a national level, by 1987 there were 54 Aboriginal community-controlled organisations providing health services, and receiving grants from the DAA totalling $18.548m. These organisations had formed a peak body in the late 1970s known as the National Aboriginal and Islander Health Organisation (NAIHO). In 1986, the DAA ceased funding NAIHO due to an unsatisfactory audit report. However, the Minister did permit Aboriginal health services to pay a voluntary annual affiliation fee of up to $3,000 each to NAIHO, so that an administratively restructured NAIHO could undertake national Aboriginal health projects on a contract basis as required[12]. The funding of the peak body, however, remained problematic. Catholic Relief funded the organisation for a year or so, but the crisis also involved dissension within the organisation, and eventually a new body evolved known as the NACCHO.

Community Control of Health Services

Community control of health services has been advocated since the late 1960s. In the 1970s 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 PHC 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 these principles into their declaration of PHC[13]. This reflected developments in Australia and around the world, especially in some third world countries where community based PHC programs were developed with few resources except the people of the community in which it developed.

Much of the literature about community control comes from urban and North American experiences[14]. Whilst this is of some interest, it has some obvious irrelevancies to the Aboriginal experience of community control.
The most obvious reason relates to the difference between an Indigenous people who have been subjugated by foreign invaders compared to people who are part of the dominant society, even if poor and powerless. Further most of these commentaries are by academics or health professionals, who rarely give credence to the possibility that ordinary community activists might actually take control.

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12 DAA *'Annual Report 1986-1987.'* AGPS, Canberra, 1987, p60-61.

13 *'Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, 1978.'* World Health Organisation, Geneva, 1978.

14 Scimgeour, D *'Community Control of Aboriginal Health Services in the Northern Territory.'* Menzies Occasional Papers, Darwin, Issue no 2/97, pp5-12.

Indeed, in Australia it is true that Women's Health Centres and Workers' Health Centres[15] did involve 'progressive' professionals in their establishment, along with community and workplace activists who would fit Gramsci's notion of 'organic intellectuals'[16] – people who generally had a radical or revolutionary socialist analysis of society and were prepared to engage in new forms of social relationships. In the 1970s (when these services were established) governments established other community health centres, and indeed some were and are little more than extensions of the hospitals, and part of these institutions. In Sydney, feminists who were dissatisfied at the lack of women-friendly services established the Leichhardt and Liverpool Women's Health Centres. Indeed, it is probably fair to say that the development of Aboriginal community controlled health services was a major inspiration behind the development of both women's and workers' health centres.

The overseas commentators quoted by Scrimgeour[17] are referring to community health initiatives which have more in common with the women's and workers' health centre positions in Australia at best, and the government controlled community health centres at worst, than the Aboriginal community controlled services. The theme of these commentators is that community control rarely leads to community empowerment, and indeed often led to the entrenchment of the power of professionals[18]. Scrimgeour refers to O'Neil's analysis of the Quebec situation[19]:

> *'... O'Neil also found that community participation rarely led to genuine empowerment, and more often led to an entrenchment of power of professionals and bureaucrats. He listed four common misconceptions about community participation. Firstly, the community as a whole does not participate; only certain individuals and groups do, and their "representativeness" can always be challenged. Secondly, participation does not usually occur spontaneously; it usually requires external motivation and support. Thirdly, participation can be cumbersome and time-consuming. Finally, citizens may not share values of progressive professionals who support participation.*
>
> *'He also listed elements that can ensure that community participation really means empowerment. Firstly, participating citizens need adequate information on the system in general and the actual operation of the agency. Secondly, they require a strong mandate from the users or the community. Thirdly, a strong personality is required. Finally, there must be mechanisms (such as community organisations) through which representatives can access easily their constituency.'*

In recent years some[20] in the Territory have used Scrimgeour's paper to claim that community control does not exist in the bush, at least, and that it is the doctors, nurses, or administrators that are actually empowered. However, O'Neil's commentary needs to be placed in a context. Quebec has been caught up in a political struggle involving that province's francophone population. O'Neil points out[21]:

> *'At a more macro-social level of analysis, however, the creation of CLSCs[22] was interpreted by some critical analysts as a subtle way for the government to tame and integrate into the mainstream of society a special brand of grassroots organisations which in urban settings (especially in poor neighbourhoods of Montreal and Quebec City), had begun at the end of the 1960s to self-organise various kinds of services, notably in the realm of health. Formal participation on the board of CLSCs is seen by these analysts as a way to curtail situations in which communities had created organisations over which they had total control, and as a more or less deliberate strategy by professionals and technocrats who had gained control over the state health apparatus through the reform to tame this threat to their newly acquired power."*

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15 Bartlett, B *'21st Anniversary of Workers Health Centre.'* Address delivered to meeting October, 1997.

16 Gramsci, A *'The Modern Prince & Other Writings.'* International Publishers, New York, 1972, pp 118-123.

17 Scimgeour, D, *op. cit.,* pp6-9.

18 O'Neil, M *'Community Participation in Quebec's Health System: A Strategy to Curtail Community Empowerment.' International* Journal of Health Services, Vol 22, No 2, 1992, pp287-301.

19 Scimgeour, D, *op. cit.*, p9.

20 Wakerman, J, Bennett, M, Healy, V, Warchivker, I *'Review of Northern Territory Government Remote Health Services in Central Australia.'* Menzies School of Health Research, August, 1997, p176.

21 O'Neil, M *op. cit.*, pp287-301.

22 CLSC is the abbreviation for *'Centre local de services communautaires'.*

These grassroots organisations were known as *People's Health Clinics* or *Cliniques Populaires.* By the end of the 1960s there were about 10 of these organisations across the province. They were totally controlled by citizens from the beginning, and professional power was minimal. They were initiated by what Gramsci called *'organic intellectuals'*.
There are strong similarities between these People's Clinics and Aboriginal health services. Whilst health professionals were involved in the development of AMSs, their power was minimal. This issue of power wielded by health professionals, and especially doctors, has been an ongoing issue amongst Aboriginal health services. In the interactions that occur between professional staff employed by AMSs and those employed in the government sector, it is common for those in the government sector to assume that their colleagues employed in the AMSs have the degree of professional power that they enjoy in the government sector. The assumption that the Aboriginal leadership is subservient to professional wisdom is frequently made.

Consumers and Practitioners

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 controlled 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 often lacks formal qualifications in the health industry, but who becomes highly qualified in the dynamics of community based PHC, including a high level of knowledge about how the health system works.

The process of establishing a 'community' controlled service (Aboriginal or non-Aboriginal) has always involved threats to the existing service providers and the health establishment. Health Departments have been defensive, and private practitioners have felt that their livelihood might be threatened. All have felt the criticism of their practice implicit in the establishment of alternatives. Further, the establishment of alternatives implicitly challenges government authority and potentially raises issues of sovereignty, legality and morality of government action/ inaction.

This conflict can be beneficial[23]. Everybody lifts their game and services can improve. 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 delivery of health care. We believe that this continues to be the situation in the NT. Recognition of the historical continuities of the colonial relationships which are played out in these conflicts ought to assist health professionals to better manage conflict so that a more productive collaborative relationship can be developed to support Aboriginal people's action to improve health.

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[24]:

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[23] Pederson, AP et al *'Coordinating Healthy Public Policy: An Analytic Literature Review and Bibliography.' Department* of Behavioural Science, University of Toronto, 1988, p 38.

[24] Ife, J *'Community Development: Creating Community Alternatives – Vision, Analyses and Practise.'* Longman, Melbourne, 1995 cited in Petersen, A & Lupton, D *'The New Public Health: Health & Self in the Age of Risk.' Allen* & Unwin, Sydney, 1996, p148.

'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".'

Women's health centres in Sydney were established by 'organic intellectuals' some of whom were also health professionals. There is little doubt that the establishment of these organisations had a cutting edge impact on the way women's health care was practised. However, the actual model was not duplicated across the country.

Similarities exist with Workers' Health Centres. However, the interventions into workplace safety issues was potentially threatening to the stability of industrial relations. As a consequence of the increased publicity about workplace hazards, largely through the work of the Workers' Health Centre, a new form of legislation was introduced which placed greater emphasis on health and safety committees in workplaces to monitor hazards. At the national level, a tripartite structure, the National Occupational Health and Safety Commission (Worksafe Australia) was established with a Board made up of trade union leaders, employers, and government representatives. The Workers' Health Centre was offered financial support but on condition that it not be involved with workers' education. This was to be controlled by the NSW Trades and Labour Council. Thus the activities of the Centre were contained in the interest of stability which was seen by sections of the Labour Movement as being in the interests of a Labour Government. It was in the spirit of the Accord. The base of the Workers' Health Centre within the working class of Sydney was not strong enough to resist these pressures. The Centre continues, but without the capacity to play the same social change roles that it was able to play in its early days.

The point of recalling these situations is to illustrate that government and professionals have an interest in asserting control over these sorts of developments. The same pressures have been a recurring feature of Aboriginal health services[25]. The initial reaction of governments was to resist these developments, but increasingly the pressure of government is to incorporate them into a system and control them that way. Currently there are attempts to narrowly use evidence-based medicine to monitor and control AMSs. Whilst quality assurance programs are as important to AMSs as they are to other sections of the health industry, the types of standards applied need to be modified to be appropriate to both community controlled PHC, and to the cultural values of Aboriginal communities, including the practice of traditional Aboriginal medicine. However, AMSs have a strong base within their own community, as well as having their own professional advisers. These factors militate against any simple bureaucratic or professional control being successful, at least as far as the larger services are concerned.

The difference between the histories of the women's and workers' health movements and the Aboriginal health movement relates to the core issue of the colonial relationship. The government is the government of the colonisers (including women and workers), whereas Aboriginal health services are the organisations of the colonised, the Aboriginal community. Aboriginal society was not party to any agreement about the governance of this country. They were excluded from any say or input into the constitutional arrangements leading to Federation. Indeed, they have had to fight on the terms of the colonisers (ie on the basis of British law) to have any legal rights established. This colonial relationship helps sustain the different model of AMSs. Whereas, women's health centres and workers' health centres have survived in only one or two places, with more appropriate services being incorporated into the mainstream health care system, AMSs have continued to expand outside the mainstream.

[25] Foley, G, *op. cit.*, p13-15.

Community Control of Aboriginal Health

We have used the terms *community control, participation, and involvement* 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, as well as issues of cohesiveness in communities. To try to give them particular meanings tends to create a rigidity, when the processes involved in a community taking control is not an ordered or predictable phenomena. However, there are differences in these concepts, and clearly a community controlled health service with AGMs which elect the controlling Boards of Management are different to a child and maternal health program which has the active participation of some local women. Table 19 shows how some of these terms might be viewed.

To a significant extent the process towards community control is determined by what is on offer – that is, what people in the community perceive as possible. This is partly 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 a communities relationship with bureaucracies and health professionals also influence responses. Unfortunately, the conflict over PHC service delivery in the NT has tended to result in an obsession by some with questions of who represents who, and who speaks for who. These questions occur within communities as well, and are what community politics is all 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. The recognition of community leadership allows some of these problems to be overcome. Although it must be recognised that there are often dual systems of power operating in communities, good leadership accommodates these systems.

Table 19: The Four Levels/ Models of People's Participation In PHC

CATEGORIES	HOSPITAL/ CLINIC BASED	COMMUNITY ORIENTED	*COMMUNITY BASED*	COMMUNITY CONTROLLED.
GUIDING PRINCIPLE	Health ***TO*** the People	Health ***FOR*** the people	Health ***WITH*** the people	Health ***BY*** the People
MAIN CHARACTER	Authoritarian	Paternalistic	Democratic	Self-determining/ Liberating
INITIAL OBJECTIVES	Rigid and statistic oriented	Closed and pre-determined; defined before the community is consulted.	Open ended and flexible; problems and needs evoked from the community.	Formulated by the community & based on their felt needs; vision of an alternative social order expressed by the people.
UNSAID OBJECTIVES	Maintain status quo; perpetuate existing health system.	Improve/ alter certain parts of the health system	Transform the health system and initiate social reforms.	Complete re-structuring of the health system together with socio-economic changes
WHO IS RESPONSIBLE	Health is the sole responsibility of the doctor.	Health is the responsibility of health professionals.	Health is the responsibility of community health workers and leaders	Health is the responsibility of everyone in the community.
OUTLOOK OF HEALTH PROFESSIONALS	Community are the recipients of health care.	Community are beneficiaries of health care.	Community are partners in health care	Community are the managers of their own health care.
LEVEL OF COMMUNITY PARTICIPATION AND MAIN DECISION MAKERS	Community is just informed of health activities. Doctors decide.	Community is just consulted on what can be done. Doctors and other health professionals decide.	Community actively discusses & decides on plans and activities together with health professionals. Decision making shared by community and health staff.	Community identifies needs, defines objectives, plans, implements, monitors and evaluates the health program on their own. The community is the main decision maker.
VIEW ON COMMUNITY AWARENESS / HEALTH PROMOTION	The community should be kept ignorant of health - they aren't educated enough to understand..	Community is made aware enough to change their (individual) behaviour.	As a means for community organising and for understanding the inter-relationships of health to the economic, political and cultural problems.	As a means to generate people's power and ensure continuing community participation.

[1] Adapted from '*Restoring Health Care to the Hands of the People.*' Proceedings of Seminars Sponsored by Bukluran Para Sa Kalusugan Ng Sambayanan (BUKAS) [Task Force People's Health]. Health Action Information Network (HAIN), Quezon City, Philippines, 1987.

Table 19: The Four Levels/ Models of People's Participation In PHC (Contd.)

CATEGORIES	HOSPITAL/ CLINIC BASED	COMMUNITY ORIENTED	*COMMUNITY BASED*	COMMUNITY CONTROLLED.
VALUE GIVEN TO COMMUNITY ORGANISING	The community is not capable of being organised.	As a means to change people's attitudes so that they cooperate with health authorities whole-heartedly.	As an end in itself and as an opportunity for people to develop leadership and management.	As the main tool for empowerment and as a long lasting safeguard to protect the people's interest.
DATA GATHERING, MONITORING AND EVALUATION	Data limited to morbidity, mortality & health service statistics. Monitoring and evaluation mainly the concern of hospital/ clinic management. No feedback of information to clientele or community.	Data gathered by outsiders via a long survey questionnaire with heavy emphasis on health data. Monitoring & evaluation done by health staff. Little or minimal feedback of information to the community.	Data gathered by community health workers & kept understandable and relevant; includes people's felt needs & concerns. Collation and analysis done together with health staff. Monitoring and evaluation done jointly by community health workers and health staff. Regular feedback given to community.	Community decides what data to collect. Community members gather, collate & analyse data on their own. Self-evaluation & self-monitoring systems established. Community members continuously informed of data gathered & relevant actions taken accordingly by them.
INTERSECTORAL LINKAGES & SOCIAL ACTION	Believes that they are doing their work well, thus there is no need for linkages.	Links usually limited to government agencies or to those who give dole-outs.	With any agency, government or non-government who maybe of assistance in giving solutions to health and other issues.	With organisations & institutions working for basic social change. Forms alliances & federations with them.
EFFECT ON THE PEOPLE AND THE COMMUNITY	Oppressive - rigid central authority allows little or no participation by the community.	Deceptive - pretends to be supportive, allowing some participation but resists genuine change.	Supportive - helps people find ways to gain more control over their lives.	Self-reliance & self-determination. People aware of their potential & uses them to the full and with responsibility.
GENERAL IMPACT	No change	Behaviour change - individuals change their habits.	Social change. That is the community begins to change together - eg they might change what sort of food is available through the store.	Structural change - that is, the power relationships change - the community genuinely takes over the running of the store to ensure health food is available.

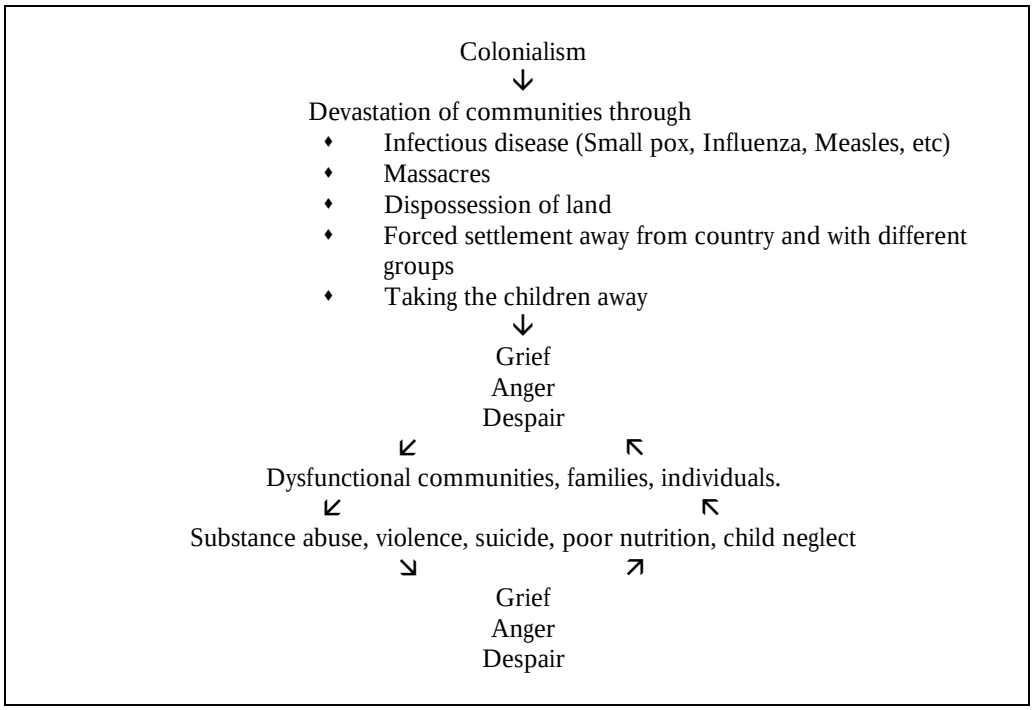
Why Community Control?

Whilst community control is clearly both Commonwealth and NTG policy, it remains the case that many working within these administrations, as well as in other government and non-government agencies either do not understand community control, or are actually hostile to it. Aboriginal people are quite clear about their experience in dealing with non-Aboriginal agencies – in numerous documents they have described the institutionalised racism that pervades Australian society. Racism is frequently used as a term of abuse. We do not use it in that sense in this document. Rather we mean it in the sense that we have all grown up in a society where issues are racialised. It is beyond the scope of this report to go into this matter more extensively. Suffice it to say that racism can express itself as being either hostile or well meaning. Much of the well meaning variety expresses itself as paternalism. However, this inevitably means that some within government departments are either not personally supportive of community control, and some see as simply a matter of rhetoric. Some claim that the existing community controlled services are just power bases for the Directors, who *'don't represent everybody'.* Some professionals seem at pains to assert that *'community control doesn't always work'.* What is actually meant by these assertions is never quite analysed or described; rather they are like clichés. Nevertheless they have been an effective way of attempting to undermine the authority and legitimacy of the Aboriginal health leadership. It seems necessary, therefore, to explain why community control is critical to the project of improving Aboriginal health status.

In Chapter 6 we have provided an overview of the current understandings about the determinants of health. Over the past 30 years Aboriginal infant and child mortality has declined quite dramatically, but appears to have plateaued at around 3 times that of other Australians. In the meantime young adult mortality has risen. Youth suicides (or attempts) are at alarming rates in many communities, substance misuse is common, as is family violence, and sexual abuse (including sexual abuse of children). It is also the case that chronic disease in adults is common, and that ischaemic heart disease and end stage renal failure are major problems. However, over all these changes in health status can be understood by recognising what medical interventions can achieve (even to passive recipients of selective PHC programs) and what medical interventions are unable to achieve. The infant mortality rate was largely caused by infectious disease (pneumonia, gastroenteritis, etc.). We know what to do about that – improved housing, clean water, adequate waste disposal, immunisations and treatment with antibiotics when indicated. Whilst inadequate housing and overcrowding continue to be an issue it has improved enormously over the last 20 years. Most communities have some access to basic clinical services even if they must travel significant distances. We suggest that this provides the explanation to the decline in infant and child mortality rates. However, there are no medical interventions that can address most of the problems explaining the high young adult mortality. The underlying causes to these problems are related to what could be termed the *injuries of colonisation.* Communities are constructs of colonisation – most being created as part of missions or government settlements as part of the processes of dispossession and the containment of Aboriginal resistance. Communities and families were broken up – in short the cohesive relationships that people depended on were fractured. This process is illustrated in the Grief-Anger-Despair Cycle.

Figure 22 shows the relationship between the damaging histories and the current behaviours that become a self-sustaining cycle with the traumatic histories at the heart of the problem often being forgotten. People who have lived through highly traumatic experiences frequently refuse to talk about them. However, their emotions which are connected to those traumatic events are passed on from one generation to the next. These feelings play a role in people's low self-esteem and other negative feelings, but these feelings are dislocated from the events which initially stimulated them. This societal dynamic cannot be addressed through particular individual therapeutic interventions, but requires community action or agency. The project of improving Aboriginal health must include a process of reconstruction of Aboriginal society. One Aboriginal leader has described this period as one of *post-war reconstruction.*

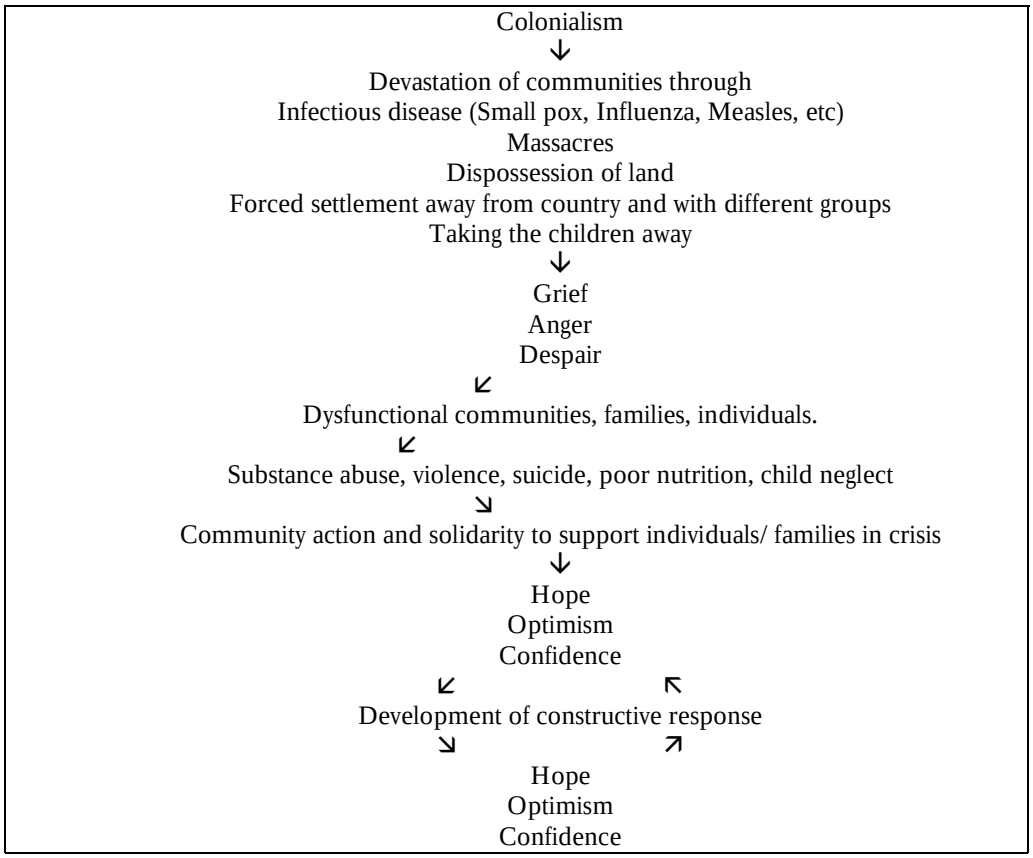
Figure 22: The Grief-Anger-Despair Cycle



Community control is thus an essential component of the project to improve Aboriginal health status. A key part of this is the continuing development and strengthening of an Aboriginal health leadership. This leadership has national, Territory-wide, regional and local aspects. If community control is to be realised beyond its current expression, then it must involve more than simply encouraging small 'communities' to take control of their services. It must support the regional, NT wide and national leadership roles. Clearly AMSANT is the body that has this role in the NT. However, its resource base is small. The NTRHWFA which has the narrow function of recruiting and supporting doctors to work in rural and remote communities has a much larger budget to achieve its objectives, than AMSANT has with a much more complex and diverse role.

The process required to turn around the Grief-Anger Despair Cycle needs to generate a reverse cycle of Hope-Optimism and Confidence. This is the point of including a category of Special Programs in the Core Functions of PHC framework with the key characteristic of these programs being *community agency*. This is represented in Figure 23. The key to turning around this cycle is community control, not just within the small population groupings called communities, but of processes at regional, Territory and national levels. There can be no reconstruction without Aboriginal leadership because if the reconstruction process is driven by non-Aboriginal professionals or bureaucracies, then the dependency relationships that are part of the cause of Aboriginal society's despair will be perpetuated.

Figure 23: The Hope- Optimism- Confidence Cycle.



Community Control in the NT

Community control of Aboriginal PHC services in the NT began with a meeting of Aboriginal people in Alice Springs in July 1973. This was the founding meeting of the Congress. There was no funding at the time, but shortly after the DAA provided a small grant of $1,400. The first programs were directed at addressing the shortage of shelter for people, and took the form of providing tents to people. The health service began in late 1974 with the employment by Congress of Dr Trevor Cutter who began providing a medical service to people where they camped from the back of an old car. Congress established a Council made up of representatives of bush communities. However, eventually the costs involved in organising meetings became prohibitive. Further many of the activists who sat on the Council had increasingly become involved in developing their own health services, or other community organisations and had little time to continue with the Congress Council. Congress, in some cases with the support of NAIHO, was directly involved in the establishment of the following health services:

- UHS, Utopia;
- PHHS, Kintore;
- Mutitjulu Health Service, Uluru;
- Imanpa Health Service, Imanpa;
- Nganampa Health Council, Pitjantjatjara Lands;
- Lyappa Congress, Papunya (which later collapsed);
- Anyinginyi Congress, Tennant Creek.

The health system in the Territory was fairly embryonic at the time Congress was established. Prior to 1911, the NT was administered by South Australia. From 1911 to the Second World War the Commonwealth was responsible for the administration of the NT, and the Chief Medical Officer until World War 2, was also the Chief Protector of Aborigines. It is clear that the key objective of this position was to secure white settlement in Darwin[1]. During the 2nd World War the military took control of the NT Administration. After they withdrew, the CDH resumed control of the hospitals in the major centres (Darwin, Katherine, Tennant Creek and Alice Springs) but insisted they were not responsible for providing health services outside these institutions. It was left to the NT Department of Native Welfare to provide health services to Aboriginal people either through directly employing nurses, or providing grants to missions for this purpose. In 1973 the CDH accepted the responsibility for the provision of health services to Aboriginal people. In 1978, the NT was granted self-government and THS was established and took over the running of services previously run by the CDH. In 1973 there were no private GPs in Alice Springs.

How did the community-controlled services in the bush happen? Unfortunately much of the history has not been adequately recorded. However, in the case of the UHS, we can outline the process. The Utopia Station had been bought by the Commonwealth and handed back to the traditional owners. This allowed people to return to their country. Utopia is an exceptional place because it does not have a central town like most communities, but rather consisted then of around 6 out-stations. Now there are around 17 out-stations with populations of fewer than 50 people each. Health care was an issue here as elsewhere, and Congress conducted a study of health service needs[2] for both the Eastern side (Utopia) and the Western side (Papunya) of Alice. This outlined a model for health service delivery to these areas, and the DAA provided some funding support to Congress to develop these services. In 1977 Congress employed a doctor and a nurse to deliver the service. They were resident in make shift accommodation, and developed a mobile service at Utopia which was appropriate to the people's needs. It was initially called the *Angarrpa (Ankerrapw)* Health Program. In 1979, this program was renamed the UHS when it became independent of Congress, having developed a health council and become incorporated as a legal entity.

Whilst it is difficult to recreate the circumstances that enabled the people of Utopia to take control of their health service, the story does illustrate an important and central principle ... get the health service resource out on the ground while people are motivated and then there is a real chance that they will engage with the health service staff to develop a health service that suits them. As Governments have become more supportive of community control, they have tended to surround the process with overly bureaucratic requirements which have the effect of stifling community enthusiasm, interest and motivation.

In the Top End community control has proved more difficult. Initially the Kalano Association ran the health service in Katherine, and in the early 1992 the health service was separately incorporated to become Wurli Wurlinjang.
Danila Dilba was established in Darwin from community initiative in 1991 with NAHS funds. However, it had been a *'dream that had never died'* since the late 1970s[3]. Protests and calls for the establishment of a community controlled service in Darwin in the late 1970s were strongly resisted by THS who *didn't want another Congress saying there was something wrong with existing services*[4]. Negotiations led to the establishment of the Aboriginal and Islander Medical Service (AIMS). However this was a transport service only based at RDH, and does not provided medical services. Local people continued to organise for a community controlled health service until it eventually became a reality in 1991.

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1 Parry, S *'Disease, Medicine and Settlement: The Role of Health and Medical Services of the Northern Territory 1911-1939.'* PhD Thesis, University of Queensland, 1992.

2 Cutter, T *'Report on Community Health Model: Health by The People.'* Central Australian Aboriginal Congress, Alice Springs, 1976.

3 Crawshaw, J & Thomas, D *'It's not enough to know about diseases: Report of the review of Aboriginal & Torres Strait Islander health care in the Darwin area.'* Danila Dilba, Darwin, 1992, p13.

4 *Ibid*, p14

Miwatj Health was established in 1992 with NAHS funds, and provides health services to communities in the North East Arnhem area, often supplementing services provided by other agencies including THS.

The Commonwealth's Role

Constitutionally the States are responsible for the provision of health services in their jurisdictions. However, after the 1967 Referendum the Commonwealth gained the right to legislate on behalf of Aboriginal people. This led to the Commonwealth developing explicit policies on Aboriginal health in 1973.

However, it is sometimes falsely stated that the CDH *resumed* their responsibility for funding Aboriginal health services in 1995. The truth is that from the early 1970s when the Commonwealth first took some responsibility for Aboriginal health, it was through the DAA (and later ATSIC), not the CDH, that Aboriginal health services were funded. CDH had provided some one off funding grants, and had provided AMSs with Health Program Grants under the old Medibank program to fund professional salaries. These were incorporated into the DAA core funding of the AMSs in the early 1980s.

Inquiries[5,6] into Aboriginal health have fairly consistently illustrated a fundamental difference in approach between the CDH, the States, DAA and the Aboriginal community health leadership. Basically the States and CDH have seen the solution to Aboriginal health to be in the hands of health experts, whilst the DAA (at a senior policy level) and the Aboriginal community leadership have seen the way forward as developing self determination, and for the community to be in control.

What led the Aboriginal health leadership to lobby in 1994-95 for the control of Aboriginal health service funding to be transferred from ATSIC to Commonwealth Health related to the stagnation of Aboriginal health services due to inadequate funding through ATSIC, and the impossibility of health services having to fight with other community leaders about getting a better share of a too small cake, when these other needs of communities (housing, cultural issues, women's centres, etc) were just as legitimate.

So, whilst the community controlled health services, and particularly AMSANT, lobbied for the change, the community sector has a different view of the OATSIH's role to that of OATSIH itself. It would appear that the community sector sees the role of OATSIH as being to *fund* AMSs, whereas OATSIH sees its role as much broader than that – it has been suggested to us that *OATSIH think they are responsible for Aboriginal health.* The Aboriginal health leadership would argue, we think, that the community itself is responsible, not OATSIH, and that the OATSIH responsibility is to provide adequate funding to the community so that the community's responsibility for their own health can be realised. However, OATSIH sees funding as just one of their roles with others including policy development (collaboratively), addressing workforce issues and research. Further OATSIH are involved in working with other sections of the CDH, and other Departments, on their activities that impact on Aboriginal health. The community sector's concern is that many of these functions operate outside any real ability of the community sector to meaningfully collaborate due to a vast differential in resources.

This difference in view has been a cause of tension over the past few years.

It is certainly true that CDH has little experience in actually establishing and nurturing community controlled health services, or delivering PHC services to any community, Indigenous or otherwise. This is a reflection of the constitutional responsibility for the delivery of health care services residing with the States. Thus the Commonwealth practice has tended to be towards attempting to influence State practice by the manipulation of funding arrangements to them.

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5 '*Report of the House of Representatives Standing Committee on Aboriginal Affairs'*, Canberra, 1980.

6 Codd, M. *'Developing a Partnership: A Review of the Council for Aboriginal Health.'* March, 1993.

Recent attempts at getting services on the ground through the RCI funds have been mixed. Communities were nominated as sites for the first round of this funding of up to $220,000 per site in 1997. In Central Australia all the funds in the first round were allocated through THS who have succeeded in getting services on the ground in most of the selected sites. This has been through increasing their own service delivery capacity to those communities. Issues of community control in those communities are to be addressed over time according to memoranda of understanding (MOU) developed between THS, OATSIH and the local communities. Debates occurred regarding what, if any, involvement, CARIHPC would have in the process of development of the MOUs. The process adopted is that THS will develop draft generic MOU which will be tabled at CARIHPC where both the content and the process will be discussed. It remains to be seen how successful this approach will be.

In the Top End a different process has been applied where OATSIH have attempted to negotiate with communities, and appoint consultants to address the issue of community control up front. However, this has thus far failed to get resources into those communities. OATSIH lacked the staff initially to pursue these proposals effectively, and we understand it took sometime before approval was granted to use consultants to develop these projects. However, there have also been problems in OATSIH unilaterally developing guidelines which we believe are inappropriate. The document[7] outlining the process reveals a complex process which could be greatly simplified to facilitate getting the resources into the selected communities.

We acknowledge that this issue is highly contestable. OATSIH have, with the best intentions, embarked on an implementation strategy. They feel that AMSANT's initial reluctance to get involved has not assisted the implementation process[8]. The views of the various partners in the Framework Agreement about this issue is divergent. THS and AMSANT have both expressed their frustration to us. THS have expressed concern about the lack of progress. AMSANT says that they were not prepared to *rubber stamp* decisions made without them about which communities would receive first round RCI funds, but that they were otherwise prepared to cooperate. However, OATSIH feel that they are being unduly criticised. On the one hand they are criticised for allocating all of the first round of the RCI funds in Central Australia through THS. On the other, their attempts to implement the Top End sites in a way that seriously fosters community control is criticised for the lack of outcome. Our discussion below is an attempt to tease out the issues and stimulate a deeper level discussion about the problems that the RCI program has exposed.

To this end, it is worth examining in some detail the OATSIH Implementation Plan. Our understanding is that this plan was initially generic, and in more recent times have been modified to suit the circumstances of each RCI site.

The implementation plan has the following features:

- *A commitment to control of the implementation process by the communities that are linked to each of the sites nominated in RCI Round #1.*
- *A system of primary care that is responsive to local need and which is linked to existing primary and tertiary care systems in the region;*
- *Use of consultants to help implement the initiative who are committed to community control and who are acceptable to residents at the RCI sites.*

The NT office of OATSIH identified a preference to:

- *Use the RCI Initiative as a stepping stone in the development of a regional approach to Aboriginal control of PHC;*
- *Involvement of individual AMSANT members as implementation for the sites in their region of influence.*

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[7] *The Remote Community Initiative – Top End Implementation Plan: Round #1 Sites.* OATSIH NT: Brails: 03/08/99.

[8] OATSIH stress that AMSANT's reluctance to be involved pre-dates the development of the OATSIH Implementation Plan. AMSANT, on the other hand stress that their reluctance to be involved related specifically to the *endorsement* of the communities nominated as sites for RCI funds, not on other issues of implementation or development of the program. There is clearly misunderstanding between the parties in regard to this issue.

It is proposed that the consultancy will have two distinct parts:

- *An information collection phase*
- *A consultation phase in which a health services plan is developed and proposed for endorsement by the residents of the nominated community(ies);*

A subsequent and later phase will follow once the Department has endorsed the outcomes of the first two phases.

The document specifies some detail about both the information phase and the consultation phase. Further the document describes a number of structures to oversee the development. These include:

1. RCI Management Group. This is a local residents group *who have authority in that setting* who would supervise the RCI Consultant, work with the consultant and resolve any pre-planning issues that may become a barrier, *invite participation of other stakeholders in a planning process to define technical aspects of extending PHC to the nominated sites through a formally constituted technical reference group*, review and endorse proposed implementation plan, endorse implementation arrangements, and supervise the implementation process.
2. Technical Reference Group which includes local AMS, THS, Local Government, consumers, OATSIH, and other providers. This group will recommend to the RCI Management Group what model of PHC should be adopted, how it will be sustained, how the funds can be used to purchase services, what additional capital costs are appropriate, what standards should apply, how services will be monitored, a model of ongoing management of service provision, what non-community based health care resources should be linked to the recommended care delivery model and how it should be linked.

The summary of this section states that *it is the analysis of OATSIH NT that this approach to the development of the RCI initiative within the NT will*

- *Preserve and foster community control;*
- *Avoid solutions for small local sites and encourages issues to be addressed on a zonal/ language group/ regional basis*
- *Enhance the potential to develop the* 'hub-spoke' *relationships between community controlled health services.*

It is encouraging that the intent here is clearly to foster community control, and to move towards developing a system of support for community controlled services utilising the existing Aboriginal health leadership located in the main regional centres. However, we believe that the structures proposed are unnecessarily cumbersome. It is again worth reflecting on the experience of the TPF where inter-sectoral collaboration was attempted by including a wide range of agencies whose activities certainly impacted on health status, but who were not directly involved in health service delivery. The Technical Reference Group appears to be predominantly made up of people outside the nominated site, and largely outside the broader Aboriginal health politic. This is likely to create conflicts, misunderstandings and protracted delays. Many community people would have great difficulty in engaging with such forums. The role of the Management Group is also problematic. Where people have not had experience of health service delivery or managing consultants, they are unlikely to effectively control and direct the consultants or be able to successfully supervise implementation to achieve what they want. This is not an argument that *experts* should be driving the process, but an argument about how the community can best influence developments. The development of community controlled health services elsewhere has involved relationships developing between providers and community members in the respective communities, not through an abstract process of determining the structures of the health service through the workings of committees. This clearly applies to the existing community controlled services represented in AMSANT, including the KWHB where previous THS staff known to community members are now working for the KWHB.

We have discussed issues of community control in some detail above, and our comments here should be read in conjunction with that. We know of no example of effective community control in the NT context (or else where) that has been implemented through the processes outlined in the Guidelines. The THB developed in the context of a particularly homogenous region, with some significant experience of governance through the Tiwi Land Council and some experience of having access to a PHC service. Further, local health service staff employed from the beginning of the CCT process have played important roles with the Tiwi leadership in developing the health service under the CCT. The development of the KWHB was a much slower and more complex process with significant resources expended to establish it. It also had significant health service staff on the ground that had (or developed) relationships with local leaders.

OATSIH have informed us that the guidelines are not meant to be prescriptive, and that it is up to what the communities want. However, the guidelines do not read that way, and certainly a number of consultants working to these guidelines have not been clear about that. Indeed, some have complained to us about the impossibility of getting the Technical Reference Group together. OATSIH need to make it clear to all parties that these guidelines have no real substance in terms of a process that must be followed.

However, the main problem in the OATSIH implementation plan is that for OATSIH to determine alone what structures are established, what their role is, and who should be on them fundamentally contradicts the notion of community control. At the very least, such processes and guidelines should be developed collaboratively through the Framework Agreement.

The intent as stated in the document is more likely to be achieved through processes that focus on simple increments in service delivery, utilising existing community health organisations (if necessary outside the selected site), and getting health professionals on the ground to deliver the service and relate to the community leaders directly about how the service should be organised. This process has proven successful in the way existing community controlled health services have been developed. OATSIH have expressed concern to us in their feedback that this implementation strategy is contrary to community control, and risks being driven by non-Aboriginal health professionals. However, the existing OATSIH guidelines leave much of the control of the process with bureaucrats and consultants based outside the community that make it extremely difficult for the local community processes to influence. Community politics does not comfortably operate through committees, but is based on an often slow development of relationship. The development of such relationship is unlikely to happen without human resources based in the community – this does not apply to either the OATSIH bureaucrats or to the consultants.

We think the evidence is clear that people know that they want a health service – meaning an AHW, nurse and/ or doctor (a service to deal with illness). Issues of how they the staff are to be employed, lines of control and accountability, etc. are much more problematic. Of course, people want control of the money because they recognise that this is the ultimate power, and most communities have experience about people using money inappropriately – however in many communities people do not have the necessary skills to manage funds and remain dependent (and vulnerable) on either outside organisations or non-Aboriginal financial advisers.

The notion that a particular group of people will automatically have authority in a particular community may also be erroneous. The actual power relationships operating within Aboriginal communities can often be difficult for an outsider to recognise.

The idea of hub centres and the development of an Aboriginal health system driven largely by the Aboriginal health leadership is important to counter the risk of non-Aboriginal health professional control.

If community controlled services are to develop along the hub-spoke model referred to, increased resources will be required. Utilising the community knowledge and experience of the existing community controlled services is likely to facilitate health service development in the nominated community as well as strengthen the Aboriginal health leadership and local community involvement (control).

At present there are two working groups in the NT relevant to health service development (apart from TERIHPC and CARIHPC). These are the PHC Development Working Group of CARIHPC in Central Australia and the Primary Health Access Working Group under the NTAHF. We consider that it would be more appropriate to develop a more integrated approach under the NTAHF. This could involve a working Group under the Forum to consider all PHC service development processes including the RCI developments and the PHC Access Program announced in the 1999 Budget. Regional sub-groups could focus on the details of development in Central Australia and the Top End respectively.

Recommendation 26

We propose that, wherever possible, PHC services be developed under community control arrangements, whether through health committees under existing community councils, or through the establishment of incorporated Health Councils/ Boards, 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 NTAHF should facilitate these processes, rather than funding bodies attempting to implement programs alone. The special role of AMSANT should be recognised and utilised.

Recommendation 27

That OATSIH, THS & AMSANT work collaboratively to facilitate a simplified process for implementing PHC service development policies, including:

- ***the establishment of a PHC Service Working Group under the NTAHF to oversee the implementation of all PHC Service development programs, including the RCI and the PHC Access Program, with regionalised sub-groups in the Top End and Central Australia;***
- ***the provision of adequate resources to the proposed AMS PHC Hub Centres to enable them to carry out identified regional support to PHC services, including the facilitation of community control;***
- ***the withdrawal of the current guidelines to RCI programs, and specifically the abandonment of the concept of Technical Advisory Groups;***
- ***the adoption of uncomplicated and flexible implementation plans developed collaboratively through the PHC Service Working Group;***
- ***ensuring clarity about the amount of funds available for particular health service development before discussions with communities are undertaken.***

THS's Role

THS have changed their view over the years. In the late 1970s – early 1980s THS was hostile to community controlled services, and took the view that ALL services would be withdrawn from a community if they opted for this path. In the early 1980s the PHHS, for instance, was expected to transport patients flown into Alice Springs for routine investigations from the airport to the hospital because they were community controlled and should not rely on THS to provide this function. Clearly things have changed. Many communities with community controlled health services receive THS services including specialist and allied health visits.

However, some communities fear they will be abandoned if they choose to go down the community controlled path as a consequence of these past practices. This has been evident in various consultations with communities in recent years (eg Anmatjere consultations[9]). This fear may be felt more in Central Australian communities where community control of health services in remote communities has been more common than in the Top End. However, the lessons regarding continuing support from government agencies is relevant. The failure of around 25% of the SA arrangements (see above) is partly due to the tendency of THS to wipe its hands of any further responsibility once such agreements have been put in place.

Since the early 1990s THS has embraced a policy of active support for community control, and have provided funds through SAs in an attempt to foster community control in particular communities. This service model has been known as *Grant in Aid* or *SA Health Services*. However, this THS version of community control has been problematic. THS has a strength which relates to its corporate experience in delivering health service in communities. However, the SA arrangements are widely accepted as inadequate in terms of the funding received, and the support provided.

In the Top End the following communities have received services through this mechanism:

1. Daly River
2. Galiwin'ku
3. Jabiru
4. Minjilang
5. Palumpa
6. Peppimenarti
7. Warruwi
8. Binjari
9. Belyuen
10. Bagot
11. Laynhapuy Homelands
12. Gunyangara
13. Oenpelli
14. Gapuwiyak
15. Wadeye

Of these 15 services Oenpelli, Gapuwiyak, Wadeye and Palumpa have failed. THS have resumed responsibility for direct service delivery to these communities. The reasons for this are varied, but generally are:

1. The inadequate capacity of Community Councils to manage PHC services. The main function of Councils is matters of local government - the development of community infrastructure (roads, maintenance of power, water supplies, waste disposal, CDEP activities, etc.), not the running of health services. By the time local government issues are dealt with there is often little time left to address health service issues. Further the management of PHC services is a reasonably specialist area, often outside the experience of town clerks. It has long been recognised that Councils have their own problems with managing their core business, and being dependent on non-Aboriginal staff who have not always proved either skilled or reliable.

> *'Small NT communities, particularly Aboriginal communities are constrained as much by lack of formal skills and training in the art and the tasks expected of local governance, as they are by inappropriate structures, or even by lack of funds.'*

and

> *Aboriginal councils operate at the interface between often conflicting and mutually mysterious value systems, ways of doing business and ways of reaching decisions.'*

[9] Bartlett, B & Tilton E *Report* of the Consultancy for the *Development of an Independent Medical Service and an Aged Care Pilot Program based at Ti Tree.* Central Australian Aboriginal Congress, Alice Springs, 1998.

These quotes[10] express the contradictions that councils often experience. To simply expect that they can take on the responsibility of running fundamentally different functions such as health services without the ability to employ staff with appropriate specialised experience is unreasonable, and may well compromise the other functions that the council is responsible for. Frequently Council act as little more than the paymaster leaving other issues of health service management to over-worked clinicians. We are not suggesting that Councils should never be involved in health service management, but that to do this requires both a health committee that can report to the Council, and resources to perform the management and administrative functions that are essential to both ensuring the smooth functioning of an essential service and developing the means of community control. Further, funding bodies have a responsibility to insist that Health Committees under Community Councils are tied in to the health care system in appropriate ways. This should happen through their involvement with AMSANT and receiving support from Hub Centres[11].

It should be kept in mind that Local Government is generally not expected to take responsibility for health service delivery, although some Councils in rural Australia have got involved mainly through the bundling of resources to attract GPs. Once a GP arrives, it is left to that GP to provide the service.

2. SAs have not provided resources for PHC service administration and management, and have tended to limit funding to clinical staff, transport and clinic supplies (including pharmaceutical). This under resourcing has been a major issue for these communities, and their staff.

3. Staff relief has been inadequately resourced in the agreements whether for in-service training, or for leave. It has been common for these services to hire THS staff for leave, and due to NT Government instructions, a charge of 52% has been added. This has further thrown these services into financial difficulty. Further, the purchase of pharmaceuticals and other supplies attract a 25% handling charge which directly serviced communities avoid. A whole range of other administrative matters has often been difficult for these services to manage. Recruitment has been a problem with little local resource to undertake this, and the cost of agency recruitment very high.

4. Despite this model being promoted as a type of community control, we have received numerous reports about THS continuing to make decisions about how these health services will operate – including decisions about vehicles and staff. It appears that approval must be sought from THS for quite minor budgetary decisions. This reflects the core problem that the means of community control have not been resourced – thus they are not community controlled at all.

Many communities are actually receiving funds from multiple sources – mainly from OATSIH, THS and NTRHWFA. This means a different set of accountability requirements which further complicates the administrative tasks in these small services. The more funding sources there are, the more complex the administrative requirements and the less likely it is that the community will effectively take control. Further, in communities where local people have little experience and education in these matters, they are potentially vulnerable to unscrupulous non-Aboriginal staff who can manipulate the operations and/or the books to their own interest.

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[10] Wolfe, J *That Community Government Mob: Local Government in Small Northern Territory Communities* ANU, North Australia Research Unit, Darwin, Monograph, 1989, p 177.

[11] Some within government agencies have questioned this approach as being against community control. However, is an Aboriginal health care system is to be developed and established, then it is up to authorities to determine how it will work. That is never a local community decision. Membership of an organisation (eg AMSANT) should not be compulsory, but the structures established must be worked through. In other areas governments are not so shy in recognising peak bodies or authorities. For example the AMA does not represent all doctors; but the government recognises the AMA as the peak body representing doctor interests.

Funding accountability complexities.

Where services have multiple sources of funding, an unnecessarily complex situation is often created through different funding agencies demanding different sets of accountability requirements. This should be overcome through funding bodies working together with the peak body of the health services (AMSANT) to develop simplified requirements.

Recommendation 28

That funding bodies (THS and OATSIH) move towards collaborative arrangements with AMSANT, through the NTAHF, to:

- ***develop a single instrument of accountability suitable for all funding bodies and that is able to be readily provided by the health service;***
- ***ensure an adequate level of funding that enables delivery of comprehensive PHC, including adequate administrative resources.***

AMSANT's Role

AMSANT is the peak body of Aboriginal community controlled health services in the NT and was instrumental in the development of both the transfer of funding responsibility from ATSIC to OATSIH, and the Framework Agreements under which Aboriginal health is collaboratively addressed.

AMSANT is also the body which provides the Aboriginal health leadership in the NT. AMSANT has three areas of core business:

1. Provide services to the membership
   - Provide information about AMSANT and Aboriginal health issues;
   - Develop resources useful to members eg policy and procedures manual for members;
   - Provision of professional development opportunities for members;
   - Assist members with negotiations with funding bodies.

2. Represent membership:
   - Lobby government on issues effecting members;
   - Represent members interests to inquiries, professional organisations, etc.

3. Promote rights of all Aboriginal people to community-controlled, comprehensive PHC, including working collaboratively to develop:
   - Flexible pathways to community control comprehensive PHC;
   - Needs-based planning processes;
   - Development of policies towards improving access to comprehensive PHC;
   - Strategies to get health services operating in communities.

AMSANT is constrained in what it can do by very limited resources as well as attitudes within other agencies about community controlled health services and AMSANT.

It is apparent that outside the senior levels within THS, that few THS staff know anything about the Framework agreement or the structures that have been formed as a consequence. This makes it difficult for those on the ground to work collaboratively with other agencies in the spirit of the Framework Agreement.

The issue of representativeness demands some attention here. This appears to be a significant barrier in developing a collaborative process at the program level, aimed at developing better access to health care for Aboriginal people. It is claimed by some, 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 the Aboriginal Community Controlled Health Services in the NT. AMSANT has also established an Associate Membership for communities who are in a transitional phase in the development of their health service. Currently Santa Teresa (a SA community in Central Australia) is an Associate Members of AMSANT. The KWHB was an Associate Member, but has recently been accepted as a full member as they have taken over direct service delivery to four of their communities.

AMSANT's role is by virtue of its leadership in Aboriginal health. This leadership capacity has developed over a 25 year period, and is the most consistent influence in Aboriginal health development in the NT over that time. If, as argued above, community control is central to the project of improving Aboriginal health status, and that community control includes the development of an Aboriginal health care system that has both regional and NT-wide expressions, then AMSANT is the only body with the capacity to play that role.
Developing and strengthening this leadership requires that AMSANT is more centrally included in the process of community consultation about the development of health services than has been the case in the recent past. Thus in the development of the PHC Access Program in HSZs initially in Central Australia, AMSANT needs to be actively present in planning and participating in the process from the beginning. Further AMSANT needs to be provided with the resources required to participate. Currently, both THS and OATSIH are employing project officers to develop the Zone plans, but AMSANT has only 2 project officers, an Education Project officer and a trainee office person as its total complement of staff. This is inadequate for AMSANT to play the central role required.

Recommendation 29

That both THS and OATSIH modify the way they work with remote communities to ensure that AMSANT is fully informed and involved in the whole process of health service development from the development of guidelines, consultations, implementation strategies, and continuing support.

Recommendation 30

That adequate resources be provided to AMSANT so that it can more effectively service its membership, and play its pivotal leadership role in the continuing implementation of improved health service to Aboriginal communities, and specifically the development of community control of PHC services.

Community Input

The issue of the development of consumer input into health service delivery is an issue that the Planning Forum itself should address. AMSANT has been organising annual Health Summits over the past few years. These are major and important forums for both community leaders, and community members who are particularly concerned about health issues to have input into priority setting, and program development. These Summits need financial support from funding bodies if they are to continue and grow. OATSIH have expressed the view that funding will be difficult unless the Summits are evaluated. Whilst it is appreciated that some form of assurance that the funds are not being wasted is appreciated, and that some documentation and accountability is required for funding, the notion of evaluations that attempt to show outcomes tend to clash with the dynamic involved with these meetings. AMSANT has already demonstrated a significant attendance at these meetings and have produced reports as to the issues discussed and the resolutions carried. We urge the funding bodies to approach this matter with flexibility, and allow the Aboriginal process to determine the pace and form of what is a long term strategy.

Recommendation 31

That the annual AMSANT Health Summits be strongly supported and that secure funding be identified to enable them to continue and grow in their significance.

D. Top End Regional Planning Processes

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. Over the past few years significant progress has been made in developing appropriate collaborative planning processes.

With the signing of the Framework Agreement, the NTAHF was established, as well as the CARIHPC in Central Australia and the TERIHPC in the Top End.

CARIHPC was established before the signing of the Framework Agreement and is, consequently more developed than TERIHPC. A number of working groups have been established under CARIHPC. These are:

- Renal Working Group;
- PHC Implementation Working Group;
- Women's Health Working Group;
- Central Australian Disease Control Coordinating Committee (CADCCC).

CADCCC was established some years ago with the specific aim of coordinating communicable disease control. It now reports to CARIHPC. Further, the Tristate STD/ HIV Program in Central Australia operates under CADCCC.

A number of working groups have also been established under the NTAHF. These include:

- TERIHPC;
- PHC Access Working Group;
- Indigenous Sexual Health Strategy Committee;
- Eye Health Committee.

There is always a risk of establishing committees which never quite know when to cease. What is clearly a high priority health issue now may be relatively insignificant in ten years time. However, establishing disease focused organisations has been a way of fostering power bases and the flow of resources. The old Trachoma and Eye Health program was seen as being like this by some. These approaches also lend themselves to selective rather than comprehensive PHC strategies. Thus working groups should not be seen as permanent.

The principles that should govern the establishment of working groups/ committees are:

- There should be clear terms of reference;
- There should be a clear time line within which the work of the group will be completed;
- Composition of the working groups should not be restricted to (or necessary include) the partners involved in the Framework Agreement, but should include those who have knowledge and experience relevant to the tasks of the working group.

In recent months there has been a frustration with the way CARIHPC has operated. This is partly a consequence of the restructuring within THS which has resulted in power shifting significantly to Darwin. Nevertheless, some partners have suggested that CARIHPC (and by implication TERIHPC) are duplications of the Forum and should be abolished. Regional working groups could still function to do the detailed work necessary for sound planning decisions to be made, but these groups would be answerable directly to the Forum. A Review of CARIHPC has been proposed, and this Review should address these concerns.

Despite some of these difficulties, and the possibility that some reorganisation may be required we would strongly support some form of continued collaborative regional health planning processes.

Health planning is necessary to:

- Allow consideration of needs across the whole Region to ensure a degree of equity of access to health care services between and within *all* HSZs.
- Allow changes to occur in health service delivery in terms of changing demographic patterns – ie the movement of people to out-stations, etc.
- Identify changing needs in terms of illness patterns, and the availability of specialist, allied health and other services;
- Provide coordinated effort in disease control programs that are unsustainable by small PHC services alone;
- Identify gaps in services, and to prioritise the expenditure of new resources as they become available;
- To develop appropriate ways of assessing both need and capacity which are appropriate to remote communities and get beyond hear-say and rumour, that is that has some built in objectivity.

These processes should include those organisations involved in PHC service delivery to Aboriginal people in the Top End. The structure of the NTAHF, established under the Framework Agreement, with participants limited to THS, OATSIH, ATSIC and AMSANT remains most appropriate in our view. The Forum is able to coopt other organisations and individuals for specific purposes, through limited term working groups to investigate and inform the Forum on specific health service issues from time to time.

Recommendation 32

That the current planning structures of the NTAHF, TERIHPC and CARIHPC be reviewed with a view of ensuring that they remain effective, efficient and relevant whilst continuing to be appropriately regionally focused.

An Integrated Planning Approach:

As health professionals and 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 Danila Dilba 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.

We consider that more work needs to be done to develop the NTAHF into a more effective and integrated planning forum. Specifically there needs to be improved information flows regarding research projects, routinely collected data and service delivery. The current inadequacies of basic PHC service in communities makes this a primary concern. The analyses of routinely collected data (eg hospital separations) and research programs need to better inform the development of more adequate PHC service delivery. This particularly apples to the Menzies School of Health Research and the CRCATH. However, we acknowledge the CRCATH was established through a collaborative approach with the Aboriginal health leadership who are represented on the Board.

Recommendation 33

That research institutions, specifically Menzies School of Health Research and CRCATH, provide a report to the NTAHF twice a year outlining their Aboriginal health research strategies and seek input from the Forum a regarding particular issues that may inform the further development of their research work.

E. A Northern Territory Indigenous Health Authority

The Parliamentary Inquiry into Indigenous Health[1] produced a Discussion Paper[2] which sought public views on a number of options. These options were:

1. Support for Existing Arrangements.
2. States to Resume Responsibility.
3. Commonwealth Assume Responsibility.
4. A New Approach.

The *New Approach* is based on pooling of all funding, State and Commonwealth, and the creation of a new body which would:

- Allocate the funds, ideally through contracts with community organisations;
- Monitor expenditure and outcomes;
- Develop appropriate standards;
- Provide simplified funding arrangements to facilitate community control;
- Develop appropriate ongoing evaluation strategies with community services;
- Provide for appropriate regional support for PHC;
- Fund Special Preventive Health Programs.

During the course of this consultancy many issues have arisen which has led us more and more to the conclusion that a singular Indigenous Health Authority for the NT would be a real step forward. Currently an enormous amount of effort is put into the Framework Agreement structures for exceedingly slow progress. The complexities of service arrangements are actually quite staggering and are a major impediment to the prospect of communities taking control of their health services. The Authority could play an enormously useful role in simplifying the process by having a single funding authority.

This proposition also fits into the funder-purchaser-provider split model that we understand THS is keen to pursue.

Recommendation 34

That an independent Indigenous Health Authority be established in the NT which will receive all funds for Aboriginal health and take responsibility for the delivery of Aboriginal PHC services in the NT through contracting community organisations as providers wherever possible.

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[1] House of Representatives Standing Committee on Family & Community Affairs, Inquiry into Indigenous Health.

[2] House of Representatives Standing Committee on Family & Community Affairs, *Inquiry into Indigenous Health: Discussion Paper.* Canberra, September, 1999.

CHAPTER 9 - GAPS IN PHC SERVICE DELIVERY

Health Resources and their Distribution

The following show how the various HSZs rank in terms of health service staff: population ratios for AHWs, nurses, and doctors. The number in the Pop/ AHW, RN or Dr columns are the number of people in the serviced community for each of those type of staff. For example, in the South East Top End HSZ for each AHW there are 1,805 people. There is the equivalent of 1 doctor for every 4,746 people in the Top End West Zone. For doctors, the number of people/ doctor in other parts of Australia vary. In 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[1]. As can be seen in the table below, some HSZs are much worse off than that.

Table 20: Ranking of AHWs, Nurses & Doctors to Population Ratios by HSZ.

Rank	*AHWs*	Pop/ AHW	Rank	Nurses	Pop/ RN	Rank	Doctors	Pop/ Dr
1	South East Top End	1,805	1	Darwin	1,525	1	Top End West	4,746
2	Maningrida	512	2	Katherine East	604	2	Darwin	2,515
3	Darwin	499	3	South East Top End	602	3	South East Arnhem	2,045
4	Top End West	410	4	South East Arnhem	467	4	South East Top End	1,804
5	Katherine West	324	5	North East Arnhem	439	5	Katherine East	1,302
6	South East Arnhem	299	5	Top End West	415	6	Katherine West	1,222
7	North East Arnhem	305	7	Tiwi	375	7	West Arnhem	1,086
8	West Arnhem	204	8	West Arnhem	362	8	Maningrida	1,031
9	Katherine East	211	9	Katherine West	297	9	North East Arnhem	1,017
10	Tiwi	115	10	Maningrida	230	10	Tiwi	918

From Figure 24 it can be seen that the South East Top End, Maningrida, Darwin, Top End West and Katherine West are the worst of areas for AHWs; Darwin, Katherine East, South East Top End and South East Arnhem are worst off for nurses; and Top End West, Darwin, South East Arnhem, and South East Top End are worst off for doctors.

We might therefore decide that the South East Top End and Darwin are the high priority areas, because they represented in the top 4 of each three ranking. Top End West and Katherine East appear in all categories in the top 5 and could be considered the next areas of priority. However, the policy of Danila Dilba and Wurli Wurlinjang regarding the employment of doctors and AHWs in preference to nurses for clinical work, needs to be taken into account.

[1] Commonwealth Department of Health & Family Services *'General Practice in Australia: 1996.'* AGPS, Canberra, 1996.

Table 21: Ranking of the Actual: Ideal Health Service Resource for each PHC professional resource (AHWs, Nurses & Doctors).

Rank	AHWs	%	Rank	Nurses[2]	%	Rank	Doctors	%
1	South East Top End	5	1	Darwin	25	1	Top End West	13
2	Maningrida	18	2	South East Top End	33	2	South East Top End	29
3	Katherine West	26	2	Katherine East	34	2	South East Arnhem	30
3	Top End West	27	4	South East Arnhem	49	4	Darwin	32
5	West Arnhem	33	5	North East Arnhem	53	5	Katherine East	41
5	North East Arnhem	34	6	West Arnhem	56	5	Katherine West	42
7	South East Arnhem	38	7	Top End West	62	7	West Arnhem	46
8	Darwin	43	8	Katherine West	66	8	Maningrida	56
9	Katherine East	45	9	Tiwi	77	9	North East Arnhem	59
10	Tiwi	119	10	Maningrida	94	10	Tiwi	75

In Table 21 the percentages represent the proportion of health service staff that HSZs have compared with what they should have according to our standard. Thus, in the South East Top End HSZ there are only 5% of the AHWs they ideally should have.

It is difficult to put these rankings 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.

Table 22: Overall Rank of Percentage of Actual Staff to Ideal Staff (AHWs, Nurses, Doctors) for each HSZ.

Rank	Health Service Zone	%
1	South East Top End	15
2	Top End West	35
2	Darwin	36
4	Katherine West	39
4	West Arnhem	40
6	South East Arnhem	41
6	Katherine East	42
6	Maningrida	42
6	North East Arnhem	42
10	Tiwi	102

It can be seen that the services are strongly clustered. Clearly the South East Top End has a glaring overall lack of health service staff with only 15% of the ideal. Top End West and Darwin are next worse off, but then there are 6 Zones clustered between 39% and 42% of ideal staffing, with Tiwi just exceeding its ideal staffing.

The actual qualifications and the different skills of the different types of staff are not considered in this analysis. We are aware that the different health professionals at the centre of PHC service delivery are not equivalents, but the different skills that different types of staff have are of significant importance. We are reluctant to argue that one type of health staff is worth more than another. However, it is nevertheless true that the costs of different types of staff do vary and we have used this as a means of combining the rankings. (see Chapter 2). Table 23 shows the rankings of HSZs using this method.

[2] The community controlled health services (Danila Dilba, Wurli Wurlinjang, and Miwatj Health) have had a consistent policy for many years of employing doctors rather than nurses for clinical work. Thus, they come in as the services of greatest need in regard to nurses. This is not necessarily the case, and needs to be judged in the light of their ranking in regard to doctors. 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.

Table 23: Ranking of the Percentage of Actual to Ideal Staffing Costs for HSZs.

Rank	Health Service Zone	Actual Staff Cost: Ideal Staff Cost %
1	South East Top End	21
2	Darwin	33
3	Top End West	36
4	Katherine East	40
4	South East Arnhem	40
6	West Arnhem	44
6	Katherine West	44
8	North East Arnhem	47
9	Maningrida	54
10	Tiwi	92

Overall, this is the ranking that we will refer to in our discussions.

It is worth emphasising here that we are not suggesting what balance of AHWs, nurse or doctors should be employed in PHC services. Different services will wish to make different decisions about this. Given the expensive nature of doctors, it would make sense in some situations to carefully use doctor services for the high level of skills they have, whilst employing more AHWs and nurses (or even administrative staff and drivers) to carry out the bulk of PHC service work.

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.

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:

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

Before examining details of population groups within Zones, we have ranked population groups according to the methodology followed above using the costs of health service staff to compare actual with ideal health service staff/ population. The populations of all out-stations/ homelands and communities that make up the population group are included in the population figures in Table 24.

Table 24: Ranking of Top End Population Groups by Actual: Ideal Staff: Population Ratios Weighted by Staff Costs.

			ACTUAL STAFFING			IDEAL STAFFING			Actual: Ideal Staff%			Costs - Actual: Ideal %
RANK	Population Groups	Population	AHWs	Nurse	Doc	AHWs	Nurse	Doc	AHWs	Nurse	Doc	All Staff
1	Robinson River	285	0	0.1	0.05	4.4	1.9	0.7	0.0	5.3	7.0	3.5
2	Milyakburra	220	0.05	0.05	0.1	2.9	1.5	0.6	1.7	3.4	18.2	6.4
3	Jilkminggan	205	0	0.1	0.1	2.9	1.4	0.5	0.0	7.3	19.5	7.3
4	Mialuni	100	0	0.1	0.05	1.3	0.7	0.3	0	15.0	20.0	10.5
5	Alyangula	100	0	0.1	0.1	1.3	0.7	0.3	0	13.6	36.4	14.0
6	Miniyeri	455	0	1.0	0.1	6.8	2.5	1.1	0	40.8	8.8	15.1
7	Peppimenarti	405	0	1.0	0.1	6.1	2.2	1.0	0	45.5	9.9	16.8
8	Wardaman	270	0	0.5	0.2	3.9	1.8	0.7	0	27.8	29.6	17.2
9	Laynhapuy Homelands	755	1.0	2.0	0.4	13.7	5.0	1.9	7.3	39.7	21.2	21.1
9	Woodycupaldiya	130	1.0	0	0.06	2.6	0.9	0.3	38.5	0	18.5	22.1
11	Gunyangara	380	0	1.0	0.3	5.6	2.0	1.0	0	49.2	31.6	23.4
11	Mataranka	700	0	1.9	0.2	7.7	3.6	1.2	0	52.5	16.3	23.4
13	Adelaide River	410	0	1.5	0.1	5.9	2.2	1.0	0	69.8	9.8	24.4
13	Palumpa	300	0	1.0	0.1	4.0	1.5	0.8	0	66.7	13.3	24.5
15	Umbakumba	530	1.0	1.0	0.2	6.1	2.8	1.0	16.4	35.9	21.1	24.7
16	Borroloola	1,520	1.0	2.9	1.0	15.7	7.2	2.7	6.4	40.1	35.0	25.5

Table 24: Ranking of Top End Population Groups by Actual: Ideal Staff: Population Ratios Weighted by Staff Cost (continued)

			ACTUAL STAFFING			IDEAL STAFFING			Actual: Ideal Staff%			Costs - Actual: Ideal %
RANK	Population Groups	Population	AHWs	Nurse	Doc	AHWs	Nurse	Doc	AHWs	Nurse	Doc	All Staff
17	Timber Creek	875	0.6	2.7	0.4	11.9	4.9	1.7	5.0	55.1	23.2	26.7
18	Wugularr	510	1.0	1.0	0.2	5.2	2.6	0.9	19.2	39.0	23.3	27.8
19	Minjilang	425	2.0	1.0	0.02	6.8	2.4	1.1	29.3	41.4	15.1	29.7
20	Darwin	9,060	17.5	2.0	3.4	33.7	20.6	10.0	51.9	9.7	33.7	30.2
20	Pine Creek	625	0.9	1.8	0.2	7.0	3.3	1.1	13.1	56.6	16.7	30.3
22	Yirrkala	750	1.0	2.0	0.3	7.5	3.8	1.3	13.3	53.3	24.0	31.3
23	Bulman	400	2.0	1.0	0.1	5.8	2.3	1.0	34.5	44.4	10.0	31.6
24	Bulla	120	0.6	0.3	0.1	1.6	0.8	0.3	37.5	37.5	16.7	32.4
25	Ramingining	1,035	1.0	3.0	0.3	8.7	4.2	1.6	11.6	70.9	18.9	35.5
26	Belyuen	260	3.0	0	0.1	3.6	1.7	0.7	83.3	0	15.4	36.0
27	Numbulwar	1,060	3.0	2.0	0.3	7.7	4.1	1.5	39.0	49.2	19.7	38.1
28	Ngukurr	1,260	5.5	2.0	0.3	9.6	5.1	1.9	57.5	39.5	15.8	40.2
29	Warruwi	395	3.0	1.0	0.1	5.6	2.1	1.0	53.3	48.4	10.1	40.6
30	Milingimbi	1,065	5.0	2.0	0.3	8.8	4.4	1.7	57.0	45.1	18.1	43.0
31	Pirlangimpi	360	2.5	1.0	0.2	4.9	1.8	0.9	51.4	55.1	22.2	43.3
32	Yarralin	445	2.0	2.0	0.2	6.4	2.5	1.1	31.3	81.1	18.0	44.1
33	Wadeye	2,455	5.0	5.0	0.4	13.9	6.6	2.8	36.0	75.9	14.1	44.5

Table 24: Ranking of Top End Population Groups by Actual: Ideal Staff: Population Ratios Weighted by Staff Cost (continued)

			ACTUAL STAFFING			IDEAL STAFFING			Actual: Ideal Staff%			Costs - Actual: Ideal %
RANK	Population Groups	Population	AHWs	Nurse	Doc	AHWs	Nurse	Doc	AHWs	Nurse	Doc	All Staff
34	Oenpelli	1,360	3.0	4.0	1.1	11.7	5.7	2.2	25.7	69.8	50	48.1
35	Daly River	565	4.0	2.0	0.1	6.6	3.1	1.1	60.3	64.5	9.3	50.5
36	Barunga	425	4.0	1.1	0.3	5.7	2.3	1.1	70.6	48.5	23.5	51.0
37	Jabiru	355	2.0	1.0	1.0	6.6	2.4	0.9	30.5	42.3	112.7	51.8
38	Batchelor	1,020	1.1	3.6	0.7	7.0	4.0	1.5	15.1	89.5	47.1	52.8
39	Maningrida	2,085	4.1	9.1	2.0	22.7	9.7	3.6	18.0	93.8	55.8	53.6
40	Dagaragu	250	1.0	1.0	0.4	3.3	1.3	0.6	30.0	80.0	64.0	54.8
41	Kalkarindji	485	2.0	2.0	0.6	5.7	2.6	0.9	35.1	77.9	68.3	58.2
42	Gapuwiyak	1,120	4.0	3.0	1.0	8.2	4.3	1.6	49.1	69.8	62.0	60.3
43	Lajamanu	1,025	4.0	3.0	1.0	8.5	4.2	1.6	47.1	72.0	64.0	60.5
44	Galiwin'ku - Elcho	1,740	8.0	3.0	1.4	12.4	5.4	2.3	64.5	55.8	62.2	60.9
45	Milikapiti	480	4.0	2.0	0.3	4.8	2.4	0.8	83.3	83.3	37.5	73.2
46	Angurugu	935	5.5	3.0	0.7	6.7	3.6	1.3	81.3	82.7	52.3	74.7
47	Katherine	1,570	15.0	1.0	3.0	13.0	7.0	2.6	115.1	14.3	114.3	75.7
48	Nguiu	1,410	13.0	3.0	2.0	6.7	3.6	1.6	193.1	83.8	127	133.4
49	Nhulunbuy	175	3.0	0	2.9	2.6	1.2	0.4	116.9	0	662.9	202.2

It is appropriate here to consider the special case of Darwin. We have discussed some of the issues relevant to Darwin under our analyses of population groups within HSZs. Clearly comparing Darwin with many other communities is like comparing chalk and cheese. However, the needs of Aboriginal and Islander people in Darwin should not be lightly dismissed. The gap between life expectancy of non-Aboriginal urban people and Aboriginal urban people is much wider that the gap between Aboriginal urban people and Aboriginal rural/ remote people. Access to PHC service is only one of the factors that are responsible for poor Aboriginal health status, and it is probable that addressing most of these other factors will occur through larger services primarily servicing urban populations (including rural/ remote visitors) rather than health services servicing small rural/ remote communities.

Some population groups in this list either have had funds allocated to them, but not yet expended, or have particular funding arrangements already in place. In regard to the particular issues around the RCI funds, we have been told that if a site received funds in the first round, that they are not eligible for consideration in the second round. Thus we have excluded the following population groups:

1. First Round RCI Sites:
    - Robinson River
    - Angurugu
    - Milyakburra
    - Umbakumba
    - Miniyeri
    - Dagaragu
    - Galiwin'ku (Marthakal Homelands)
    - Wardaman (Binjari)

2. Coordinated Care Trials
    - Nguiu
    - Pirlangimpi
    - Milikapiti
    - Dagaragu
    - Kalkarindji
    - Lajamanu
    - Yarralin
    - Mialuni
    - Timber Creek
    - Bulla

3. Communities that are not remote (relatively) or have no communities >100
    - Darwin
    - Katherine
    - Pine Creek
    - Adelaide River
    - Nhulunbuy
    - Gunyangara
    - Mataranka
    - Alyangula
    - Woodycupaldiya

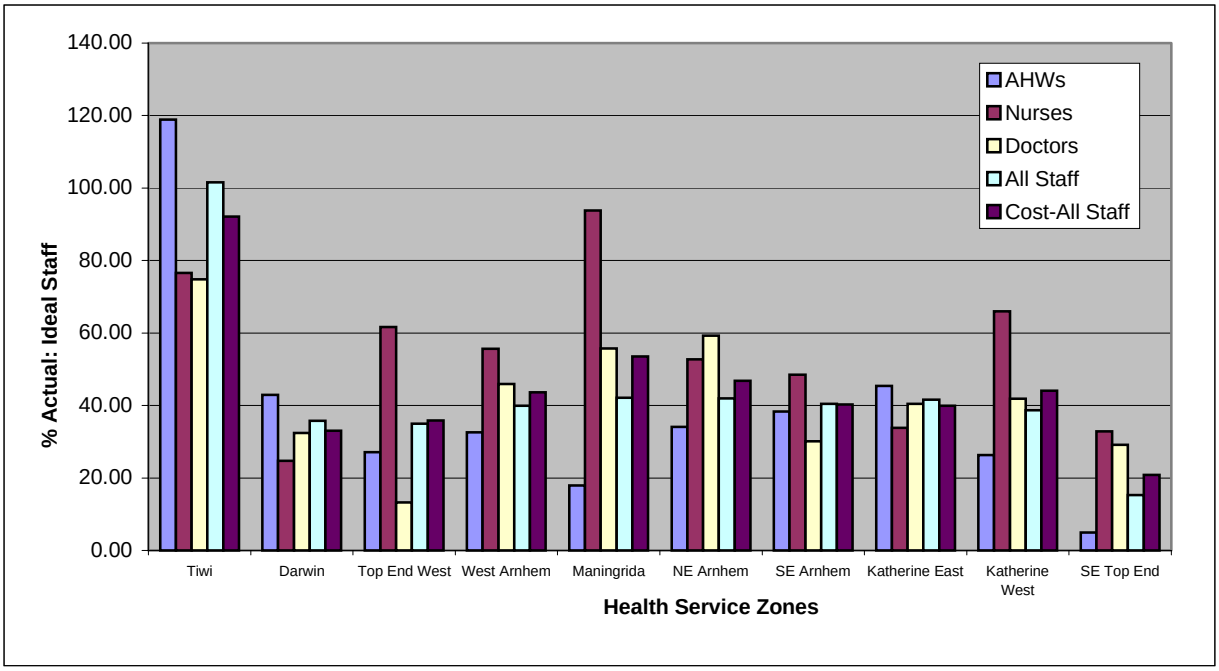
Thus the remaining rankings are shown in Table 25.

Table 25: Rankings of Population Groups according to RCI Criteria.

Rank	*Population Group*	*Actual: Ideal Costs %*
1	Jilkminggan	7
2	Peppimenarti	17
3	Laynhapuy Homelands	21
4	Palumpa	25
5	Borroloola	26
6	Wugularr	28
7	Minjilang	30
8	Yirrkala	31
9	Bulman	32
10	Ramingining	36
10	Belyuen	36
12	Numbulwar	38
13	Ngukurr	40
14	Warruwi	42
15	Milingimbi	43
16	Wadeye	45
17	Oenpelli	48
18	Daly River	51
19	Barunga	51
20	Jabiru	52
21	Batchelor	53
22	Maningrida	54
23	Gapuwiyak	60

These are the rankings that we refer to in our recommendations. Note they are population groups, and not either single communities or Health Service Zones.

Figure 24: Distribution of Health Service Staff by HSZ



The graph in Figure 24 shows the actual staffing levels for AHWs, nurses, doctors and all staff expressed as a percentage of the ideal for each HSZ. 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. Of course being close to the highway does not help in the wet when, short, but poor, connecting roads are washed away.

Finally, we reiterate the lack of homogeneity within HSZs. 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. Tiwi HSZ

Table 26: Tiwi HSZ – Population Groups, Living Places and Health Service Staff.

Community	Number of Assoc Pop		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Nguiu		-	1,300	11.9	5.2	231	2.9	2.9	100	1.9	1.3	146
Assoc Pop	2		110	1.0	1.5	65	0.1	0.7	14	0.1	0.3	36
Milikapiti			480	4.0	4.8	83	2.0	2.4	83	0.3	0.8	38
Pirlangimpi		-	350	2.5	4.7	54	1.0	1.8	57	0.2	0.9	17
Assoc Pop	1	-	10	0	0.2	0	0	0.1	0	0	0	0
Total for Zone	3	-	2,250	19.5	16.4	119	6.0	7.8	77	2.5	3.3	75

Table 27: Population and Distribution of various sized communities – Tiwi HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
6	2,250	-	1 = 1,300	-	1 = 480	1 = 350	1 = 100	2=20

The Tiwi HSZ is marked by a high degree of homogeneity amongst its population. It has a single language and Land Council, and has been able to take over the running of health services through the THB established as part of the CCT. It can be seen that, overall, it is well resourced, with 119% of AHW positions, and more than 75% of nurse and doctor positions. Nguiu also enjoys close proximity to Darwin with regular flights of 20 minutes duration.

Overall the need in this Zone is ranked 10/10.

This Zone is made up broadly of 3 population groups:

Nguiu

Health service resources are concentrated at Nguiu. This estimate takes account of visits to other communities/ out-stations from Nguiu.
Rank - 48/49 (see Table 25).

Milikapiti

Milikapiti is fairly well resourced for AHWs and nurses, but has only around a third of its doctor needs. Rank - 45/49.

Pirlangimpi

Pirlangimpi (Garden Point) has around half its AHW and nurse positions, but only 25% of its doctor needs. Rank - 31/49.

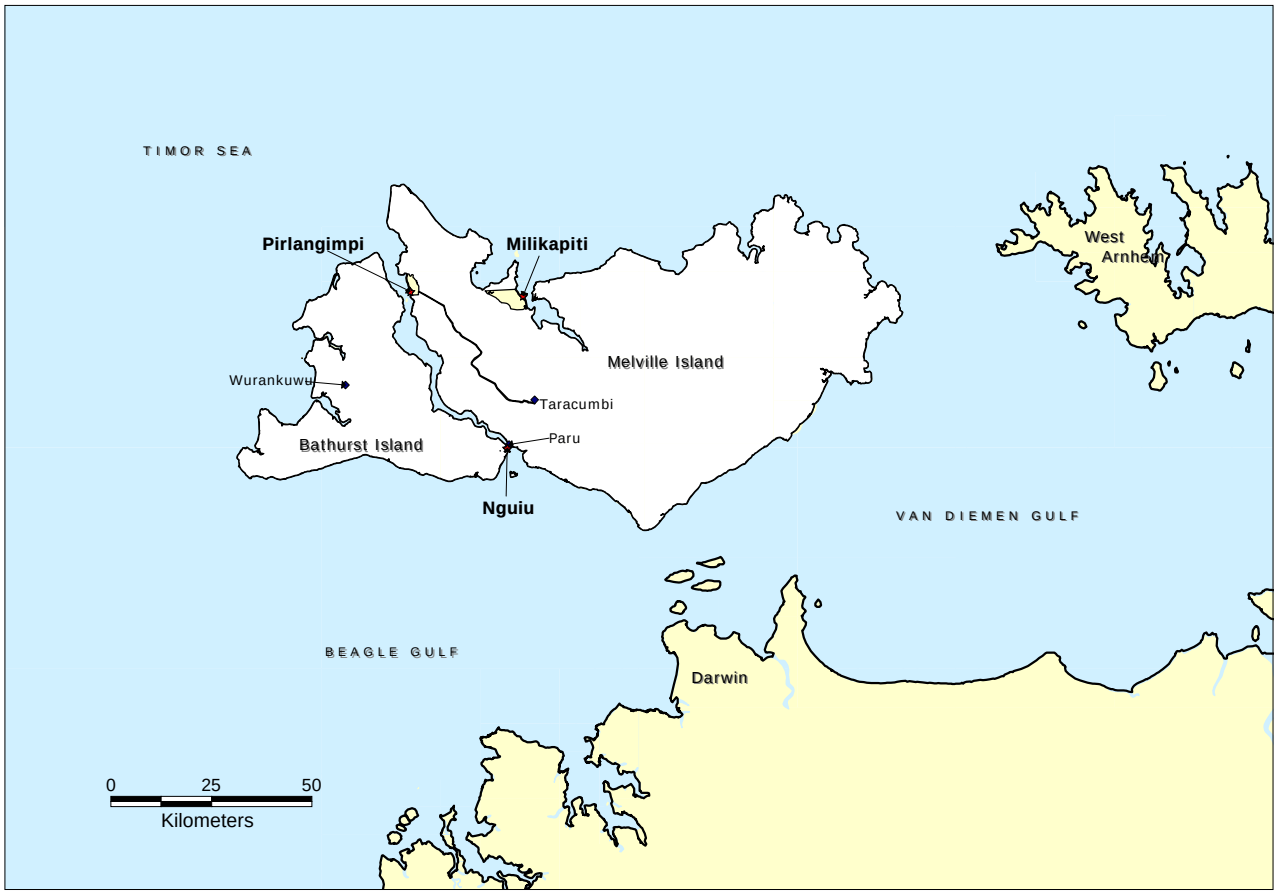
Opportunities for Community Control

The THB that was established to run the CCT is the vehicle that has been developed for community control of health services in this Zone.

Substance Misuse Services

A&IAAFR run community centres at Nguiu, Pirlangimpi and Milikapiti.

Figure 25: Map of Tiwi HSZ Showing Communities & Out-stations



2. Darwin HSZ

Table 28: Darwin HSZ – Population Groups, Out-stations and Health Service Staff.

Community	Number of Assoc Pops		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Darwin			8,420	12.6	24.1	52	1.9	16.8	12	2.7	8.4	32
Assoc Pop	7	0	300	2.4	4.7	51	0.1	2.0	3	0.3	0.8	38
Bagot			280	2.5	3.7	67	0	1.4	0	0.4	0.7	54
Assoc Pop	1	0	60	0	1.2	0	0	0.4	0	0	0.2	0
Adelaide River			350	0	4.7	0	1.5	1.8	86	0.1	0.9	11
Assoc Pop	2	0	60	0	1.2	0	0	0.4	0	0	0.2	0
Batchelor			850	1.0	4.3	24	3.5	2.8	124	0.7	1.1	66
Assoc Pop	3	0	170	0.1	2.7	2	0.1	1.1	4	0	0.4	0
Belyuen			240	3.0	3.2	94	0	1.6	0	0.1	0.6	17
Assoc Pop	1	0	20	0	0.4	0	0	0.1	0	0	0.1	0
Total for Zone	**14**	**0**	**10,750**	**21.5**	**50.1**	**43**	**7.1**	**28.5**	**25**	**4.3**	**13.2**	**32**

Table 29: Population and Distribution of various sized communities - Darwin HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
19	10,750	1 = 8,420	1	1=850	-	2 =630	4 =535	11=315

The population groups in this Zone are:

1. Darwin (including Bagot);
2. Adelaide River;
3. Batchelor;
4. Belyuen

Overall the need in this Zone is ranked 2/10.

Darwin

Darwin is on Larrakia country, but people from all other regions both live in Darwin, and visit for a range of reasons, including those relating to health.

The main PHC service in Darwin is the community controlled Danila Dilba Medical Service that began as a fledgling health service in 1990 with financial assistance from ATSIC and with a trickle of clients. When it was officially opened in 1992 patient numbers had increased to between 1000-1200 per month. Among its aims and objectives is to provide Indigenous people with free PHC including preventive and public health care; and to ensure, by the employment of Indigenous Health Workers, that the type of service provided meet community needs and wishes. Danila Dilba has expanded and now has a number of clinics that deal with specific health issues. For example, there is the Gumileybirra Women's Health Centre established in 1994, a Men's Health Centre, an Education and Training Centre, and a Counselling/ Healing Centre that arose through the establishment of Social and Emotional Health programs, and funding to AMSs as a consequence of the Stolen Generations report. A mobile team provides a service to the town camps in the surrounding areas of the city zone, as well has housebound patients at Palmerston and the northern suburbs. A major achievement has been the establishment of its own Training School for AHWs. Danila Dilba employs more than 90 staff the majority of whom are Aboriginal.

THS run a number of Community Care Centres at Darwin, Casuarina and Palmerston. Their work includes some PHC activities with Aboriginal clients. We have included an estimate of how much of this resource is directed to Indigenous health needs as a basis of our analysis.

Bagot has a SA with THS and services the nearby community of Minmarama Park. 90.5% are a permanent client group, the rest are visitors.

Darwin is quite under resourced in terms of PHC resources, given the complexities involved in providing a service to highly mobile populations with people coming from all over the Top End, and even the Centre. This is even more the case if the Hub Centre role of Danila Dilba is considered.

Darwin is difficult to compare with other population groups in the Top End. It certainly cannot be considered remote, but it has other health needs which remote communities do not. The complexity of issues in Darwin include the local people being overwhelmed by the processes of colonisation and their influence over what happens on their country markedly reduced; there is an influx of other Aboriginal people into Darwin from remote communities for a wide range of reasons including serious illness, prison matters, and to rage.

The difference in health status measure between urban Aboriginal people and non-Aboriginal people is much greater than the gap between urban Aboriginal people and rural/ remote Aboriginal people.

The fact that there are a wide range of health services in Darwin needs to be taken into account when considering resource allocation issues. However, numerous reports on Aboriginal health have illustrated that urban Aboriginal people do not access non-Aboriginal services except in a crisis. Thus the presence of services, does not equate to access.

We consider that it is important that the needs of the Darwin Aboriginal population (and their visitors from elsewhere) not be glossed over because they are not remote. Strengthening Aboriginal PHC strategies in Darwin has potential for impacting on Aboriginal health beyond its narrow service role. After all, Aboriginal health status is unlikely to be improved by simply making people clients of health services.
Rank: 20/49.

Adelaide River
This is largely a non-Aboriginal community, is on the Stuart Highway, and has many traveller visitors. The health service is delivered by THS with a visiting GP from Batchelor.
Rank 13/49.

Batchelor
Batchelor has a resident AHW, and nursing staff employed by THS and a private GP. The majority of residents are non-Aboriginal many of whom holding staff positions at Batchelor Institute as well as entrepreneurs in private business supplying services to the townspeople, students and tourists. It is under resourced for AHWs but well resourced for nurses and has the highest doctor attendance in the zone.
Rank 38/49.

Belyuen
Belyuen has a SA with THS and is under resourced for nurses and doctors. Many non-Aboriginal people come from Cox Peninsula to see the visiting doctor at Belyuen, but there is no funding for this.
The Cox Peninsula has an volunteer emergency service that will stabilise someone in an emergency and contact the DOM on call for advice. The DMO will organise evacuation if indicated.
The people of Belyuen relate culturally and ceremonially to the people of Wadeye, rather than to people in Darwin or Batchelor.
Rank 26/49.

Opportunities for Community Control

Danila Dilba represents the successful model of Comprehensive Community Controlled Health Services as advocated and promoted by AMSANT. It plays a role well beyond its health service delivery role to the local community through its role with Health Summits, NT and national policy development, and the leadership it provides in Aboriginal health.

In order for the potential of Danila Dilba to be realised, issues of resourcing need to be addressed. This includes defining the role of Hub Centres as discussed elsewhere in this report. In order to develop this role, resources for providing high quality PHC services to the local community must be adequate.

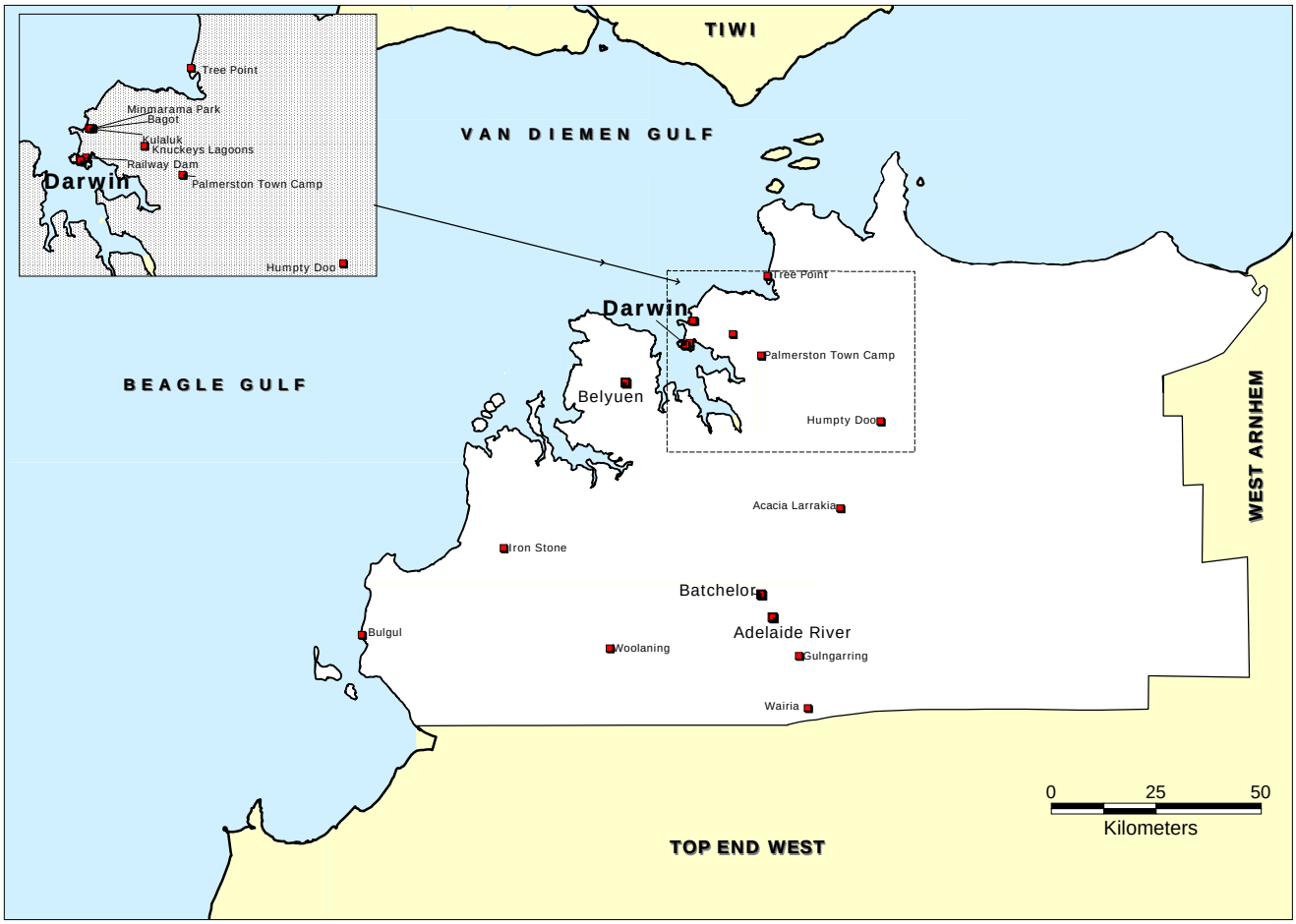
The opportunities at Batchelor and Adelaide River are difficult to identify due to the local Aboriginal populations being fairly overwhelmed by other agendas. At Adelaide River this is largely catering for tourists, and at Batchelor relate to the influx of outsiders (both staff and students) around the operations of the Batchelor Institute.

At Belyuen, the Community Council runs the health service with funds provided by a THS SA. This is through a multi-purpose centre incorporating PHC service and a Commonwealth funded aged care program. The Council prides itself on the fact that it runs these services with minimal non-Aboriginal involvement. However, there is no current Health Committee, and it is not clear what capacity the council has to fully manage and control the service here.

Substance Misuse Services

AIMSS provide short-term care to intoxicated adults at the Darwin sobering up shelter. They also provide training support for sobering-up shelter workers and run a Night Patrol in Darwin and Palmerston. They receive funding from LWAP.
FORWAARD provide an AA based residential treatment program for Aboriginal people with funds from LWAP.
CAAPS run an AA based Aboriginal Residential Treatment Program with funding from OATSIH, LWAP.
A&IAAFR run a non-residential counselling and support service for the partners and families. They also have a Family Worker program to provide interventions and community development for remote communities in the Darwin rural area. They offer an outreach program at Belyuen. OATSIH and LWAP are the funding bodies.
THS manage the only detoxification unit in the Top End at Coconut Grove in Darwin that is mainly used for illicit substance detoxification.
LWAP fund four community educators who are based in Darwin and deal with the general population.

Figure 26: Map of Darwin HSZ showing Communities & Out-stations.



Fish Camp is not shown in this map.

3. Top End West HSZ

Table 30: Top End West HSZ – Population Groups, Out-stations and Health Service Staff.

Community	Number of Assoc Pop		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Pine Creek			550	0.9	5.5	16	1.8	2.8	64	0.2	0.9	19
Assoc Pop	2	0	75	0.04	0.5	8	0.0	0.5	8	0.01	0.2	4
Daly River			400	2.8	4.0	71	1.4	2.0	71	0.1	0.7	11
Assoc Pop	3	0	165	1.2	2.6	44	0.6	1.1	53	0.03	0.4	7
Palumpa			300	0	4.0	0	1.0	1.5	67	0.1	0.8	13
Peppimenarti			300	0	4.0	0	1.0	1.5	67	0.1	0.8	13
Assoc Pop	4	0	105	0	2.1	0	0	0.7	0	0	0.3	0
Wadeye			2,200	5.0	8.8	57	5.0	4.9	102	0.4	2.2	18
Assoc Pop	15	2	255	0.0	5.1	0	0	1.7	0	0	0.6	0
Woodycupaldiya			30	0.9	0.6	156	0	0.2	0	0.06	0.1	80
Assoc Pop	13	1	100	0.1	2.0	3	0	0.7	0	0	0.3	0
Total for Zone	37	3	4,480	10.9	39.2	28	10.8	17.5	62	0.9	7.1	13

Table 31: Population and Distribution of various sized communities – Top End West HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
46	4,480	-	1 = 2,200	-	2 = 950	2 = 600	1 = 100	37=630

There are 6 main population groups in this zone with many permanently occupied out-stations. Providing these out-stations with a reasonable service is logistically difficult as the populations are small and the condition of the roads is atrocious. Access is often cut in the wet and there is a lack of resident and visiting staff accommodation and transport. A mixture of solutions will be needed which may include resident doctors, increased resident nurses and AHWs, medicine kits, telephones and a visiting bush mobile service.

Within this zone there has been a plethora of conflicting information about who associates with who, who will /will not use what service. Consequently it has been quite difficult to decipher what communities would comfortably share a health service resource.
There are a floating number of clients between Wadeye, Palumpa, Peppimenarti and Daly River and associated out-stations either for family, cultural, social and club visits. There are 32 out-stations with a combined population of 460 that relate to each other in various ways and to a number of larger communities (esp. Palumpa and Peppimenarti). There is no regular visiting service and people access services at larger communities as suits them from time to time. This mobility and marked under resourcing puts enormous strain on service providers in these communities.
Overall the need in this Zone is ranked 3/10.

Pine Creek

Pine Creek is mostly a non-Aboriginal population on the Stuart Highway involved with mining, and tourism.
The Pine Creek Aboriginal Advancement Association was set up in 1972 to assist Aboriginal people to get some legal rights to occupy the land and in 1978 it negotiated for a 97 hectare property – Kybrook Farm – 5km to the south and in 1984 negotiated another lease in the town (Pine Creek Aboriginal Town Camp/ Pine Creek Compound). It has a THS service with a visiting GP from Katherine.

Rank 20/49.

Daly River

Daly River has a THS SA health service. Before this the Catholic Church delivered the service. 2 of the AHWs here are paid through the CDEP, rather than health service funds. It is clear that they are under resourced especially for nurses and doctors. The NTRHWFA has identified this community as being eligible for a Remote Area Grant (RAG) from which to employ a doctor, but this has not yet been operationalised.
Daly River has a residential alcohol treatment program, and also receives many visitors that add a burden to the health service.
Rank 35/49.

Palumpa

At the beginning of this study Palumpa had a SA with THS that had been operating since 1989. Community dissatisfaction with level of support provided has resulted in THS taking back responsibility for this service. It has been operating with a single nurse and doctor visits. They also receive funding from OATSIH for AHW wages, training and development expenses. It should be noted that the out-stations in this area have been associated with Peppimenarti because of better physical access. In fact, people from these out-stations access Palumpa as well as Peppimenarti from time to time, and people maintain relationships with both places.
Rank 13/49.

Peppimenarti

This is the most under resourced of the communities in this Zone. It is funded through a THS SA that is paid into the Clinic Association and administered by the Council. There are no AHWs and are staffed with 1 nurse with a doctor visiting 1 day a fortnight. There is also a demand from out-stations in the area to which they used to provide a regular mobile service, but are now no longer able to do so, as well as from people living on the out-stations around Woodycupaldiya. There is no health committee and there is only one house for staff accommodation.
There are two versions as to the establishment of Peppimenarti one is that it was established as an out-station of Daly River mission in 1972 and the other is that it was a break away move from Daly River mission. Note, as explained above, that a number of out-stations have been counted as associates of Peppimenarti for the purposes of this analysis, when in fact they also relate to Palumpa.
Rank 7/49.

Wadeye

Wadeye (Port Keats) has adequate nursing staff but has inadequate AHWs and medical officer. THS now provide this service after a SA with the Council collapsed. There are several out-stations in this area that do not have direct communication to the clinic but use a radiophone to the Murin Association. There have been developments within the clinic for shared management between AHWs and nurses. The NTRHWFA have assisted to have a doctor located here to be employed by the Kardu Numida Council, however a doctor is yet to be recruited.
Rank 33/49.

Woodycupaldiya

The number of permanent residents here is small but the combined out-station population in this area is significant. The service is now being provided by THS with the employment of a male AHW based at Woodycupaldiya with a DMO visiting.

Woodycupaldiya and out-stations historically used the services of the health clinic at the Daly River Mission under the control of the Catholic Mission. The health service was transferred from the mission to a SA with the Marrathiel Association (now Yantjarrwu Aboriginal Out-station Resource Centre) but has now been taken over by THS. They also ran the CDEP program that has now been transferred to Peppimenarti.
OATSIH inherited a decision made by the local ATSIC Regional Council for a new health clinic and Aged Care Hostel that were completed in 1998. Rank 9/49.

Opportunities for Community Control

During the course of this study the Nganmarriyanga Council at Palumpa decided it would not sign a further SA with THS as they felt they could not run it any longer. The level of funding was inadequate and the health service was actually a cost to the Council. There is no health committee. Palumpa's experience has probably damaged any possibility of their taking control of the health service in the foreseeable future.
There has never been a health committee at Peppimenarti and community interest in the clinic has decreased since the death of a local elder.

Wadeye have developed a proposal for a tripartite agreement with the Commonwealth and NT governments and Memelma/ Thamarrurr (a traditional structure of governance) to re-establish traditional family values (*way of life*) through the development and implementation of a Family Support Project: Kardu Darrikardu Ngumanmanpinu. Kardu Numida Inc acts as the business wing in the community and has successfully managed many projects in the community. In relation to the establishment of Memelma/Thamarrurr, this strategy is meeting with success that can be attributed to the commitment of community leaders and their supporters, in wanting to provide a better way of life for their people. These developments may offer opportunities for the development of a health committee working in with these other structures.

The opportunities for community control at Daly River appear few. According to health service staff AMSANT visited to invite community members and leaders to the Banatjarl Health Summit, but there was little interest.

Woodycupaldiya has some health service delivery needs but has had difficulties in the past running it's own services, and is probably not well placed to take on this responsibility.

The chances of this Zone lending itself to a form of Zone management are quite low. There are strongly felt histories between communities and this is likely to militate against a collaborative arrangement. However, it may be possible for the out-stations around Woodycupaldiya to be serviced from Peppimenarti and / or Daly River.

Substance Misuse Services

A&IAAFR provide a residential alcohol treatment program for families near Daly River. They also have a Family Worker program to provide interventions and community development for remote communities. They support community-based programs at Wadeye, Palumpa and Peppimenarti. Funding is from LWAP.
CCBFPT visit and provide referral to and aftercare support for their residential treatment program at Daly River and Wadeye.

Figure 27: Map of Top End West HSZ Showing Communities & Out-stations.

Malak Malak, 5 Mile, Uminuluk/ Tommy's, Nordik, Leichart, Kuriyippi, Tchindi and Table Hill are not shown on this map.

4. West Arnhem HSZ

Table 32: West Arnhem HSZ – Population Groups, Out-stations and Health Service Staff.

Community	Number of Assoc Pop		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Jabiru			30	0.4	0.6	68	0.3	0.2	158	0.1	0.1	126
Assoc Pop	15	1	325	1.6	6.0	27	0.7	2.2	32	0.9	0.8	111
Oenpelli			1,000	2.5	5.0	50	3.5	3.3	105	0.8	1.3	64
Assoc Pop	13	4	360	0.5	6.7	8	0.5	2.4	21	0.2	0.9	22
Warruwi			340	3.0	4.5	66	1.0	1.7	59	0.1	0.9	12
Assoc Pop	8	2	55	0	1.1	0	0	0.4	0	0	0.1	0
Minjilang			250	2.0	3.3	60	1.0	1.3	80	0.1	0.6	16
Assoc Pop	17	1	175	0	3.0	0	0	1.2	0	0.1	0.4	14
Total for Zone	53	8	2,535	10.0	30.7	33	7.0	12.6	56	2.3	5.1	46

Table 33: Population and Distribution of various sized communities – West Arnhem HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
65	2,535	-		1 = 1,000	-	2 = 590	2 = 160	52=785

There are four main population groups with three SA health centres (Jabiru, Warrawi and Minjilang) and one combination health centre at Oenpelli.

Overall the need in this Zone is ranked 6/10.

Warruwi

Warruwi (Goulburn Island) has a SA with THS. Warruwi is short for AHWs, nurses and doctors. There are no routine visits to the out-stations.
Rank 29/49.

Minjilang

Minjilang (Croker Island) has a SA Health Centre with THS. It is poorly resourced for AHWs and doctors. There is poor access to out-stations some of which are on the island and others are on the mainland, none of which have airstrips.
Rank 19/49.

Oenpelli / Kunbarllanjnja

Oenpelli / Kunbarllanjnja has a SA with OATSIH through the Demed Association for out-station services that are contracted to THS. THS directly employ other staff. A doctor is employed by Kunbarllanjnja Community Council. There is a health committee that includes people from Demed and the Kunbarllanjnja Council.
Rank 34/49.

Jabiru

Jabiru has a SA between THS and the Djabulukgu Association that fund 2 AHW positions. The Association also employs a doctor to provide a service to the Aboriginal people in town and on out-stations. THS employs the nurses. There is also a private GP with an arrangement with the Ranger Uranium Mine. There are also many visitors (visiting the nearby Kakadu National Park) who place variable demands on the health service.
Rank 37/49.

Opportunities for Community Control

There have been discussions about the establishment of health boards in this zone and a meeting has taken place at Jabiru. There are rumours that a health board has been established at Warruwi but this was not confirmed by a senior AHW there. There have also been suggestions that the health board could join up with Minjilang but as yet there have been no concrete discussions with Minjilang.

Increased activity has been focused on social health matters since the attempts at opening a second mine at Jabiluka. This has included a study on the Kakadu Social Impact Study Implementation. There are opportunities here for increasing community control over services, but many issues need to be resolved before these communities can take this on. Unfortunately consultants involved in some of these processes appear to have little knowledge or understanding of the health sector, the Framework Agreement or the principles of PHC. Thus whilst recommendations coming out of these processes are generally very good, they need some work to fit with best practice in the health sector.

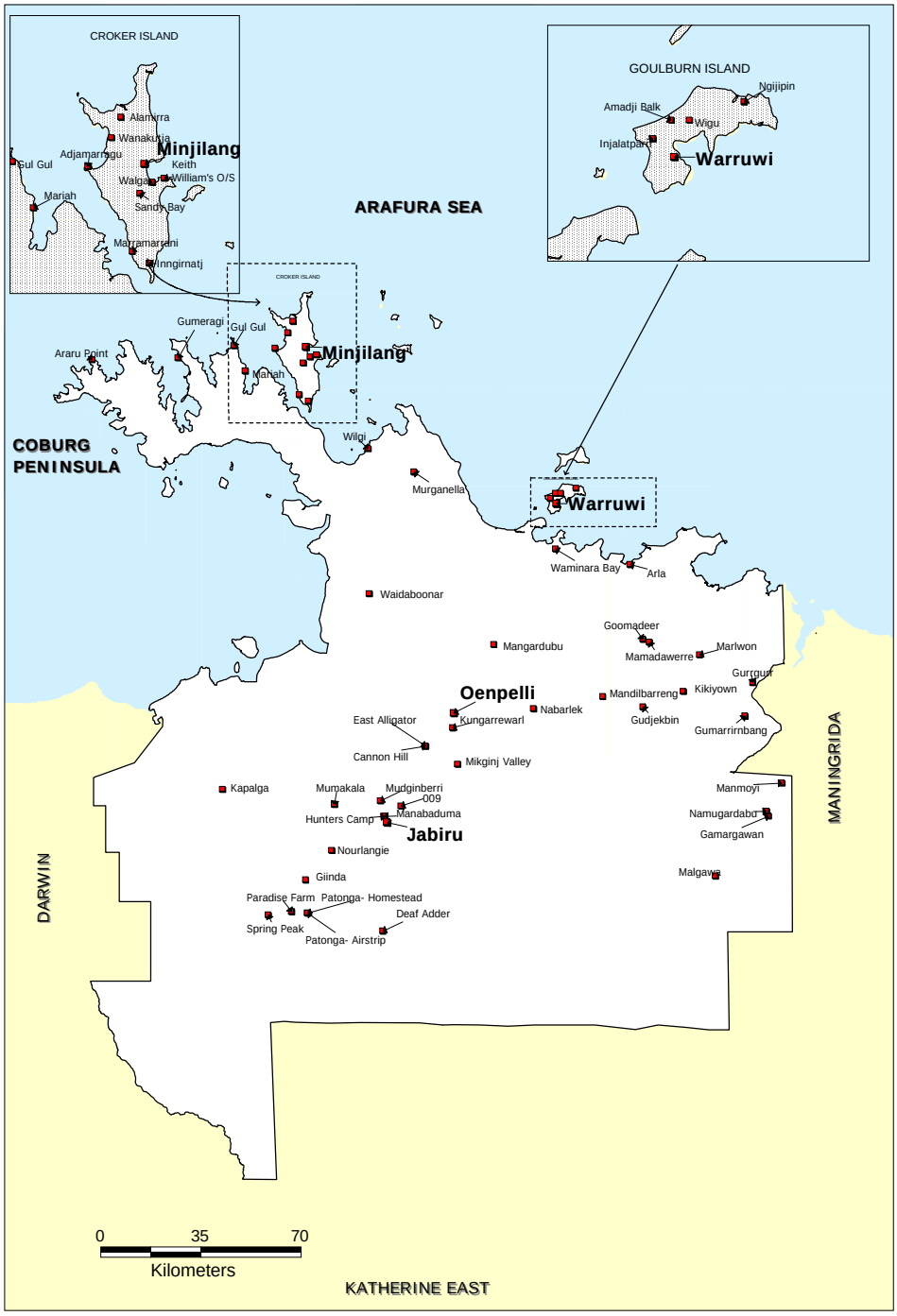
Substance Misuse

CAAPS have an Alcohol Counsellor resident at Jabiru who covers both Jabiru and Kunbarllanjnja and associated out-stations. Clientele is both Aboriginal and non-Aboriginal and most of the work is done from a 4wd vehicle. CCBFPT also visit and provide referral to and aftercare support for the residential treatment program at Oenpelli and Jabiru.

The Jabiru CDEP that is managed by the Djabulukgu Association is currently developing a night patrol to address antisocial behaviour in Jabiru. A night shelter is also under development with male and female quarters. Their main concern is alcohol and the patrol will cover the whole of Kakadu National Park.

There is a local Gunbang Action Group (alcohol management group) which has a corporate plan which aims to place effective controls on the availability of alcohol, to provide preventative and treatment services, and to reduce the risks associated with drinking environments.

Figure 28: Map of West Arnhem HSZ Showing Communities & Out-stations.



Ararlagu, Arnorrwan, Illiaru, Annesley Point, Tiger's Out-station, Cape Don, Black Point and Djirbiyak are not shown on this map.

5. Maningrida HSZ

Table 34: Maningrida HSZ – Population Groups, Out-stations and Health Service Staff.

Community	Number of Assoc Pop		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Maningrida			1,270	3.0	6.4	47	8.0	4.2	189	2.0	1.6	126
Assoc Pop	34	8	815	1.1	16.3	7	1.1	5.4	20	0.0	2.0	1
Total for Zone	34	8	2,085	4.1	22.7	18	9.0	10.0	94	2.0	4.0	56

Table 35: Population and Distribution of various sized communities – Maningrida HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
43	2,085	-		1 = 1,270	-	-	-	34=815

Maningrida populations are made up of ten different language groups largely as a consequence of migration of people from other areas to Maningrida in the wake of various colonial policies. However, as can be seen in Table 34 there is a single large community with many small out-stations/ homelands. It can be seen that the resources in this zone are concentrated at Maningrida, although visiting services are provided to out-stations/ homelands. On our standard, Maningrida is under-resourced for AHWs and over resourced for nurses and doctors. There are no health employees on the out-stations but some families have medicine kits which get stocked up on visits or when they are in town.

Overall the Zone ranks 9/10.

Maningrida as a population group ranks 39/49.

Opportunities for Community Control

In the 1994/95 budget, the Commonwealth JHPC allocated funding for a feasibility study in health services for the Maningrida community and out-stations. The purpose of the study was to explore the feasibility of establishing a comprehensive and multi-faceted health service at Maningrida.
The resultant report recommended an elaborate multi-faceted health service as well as suggesting transferring decision-making responsibilities for the health service to the local Aboriginal community.

In June 1996 a Tripartite Agreement was signed between THS, Commonwealth Health and the Maningrida Health Board (MHB) to provide a basis for co-operation between the three organisations in the delivery of health services to the Maningrida Community and out-stations. It outlined a process for the parties to consult, design and construct new health services facilities for Maningrida community and out-stations and proposed that the parties work collaboratively to develop a process to ensure the provision of an effective, efficient and integrated health service to the Maningrida community and out-stations leading to community control.

The MHB eventually incorporated in September 1998. It has 34 members, 2 places reserved for Traditional Owners (Djebbana), and 2 for other local Traditional Owners (Wallang and Nakarra), 31 out-station representatives and 3 additional places. The executive has 12 members. In mid November 1999 a coordinator of the MHB was employed.

Despite these optimistic developments, there are many problems here relating to the location of the clinic on a particular Traditional Owner's country and the need to have NLC approval for further development and the relationship that has developed between various non-Aboriginal advisors and particular powerful people within the community. Some of these problems have been aired in the national media, whilst there have also been attempts by some factions to get support from health organisations, such as the Public Health Association. Further, it has been difficult getting a quorum to Board Meetings, which raises the important question as to whether the structure is what people want, or whether it is based on other notions of organisational democracy and representation.

However, now that a coordinator has been employed, these issues may be able to be overcome. However, we must point out the long period that these developments have taken. The complexities of the issues involved deserve a closer look at what was done, and how this might have been done more productively. One of the difficulties in these sorts of situations is the sensitivity of local community business, versus the difficulties in learning from bureaucratic and professional mistakes.

Substance Misuse Programs

The community has endured petrol sniffing and alcohol misuse. Successful strategies to address the petrol sniffing have included using Avgas instead of petrol in fuel supply in the community, employment and training programs and sport & recreation programs. Whilst petrol sniffing has decreased substantially kava and marijuana are now more popular substances.
LWAP provide funding to the Maningrida Council to employ an Aboriginal Youth Development Worker to implement substance abuse programs for young people.
CCBFPT visit and provide referral to and aftercare support for the residential treatment program at Maningrida.

Figure 29: Map of Maningrida HSZ Showing Communities & Out-stations.

Kabalyarra, Kumurlulu and Namaladja are not shown on this map.

6. North East Arnhem HSZ

Table 36: North East Arnhem HSZ – Population Groups, Homelands and Health Service Staff.

Community	Number of Assoc Pop		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Nhulunbuy			140	3.0	1.9	161	0	0.9	0	2.8	0.4	800
Assoc Pop	2	0	35	0	0.7	0	0	0.2	0	0.1	0.1	114
Milingimbi			800	5.0	4.0	125	2.0	2.7	75	0.3	1.0	30
Assoc Pop	6	0	265	0	4.8	0	0	1.8	0	0	0.7	0
Ramingining			800	1.0	4.0	25	2.4	2.7	90	0.3	1.0	30
Assoc Pop	12	3	235	0	4.7	0	0.6	1.6	38	0	0.6	0
Galiwin'ku			1,400	8.0	5.6	143	3.0	3.1	96	1.4	1.4	100
Assoc Pop	30	5	340	0	6.8	0	0	2.3	0	0	0.9	0
Gapuwiyak			950	3.6	4.8	76	2.6	3.2	82	1.0	1.2	84
Assoc Pop	12	2	170	0.4	3.4	12	0.4	1.1	35	0	0.4	0
Yirrkala			750	1.0	7.5	13	2.0	3.8	53	0.3	1.3	24
Assoc Pop	20	0	755	1.0	13.7	7	2.0	5.0	40	0.4	1.9	21
Gunyangara			300	0	4.0	0	1.0	1.5	67	0.3	0.8	40
Assoc Pop	4	1	80	0	1.6	0	0	0.5	0	0	0.2	0
Total for Zone	86	11	7,020	23.0	67.4	34	16.0	30.3	53	6.9	11.6	59

Table 37: Population and Distribution of various sized communities – North East Arnhem HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
104	7,020	-	1 = 1,400	3 = 2,550	1 = 750	1 = 300	4 = 430	83=1,590

This is probably the most complex zone in terms of the funding of health services.
There is one community controlled health service, three THS SAs, two THS delivered services, and three combination health services in this zone. THS also fund Community Councils to run Strong Women Strong Babies Strong Culture programs in Galiwinku, Gapuwiyak, Milingimbi (also an environmental health grant) and Yirrkala.

Nhulunbuy is serviced by Miwatj, as well as a private GP. There is also a regional hospital here.
Overall this Zone ranks 8/10.

Miwatj Health

Miwatj Health is a community controlled health service that runs a health clinic at Nhulunbuy, and provides resident medical service to Gapuwiyak and visiting medical services for Galiwin'ku, Laynhapuy and Gunyangara. Miwatj is an accredited training provider of vocational and education training in PHC to Aboriginal people through its Health Training School. It was established as an incentive under the NAHS in the early 1990s.

Aboriginal Research and Development Services (ARDS)

ARDS is the community development arm of the Uniting Aboriginal and Islander Christian Congress. They do not deliver PHC services, but are strongly involved in this Zone with the promotion of Yolngu language and culture. They have conducted many consultancies, have attracted sexual health funds, and work collaboratively with Miwatj in conducting orientation programs.

Galiwin'ku

The Nalkanbuy Council has a SA with THS. There is a doctor employed by the Council, funded by NTRHWFA. Miwatj also provide a medical officer 2 days a week. This is a large community with many homelands that do not have a service but Marthakal Homelands (which have a resource centre) have been a nominated RCI site since the 1st round in 1997. ARDS are planning to conduct a consultancy to determine how this can be progressed. There is no health committee.
Rank 44/49.

Gapuwiyak

Gapuwiyak is a combination service with THS managing and administering the clinic (previously SA Health Centre) and OATSIH funding the Council for an out-stations service. The homelands have red first aid boxes that are refilled on visits. There is a doctor employed and accommodated by Miwatj and funded by a RAG / Medicare.
Rank 42/49.

Gunyangara

Marngarr Community Government Council has SAs with both THS and OATSIH. Miwatj Health provides medical support. A service is provided to the associated Homelands. It is poorly resourced for AHWs and medical support however it is only 13kms from Nhulunbuy which effects its need assessment.
Rank 11/49.

Milingimbi

This clinic is managed and administered by THS. It is poorly resourced for medical visits and the homelands are not serviced albeit some are in close proximity.
Rank 30/49.

Ramingining

This clinic is managed and administered by THS whilst the Ramingining Homelands Resource Centre Aboriginal Corporation has a SA with OATSIH for a homelands service. The resource centre contract THS to provide the service. More AHWs and medical support is required here. Rank 25/49

Yirrkala

This clinic is managed and administered by THS. It is a large community that is poorly resourced particularly for AHWs and medical support. Its proximity to Nhulunbuy is a consideration.
Rank 22/49.

Laynhapuy Homelands Health Service

Laynhapuy Homelands Health Service (LHHS) delivers PHC to the homelands of the Laynhapuy region surrounding Yirrkala. LHHS is a division of Laynhapuy Homelands Association lnc. that was established to service the homelands in 1985 although the homelands movement began many years before. The Resource Centre is based at Yirrkala. It is a combination health service with both THS and OATSIH having SAs with the Laynhapuy Homeland Association Inc to provide this service. Miwatj Health provides medical support. It is a mobile service travelling to the homelands by road, light aircraft or helicopter. Each homeland has nominated one or more residents to act as Health Aids and are employed under the CDEP scheme and are required to work four hours per day providing PHC. The Health Aids also assist with routine clinic visits and are responsible for medical supplies left by LHHS. Between health visits the health aids take care of minor ailments such as coughs and colds, sores and dressings and are trained in first aid. The health aids are also responsible for liaising with LHHS staff when a resident requires more care than they are trained to give. The health aids come in to the LHHS office and work with the health team to upgrade their skills and work in other homelands with the health team.
Rank 9/49

Opportunities for Community Control

There are no health committees in any of the communities outside of Nhulunbuy. Galiwin'ku has a strong Council and has managed its SA satisfactorily, but there have been problems within the health service that require specific health service management to resolve. There is no health committee, and they receive inadequate health administration resources. The further development of health services for the Marthakal Homelands could be an opportunity to assist in both the development of more adequate health service administration, and the establishment of a Health Committee.
Gapuwiyak had difficulty in managing the health service through a SA arrangement with THS, and have returned responsibility for the service to THS. The negative experience of the SA arrangements means that Gapuwiyak are likely to be reluctant to take on this responsibility again. However, some degree of community control maybe possible through their relationship with Miwatj Health.

Gunyangara and Yirrkala are under resourced, but are geographically close to Nhulunbuy. However, both are represented on the Miwatj Health Board. Strengthening Miwatj's ability to deliver services here represents the logical way of increasing community control of services.

The Laynhapuy Homelands Association lnc. has had considerable experience is providing and auspicing services to the homelands since 1985. However they are not funded for health service administration, and have no health committee. The provision of better administrative and program development resources coupled with the development of a health committee under the Association may assist this service to develop to another level.

Miwatj Health offers the best opportunity for strengthening community control in this Zone. Miwatj already have a health board with most communities represented on it, and provide at least medical services to many communities.

Substance Misuse Services

CCBFPT visit and provide referral to and aftercare support for the residential treatment program at Milingimbi and Ramingining.
Miwatj have been running an outreach program for town camp drinkers that consists of a training program incorporating work and recreational activities.

There is a pilot program underway here which is attempting to build community capacity to better manage substance misuse on remote communities. It is funded by the THS LWAP and is part of the THS Public Health Unit at Nhulunbuy. THS workers are trying to develop a network of traditional Aboriginal leaders men and women - the *Mala Leader Network* with an emphasis on developing education awareness and treatment services. It involves leaders nominating key members of their clan to help educate other clan members about tobacco and other substances. Accredited training is to be aimed at minimising the need to leave their community (eg. visiting lecturers, audio-graphic links with urban tertiary institutions, and two-way tuition). They expect that it will result in:

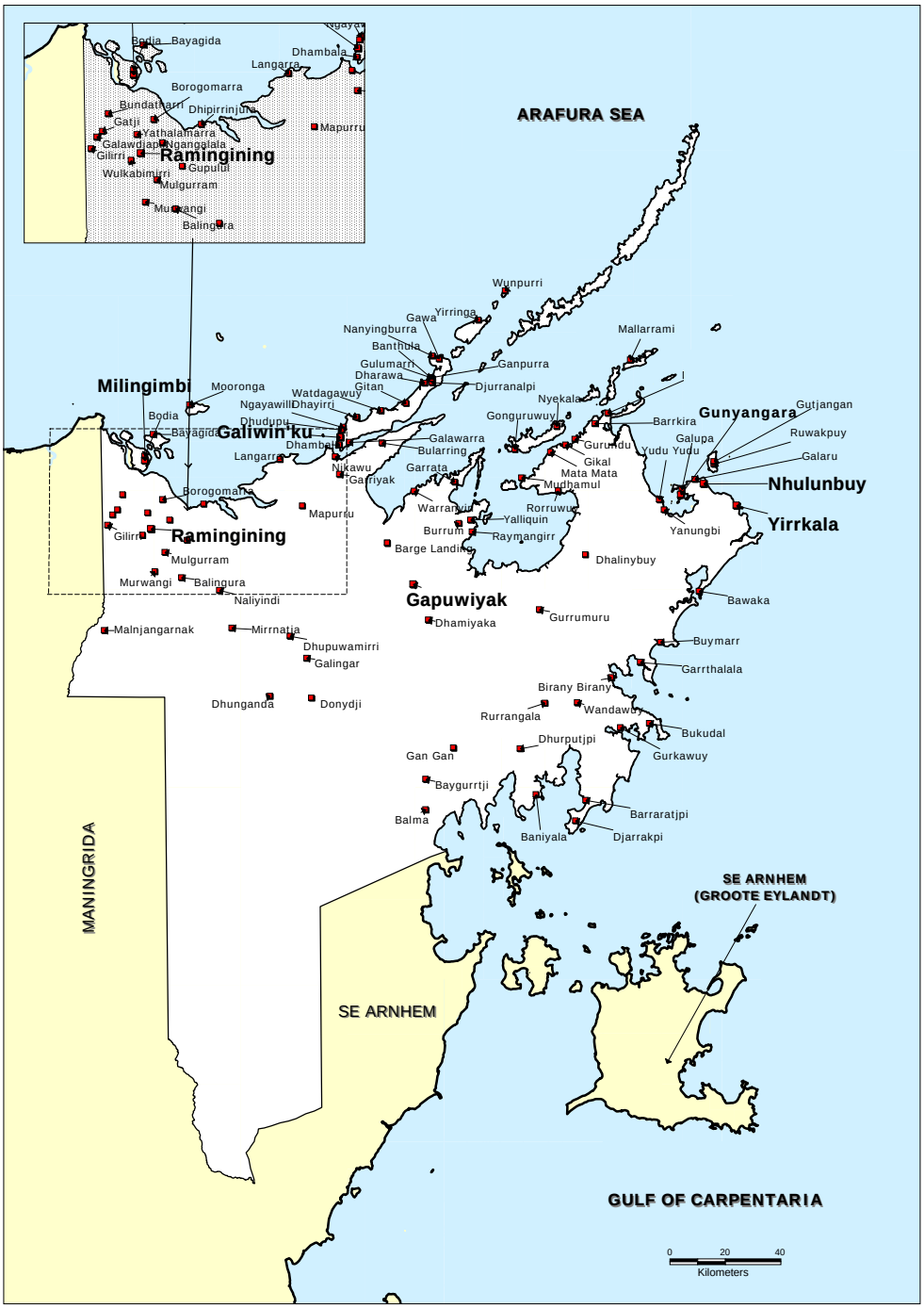
- a large number of potential substance workers on communities;
- improved understanding of why people use drugs; and
- helping key individuals discover what they can do to minimise the harm from drug abuse to themselves and their community.

Some will be paid a fee for services rendered in assisting their community to deal with drug and alcohol issues. Others will use this knowledge to change their own lifestyle and improve the well being of their family and broader community.
This approach to managing drug and alcohol addiction uses traditional Law and custom to help persuade and foster lifestyle change.
The workers' experience has been that some clans benefited, whilst others didn't. There is no recurrent funding so there is no long-term employment – the best that could be expected is that it might top up or become a CDEP scheme.

Clan leaders from Yirrkala, Nhulunbuy and Laynhapuy have also been negotiating with the liquor industry to restrict liquor sales especially banning of sales of wine and spirits.

Marngarr Council at Gunyangara received funding from OATSIH for a substance misuse program but the funding was not adequate for full time staff, for the work or accommodation. They received no response from advertising and have since returned the money to be used elsewhere in the region.
Previously a rehabilitation centre for petrol sniffing operated at Bremer Island (Ruwakpuy). There have been suggestions that this site moves be developed for a detoxification program.

Figure 30: Map of North East Arnhem HSZ Showing Communities & Homelands.



Town Beach, East Woody, Bunhunara, Gunuruguru, Garanyadjine/ Jimmy's, Mungberri, Yinimala, Daliwuy, Dhanaya, Martjanba, Ninikay, Nganmarra, Djiliwirri and Gamarrwa are not shown on this map.

7. South East Arnhem HSZ

Table 38: South East Arnhem HSZ – Population Groups, Homelands and Health Service Staff.

Community	Number of Assoc Pop		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Alyangula			100	0	1.3	0	0.1	0.7	14	0.1	0.3	36
Numbulwar			900	3.0	4.5	67	2.0	3.0	67	0.3	1.1	27
Assoc Pop	12	4	160	0	3.2	0	0	1.1	0	0	0.4	0
Milyakburra			220	0.1	2.9	2	0.1	1.5	3	0.1	0.6	18
Angurugu			800	5.5	4.0	136	3.0	2.7	111	0.7	1.0	70
Assoc Pop	7	0	135	0	2.7	0	0	0.9	0	0	0.3	0
Umbakumba			450	1.0	4.5	22	1.0	2.3	44	0.2	0.8	27
Assoc Pop	5	0	80	0	1.6	0	0	0.5	0	0	0.2	0
Total for Zone	24	4	2,845	9.5	24.8	38	6.1	12.6	49	1.4	4.6	30

Table 39: Population and Distribution of various sized communities – South East Arnhem HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
33	2,845	-	-	2 = 1,700	1 = 450	-	2 = 320	24=375

This zone consists of four Aboriginal population groups:

- Numbulwar and associated homelands on the mainland; and
- Angurugu, Umbakumba and Milyakburra and associated homelands on Groote Eylandt.

In 1997 the latter three communities were nominated as a single site to receive and RCI grant from OATSIH to improve PHC services in these communities. Thus far there have been no resources operationalised. These three communities do not have a shared view of the process, and have been unwilling to share a resource. OATSIH are currently funding two simultaneous 6-month consultancies – one in Umbakumba and the other for Angurugu and Milyakburra to determine how the funds will be best expended.

Zone Rank 4/10.

Alyangula

Alyangula has a majority of non Aboriginal residents associated with mining activities, and are serviced by an independent GP who is accommodated by and has use of facilities owned by THS, and has a contractual arrangement with the mine. THS directly provide health services here. The Aboriginal population is only around 100 people. All health service staff for Umbakumba, Milyakburra and Angurugu are accommodated at Alyangula. People access emergency after hours services from here.
Rank 5/49.

Angurugu

Angurugu is reasonably resourced but no service is provided to the associated homeland population.
Rank 46/49

Umbakumba

Umbakumba receives a daily visiting service from Angurugu and is poorly resourced particularly for AHWs and medical support. They have to get to Alyangula for treatment after hours.
Rank 15/49

Milyakburra

Milyakburra has no resident health staff. They also have to get to Alyangula for treatment after hours.
Rank 2/49

Numbulwar

Numbulwar has an unusual arrangement whereby THS fund nursing and medical support but the AHWs are paid by the Council that has a SA with THS. The Council made a decision that one of the AHWs work in their respite program so whilst the AHW is included in the numbers here they are actually not working within the clinic service. Numbulwar needs to be considered in light of its remoteness and the lack of any other support such as cleaners, receptionists and drivers. There is no service to the homelands that are mostly occupied in the dry.
Rank 27/49

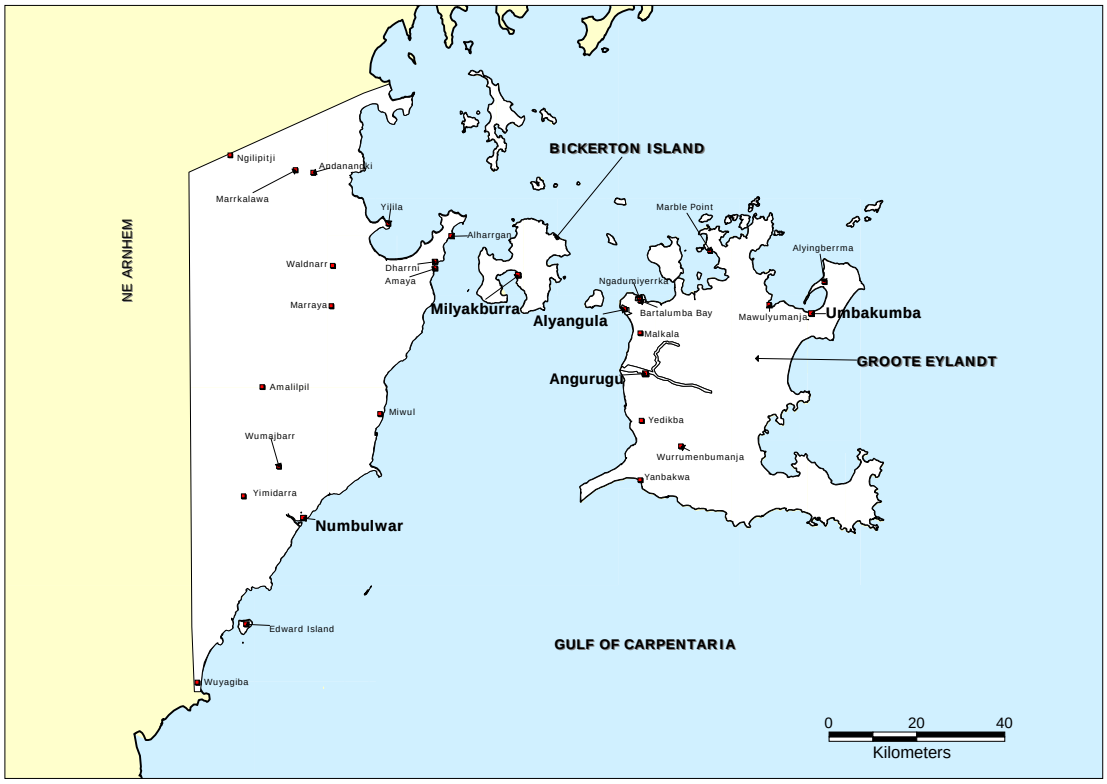
Opportunities for Community Control

There is a consultancy for the RCI program underway for both Angurugu and Milyakburra that is currently investigating this issue. The consultancy for Umbakumba has not yet progressed. ATSIC have documented that the Angurugu Council has had difficulties managing grants. Numbulwar council considers themselves to be a 'paymaster' in regards to the arrangement whereby they employ the AHWs. The newly elected council have prioritised their commitments and are specifically trying to address law & order, sport & recreation and employment issues.

Substance Misuse Services

Angurugu has a substance misuse program funded by OATSIH and managed by Anglicare on behalf of the Angurugu Council.
CCBFPT visit and provide referral to and aftercare support for the residential treatment program at Groote Eylandt.
Numbulwar Numburindi Community Government Council has a substance misuse worker who is supported by both CAAPS and THS workers. This program currently includes a community education project on marijuana.

Figure 31: Map of South East Arnhem HSZ Showing Communities & Homelands.



Rocky Point, Amirraba, Thompson Bay and Picnic Beach are not shown on this map.

8. Katherine East HSZ

Table 40: Katherine East HSZ – Population Groups, Out-stations and Health Service Staff.

Community	Number of Assoc Pop		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Katherine			1,040	10.2	5.2	195	0.7	3.5	20	2.0	1.3	156
Assoc Pop	9	1	530	4.8	7.8	62	0.3	3.5	9	1.0	1.3	73
Mataranka			630	0	6.3	0	1.8	3.2	58	0.2	1.1	17
Assoc Pop	3	0	70	0	1.4	0	0.1	0.5	17	0	0.2	10
Jilkminggan			175	0	2.3	0	0.1	1.2	9	0.1	0.4	23
Assoc Pop	1	0	30	0	0.6	0	0	0.2	0	0	0.1	0
Barunga			340	3.0	4.5	66	1.0	1.7	59	0.2	0.9	24
Assoc Pop	1	0	85	1.0	1.1	88	0.1	0.6	18	0.1	0.2	24
Wugularr			500	1.0	5.0	20	1.0	2.5	40	0.2	0.8	24
Assoc Pop	1	0	10	0	0	0	0	0.1	0	0	0	0
Miniyeri			350	0	4.7	0	0.9	1.8	57	0.1	0.9	11
Assoc Pop	3	2	105	0	2.1	0	0	0.7	0	0	0.3	0
Ngukurr			1,000	5.5	5.0	110	2.0	3.3	57	0.3	1.3	24
Assoc Pop	11	3	260	0	4.6	0	0	1.7	6	0	0.7	0
Bulman			250	1.9	3.3	56	0.9	1.3	68	0.1	0.6	16
Assoc Pop	7	0	150	0.2	2.5	6	0.2	1.0	15	0	0.4	0
Binjari			225	0	3.0	0	0.5	1.5	33	0.2	0.6	36
Assoc Pop	4	2	45	0	0.9	0	0	0.3	0	0	0.1	0
Total for Zone	40	8	5,795	27.5	60.6	45	9.6	28.4	34	4.5	11.0	40

Table 41: Population and Distribution of various sized communities – Katherine East HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
57	5,795	-	-	2 = 2,040	2 = 1,130	3 = 940	8 = 1,075	34=610

Health services to this Zone are:

1. 1 Community Controlled Health Service (Wurli Wurlinjang in Katherine);
2. 7 services directly delivered by THS; and
3. 1 THS SA health centre (Binjari).

There is also a regional hospital and a private General Practice.

Overall this Zone has inadequate nursing staff and there are no resident doctors outside Katherine itself. Apart from Wurli Wurlinjang, there are no administrative staff or drivers employed in this Zone.

The most recent development has been a proposal by the Jawoyn Association for a CCT for the communities and associated out-stations of Barunga, Bulman, Jilkminggan, Wugularr, and Mataranka as well as pastoral stations in the area.

Overall zone ranking 4/10.

Katherine

Katherine is serviced by Wurli-Wurlinjang AHS that is a community controlled health service, operating within the comprehensive PHC model. Along with similar services, it has had a policy of employing AHWs and doctors rather then nurses in clinical work. However, it should be noted that Wurli has had great difficulties recruiting doctors. Wurli-Wurlinjang also employs management, administrative staff, educators, a nutrition worker, policy staff, a women's health team, men's health worker, mental health workers, aged care workers, drivers and cleaners. It provides a mobile service to town camps and outlying communities.

Wurli-Wurlinjang was involved in the original submission to establish the CCT in the Katherine West zone and provided secretarial support to the KWHB prior to it becoming incorporated. It is currently working closely with the Jawoyn Association on the proposed CCT.

The Katherine floods in 1998 had an enormous impact on people's lives and devastated the town and some outlying communities[1]. Specifically a number of residents of Town Camps around Katherine were evacuated and people sent to bush communities only to find on their return that their homes had been bulldozed, and No Camping signs erected. Delivery of health services to these people has been difficult as they are now scattered in various places on the fringes of Katherine town.

Wurli-Wurlinjang has been working to facilitate the implementation of RCI funds for Miniyeri that was selected as a site to receive RCI funds in 1997.

Population Group Rank is 47/49.

Mataranka

Mataranka is on the Stuart Highway, has a high non-Aboriginal population and tourist resort where THS employ a nurse and a relief nurse during the tourist season. Our analysis has included the ABS data (1996) which includes the tourist population, as well as the extra staff to deal with the increased numbers. There is a visiting DMO but no AHW.
Rank 11/49.

Jilkminggan

Jilkminggan has a significant population (175) with no resident health service staff. THS provide a visiting service from Mataranka. The Jawoyn Association are interested in including Jilkminggan in their proposed CCT.
Rank 3/49.

Barunga (Bamyili)

Barunga has a THS delivered health service. Barunga is part of the proposed Jawoyn Association CCT.
The Barunga Council are keen to get an alcohol rehabilitation facility established with ATSIC funds.
Rank 36/49.

Wugularr (Beswick)

Wugularr has a THS delivered health service that is poorly resourced for all staff. The community was particularly affected by the Katherine floods and by a spate of attempted suicides in late '98 – early '99. The clinic is grossly inadequate with no space for staff to work appropriately. It is part of the proposed Jawoyn Association CCT.
Rank 18/49.

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[1] Garrow, A & McConnel, F *Good, that's my country back.* Wurli Wurlinjang, Katherine, July 1999.

Miniyeri

Miniyeri has a THS delivered health service consisting of only one nurse for 350 people. This community was selected for the RCI program in 1997. Wurli Wurlinjang has been working to get increased resources on the ground, although we understand that the proposed arrangements have stalled. To date there are no extra resources on the ground.
Rank 6/49.

Ngukurr

Ngukurr is a large community (1,000 people) and has a THS delivered health service that is well resourced by AHWs. There is a need for a doctor to be resident here.
Rank 28/49.

Bulman (Gullin Gullin)

Bulman has a resident nurse and 2 AHWs employed by THS and have a visiting DMO. The out-stations are visited fortnightly. One of the out-stations is an important ceremonial site involving people from many distant places including Ramingining, Maningrida and Oenpelli. Last year this involved an increase in population of 600 people for a three-month period. It is part of the proposed Jawoyn Association CCT.
Rank 23/49.

Binjari (Wardaman)

Binjari is 18 kms east of Katherine and has a population of 225 people. It has a SA with THS and is also a recommended RCI site. The SA funds an AHW position but is used to pay two nurses who work from 9am to 2pm 4 days a week alternately. A private GP visits from Katherine one morning a week. Binjari's proximity to Katherine is a factor that limits its claim on resources compared with more remote communities.
Other Wardaman communities receive no service at all.
Rank 8/49.

Opportunities for Community Control

The Jawoyn Association represents the Jawoyn Aboriginal traditional owners of the Katherine region. It has submitted an Expression of Interest to establish the Nyirranggulung CCTs that encompasses the communities of Bulman, Wugularr, Barunga, Manyallaluk and associated out-stations. It is intended to invite Mataranka and Jilkminggan to join this proposal.
Since 1994 the Jawoyn Association has adopted a regional approach to developments on their traditional lands[2]. In January 1997 the Association launched its Five Year Plan[3]. The Plan envisaged the development of a series of Nyirranggulung regional agreements to coordinate activities across Jawoyn lands, whether held by them under various forms of title, or alienated to other interests.
In 1999 the Council of Elders directed the Jawoyn Association to *'take all steps to establish a Nyirranggulung Health Authority to administer and coordinate all PHC delivery and related services in the region"*[4].

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[2] Jawoyn Association *Rebuilding the Jawoyn Nation : Approaching Economic Independence.* Katherine, 1994.

[3] Jawoyn Association *Five Year Plan: Nyarrang nyan-burrk bunbun yunggaihmih 'We're moving ahead'*, Katherine, 1997.

[4] Jawoyn Association *Coordinated Care Trial: Nyirranggulung Regional Health Authority: Expression of Interest*, December, 1999.

These developments represent a strong opportunity to promote community control in this area. Clearly the Jawoyn Association have a clear vision as to how the complex issues impacting on their health might be addressed. The proposed CCT will not cover the whole Katherine East Zone (it will exclude Ngukurr, Miniyeri, the Wardaman communities). This is an opportunity to take community control and the development of comprehensive PHC services to another level in these communities.

The other potential vehicle for further promoting community control in this region is the established Wurli Wurlinjang health service. They have been playing a role in developing proposals for Miniyeri to receive RCI funds. Unfortunately some internal problems have impeded progress. We understand that there is a group of women who are very keen to promote improved health services to their community. Hopefully, this enthusiasm will not be lost.

At Ngukurr there is no health committee. We understand that there is a strong team of experienced AHWs, but are unsure about community interest in the health service. Much of the energy of community leaders is focused on the problems of petrol sniffing in their community.

The Wardaman communities tend not to relate to other groups easily. There is a history of conflict and political manipulation. Binjari has a community council, but there is no health committee. The health service is a THS SA arrangement. Community members are also expected to pay a levy for medications ($4 per week). It is not clear where this was imposed from, but is a source of confusion given the mobility of people.

Substance Misuse Programs

Katherine

Katherine Hospital has 2 beds for detoxification where clients are stabilised before being referred to the Darwin detoxification centre. This has not been particularly successful as the client has to travel by bus to Darwin and they often do not arrive at the centre in Darwin.
The Katherine Town Council has been taking actions to reduce the public visibility of Aboriginal people drinking. A designated fenced in area has been established on the edge of town (at the cost of $80,000). The Katherine Combined Aboriginal Organisations (KCAO) opposed the move and argued it would not solve the problem. Anecdotal evidence is that there appears to be more public drinking since the flood, possibly because of the loss of Red Gum and Wallaby Camps leading to more people drinking in public places.

Wurli Wurlinjang provide a mobile Life Education program.

Katherine Alcohol and Drug Association (KADA) provides an 18 bed sobering up shelter that has a high recidivist rate. It is a *spin-dry* centre. Ten male and female workers are employed here. They also provide a counselling service and do assessments for corrections and legal services. They deal with all types of substance misuse although they have few kava or petrol users. Referrals come from the police, courts, Kalano night patrol, self-referrals, legal aid services and the RAAF base medical centre at Tindal. The organisation's future is uncertain due to the expected end of funding from LWAP in June 2000. Things are further complicated by internal disputes within KADA and the resignation of the Committee. The Jawoyn Association have applied to LWAP to take responsibility for running the shelter in the context of an holistic approach to addressing substance abuse problems[5]. The submission is based on a report commissioned by Jawoyn Association[6]

Kalano Community Association Inc. runs a residential AA based treatment program at the Rockhole Alcohol Rehabilitation Centre Katherine. They also run a Night Patrol program addressing antisocial behaviour and a litter service in Katherine.

LWAP funds two Aboriginal family violence workers who cover the whole region.

Banatjarl (King Valley).

There are discussions around a proposal that Banatjarl be the site for an alcohol rehabilitation program under the auspices of the Jawoyn Association as an alternative to a prison sentence, and the development of work programs on the land.

Barunga

Manyallaluk Community Government Council runs a Community Warden Scheme addressing antisocial behaviour in Barunga. This is part of the Jawoyn Association's Nyirranggulung (Regional) Agreements project on Law and Order. The primary aim of the agreement is to reduce levels of social disruption and criminality, and hence imprisonment rates, across Jawoyn lands through a process of close Aboriginal involvement with policing on their lands. Its aim is for Aboriginal people, many of whom have had little understanding of non-Aboriginal legal systems, coming to 'own' the processes of law and order on their lands. A first step, which is underway, is through a Major Employment Strategy to employ fully qualified Aboriginal police officers over all Jawoyn lands. These police officers (initially employed as Aboriginal Community Police Officers) will be based on communities as well as at the regional police station at Maranboy.

Barunga is also developing a diversional program to identify skills people have to develop a local workforce. They are currently preparing a submission for male and a female alcohol workers to oversee activities for people who are recovering. They also plan an alcohol-free venue for an arts and crafts program. Alcohol continues to be the substance most commonly misused at Barunga although there has been some petrol sniffing which recreational programs have addressed successfully.

Jilkminggan

The Jilkminggan Community Government Council runs a night patrol in Jilkminggan.

Dillinya

At Dillinya an alcohol worker is working to develop a half way house on an out-station, an excision of Delamere Station, 220km & 2.5hrs south west of Katherine. These is a phone and unused school, but no store, clinic, or airstrip.

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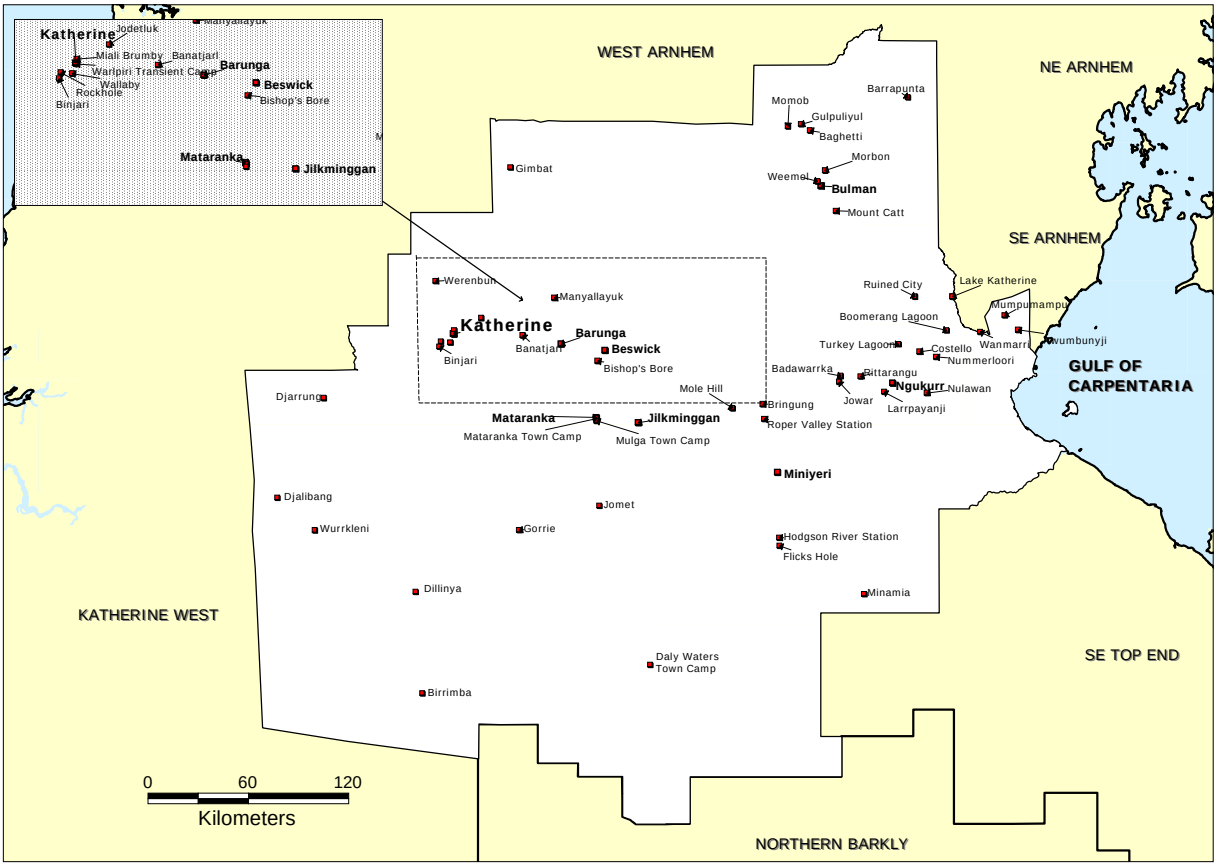
[5] Jawoyn Association *Wakmiyn Wakai: A holistic approach to substance abuse in Katherine: A Submission to Territory Health Services.* Jawoyn Association, Katherine, 1999.

[6] Magnery, Y *Report on Establishing a Holistic treatment System in Tackling Substance Abuse, Katherine District, NT.* Jawoyn Association , 1999.

Binjari

Binjari Community Council runs a night patrol addressing antisocial behaviour in Binjari. The Council also contributes about 50% of the cost, as there is no CDEP scheme operating. The patrol operates 6 nights a week from 6pm-midnight and consists of a supervisor and 2-3 assistants, both male and female. They work on a voluntary basis and are paid an allowance only. Binjari is a dry community so the aim is to minimise the number of intoxicated people entering the community. If someone is intoxicated they will be taken to the Katherine sobering up shelter in the community vehicle. If the client is abusive the supervisor will ring the police for assistance. Alcohol is the main concern here but marijuana usage is on the increase.

Figure 32: Map of Katherine East HSZ Showing Communities & Out-stations.



Prior Court, Redgum, Mission Gorge are not shown on this map.

9. Katherine West HSZ

Table 42: Katherine West HSZ – Population Groups, Out-stations and Health Service Staff.

Community	Number of Assoc Pop		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Dagaragu			250	1.0	3.3	30	1.0	1.3	80	0.4	0.6	64
Out-stations		1	0	0	-	-	0.0	-	-	0.0	0.0	-
Kalkarindji			400	2.0	4.0	50	2.0	2.0	100	0.6	0.7	90
Out-station	6	5	85	0	1.7	0	0.0	0.6	0	0.0	0.2	0
Timber Creek			560	0.5	5.6	9	2.6	2.8	93	0.3	0.9	32
Out-station	15	0	315	0.1	6.3	2	0.1	2.1	5	0.1	0.8	13
Mialuni			100	0	1.3	0	0.1	0.7	15	0.1	0.3	20
Bulla			120	0.6	1.6	38	0.3	0.8	38	0.1	0.3	17
Yarralin			300	1.0	4.0	25	1.9	1.5	127	0.2	0.8	27
Out-station	4	0	145	1.0	2.4	42	0.1	1.0	10	0.0	0.4	0
Lajamanu			800	4.0	4.0	100	3.0	2.7	113	1.0	1.0	100
Out-station	10	2	225	0	4.5	0	0.0	1.5	0	0.0	0.6	0
Total for Zone	35	8	3,300	10.2	38.8	26	11.1	16.8	66	2.7	6.5	42

Table 43: Population and Distribution of various sized communities – Katherine West HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
50	3,300	-	-	1 = 800	2 = 960	2 = 550	3 = 295	34=695

Health services in this Zone are organised through the KWHB that was established as part of the CCT in this area. Services are either delivered directly by KWHB or contracted to THS or the East Kimberly Aboriginal Medical Service (EKAMS).

Early changes in service delivery have been a 70% increase in funding into the area resulting in additional staffing, doubling of PHC doctor visits, sessional payments for specialists, development of community based health committees, mobile PHC services to non-Aboriginal cattle stations and out-stations, and MOUs with community government councils.

There is still a major need for the development of adequate and appropriate health facilities. This requires better identification of funding for infrastructure. The KWHB have identified the need to develop a mental health service with strategies to promote social, emotional and physical well-being.
Overall zone ranking 6/10.

Dagaragu

A nurse and AHW based at Kalkarindji visit daily, as there is no accommodation. The Dagaragu Community was selected as a site for RCI funding in 1997. KWHB became a provider of services for Dagaragu in November '99, but no RCI funds have as yet been directed here. There is a local health committee.
Rank 40/49.

Kalkarindji

Kalkarindji is adequately staffed for nurses and medical support but lacks adequate AHWs and out-station coverage. The service is directly delivered by KWHB.
Rank 41/49.

Timber Creek

Timber Creek is a tourist and service centre with a significant non-Aboriginal population. It is poorly resourced for AHWs and medical support. However the NTRHWFA has allocated a RAG to Timber Creek. KWHB are currently negotiating with EKAMS to provide visiting service to six of the out-stations.
Rank 17/49.

Mialuni

Mialuni (Amanbidji) has staff visiting from Timber Creek consisting of a doctor monthly and a nurse fortnightly. Mialuni requires at least one resident AHW.
Rank 4/49.

Bulla

Bulla (Gudabijin) has a resident AHW employed by THS and other staff visiting from Timber Creek.
It has inadequate resources.
Rank 24/49.

Yarralin

Yarralin has 2 nurses and 1 AHW with a DMO visiting one day a week. One of the out-stations (Pigeon Hole) has a resident AHW. Yarralin is well resourced for nurses but is low for AHWs and medical support.
Rank 32/49

Lajamanu

The health service resources are concentrated at Lajamanu.
Three out-stations of Lajamanu - Ngarnka (Blue Bush), Parrulyu (Mt Davidson), and Picininny Bore (Talywari, Tjabalajabala, or Black Hills) are part of the Central Australian region of THS as well as being part of the Papunya ATSIC Region. They have not been included in the Katherine West CCT. They are resourced by the Lajamanu Community Government Council. Mungkururrpa relates to both Lajamanu and Nyirrpi.
Picininny Bore, Yartalu Yartalu and Jiwaranpa have an agreement that was negotiated by Central Land Council and the Granites mine that in an emergency only they could access services from the Tanami mine site. This is hardly an adequate arrangement for the provision of PHC services.
Rank 43/49.

Opportunities for Community Control

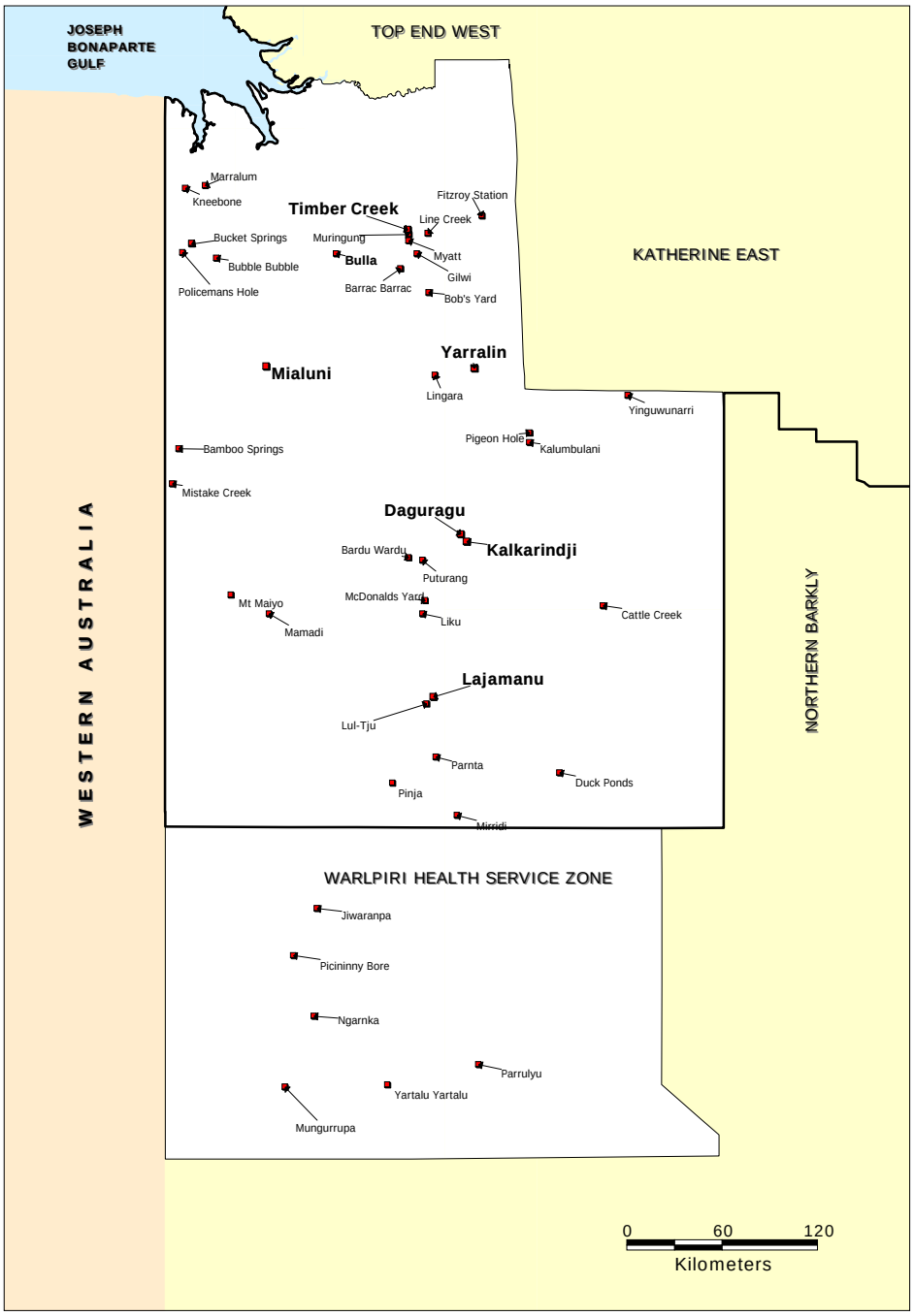
The KWHB, despite some early difficulties, has grown into an active community forum overseeing the development of health services in the Zone. Increasingly the Board is taking over responsibility for direct delivery of PHC services. The KWHB is the vehicle for the continuing development of community control in this Zone.

Substance Misuse Programs

In Timber Creek, the Ngaliwurru-Wurli Association has approached the Liquor Commission on a number of occasions to control alcohol availability as a way of reducing the alcohol related harm in the community. This was unsuccessful, and the Council purchased the Timber Creek Wayside Inn and entered into a *Joint Venture* with the other hotel in the town – the Timber Creek Hotel. This has had economic benefits, and increased employment opportunities, and has also had a significant impact on problems of alcohol misuse. The Ngaliwurru-Wurli Association governing Council implemented rules and stopped the previous 24-hour access to alcohol. The new rules relate to:

- abuse of staff;
- fighting;
- refusing to leave premises;
- bringing weapons into the town;
- spitting;
- theft;
- humbug;
- supply of alcohol to barred persons;
- bad debts (shop);
- damage to property;
- disturbing the peace;
- ceremony and funerals (as specified by Traditional Owners).

Figure 33: Map of Katherine West HSZ Showing Communities & Out-stations.



Nelson Springs, Airdroom Bore, Doojum, Jangalpangalpa, R.B. Junction, 9 Mile, Jutamaling/ Swan Yard, Blue Hole, Limbunya Homestead are not shown on this map.

10. South East Top End HSZ

Table 44: South East Top End HSZ – Population Groups, Out-stations and Health Service Staff.

Community	Number of Assoc Pop		Pop	AHWs			Nurses			Doctors		
	Occ	Unocc		Now	Ideal	%	Now	Ideal	%	Now	Ideal	%
Borroloola			800	0.7	4.0	17	2.0	2.7	75	0.7	1.0	66
Assoc Pop	21	4	720	0.3	11.7	3	0.9	4.6	20	0.3	1.7	17
Robinson River			200	0	2.7	0	0.1	1.3	8	0.1	0.5	10
Assoc Pop	9	1	85	0	1.7	0	0	0.6	0	0	0.2	0
Total for Zone	30	5	1,805	1.0	20.1	5	3.0	9.0	33	1.0	3.0	29

Table 45: Population and Distribution of various sized communities – South East Top End HSZ

No of Places	Pop	> 3000	1200-2999	800-1199	400-799	250-399	75-249	<75
37	1,805	-	-	1 = 800	-	-	3 = 500	28=505

The South East Top End has the lowest overall ranking of the HSZs, which means it is the Zone with the greatest level of unmet need. There are two major population groups and many out-stations both on the mainland and on islands off the coastline.
Overall zone ranking 1/10.

Borroloola

Borroloola is a combination health service with THS employing nurses and AHWS and a private GP. There is a large Aboriginal population, a significant non-Aboriginal population. The town is a service centre, and a centre for tourism. The health service provides a visiting service to Kiana station and Robinson River but no other out-stations are serviced.
Rank 16/49

Robinson River

Robinson River receives a visit by the Borroloola nurse weekly. The GP also visits but more irregularly. There is no resident health service staff, although there is a clinic, and THS have allocated an AHW position, but this has remained unfilled.

During the wet the community is cut off from Borroloola, and during these times there is no health service available at all. It is clearly the most needy community in the Top End.

The community has a resource centre, the Mungoobada Aboriginal Corporation, which employs an administrator. There is also a Women's Council that has expressed concern about health issues, including the lack of fresh fruit and vegetables at the store.

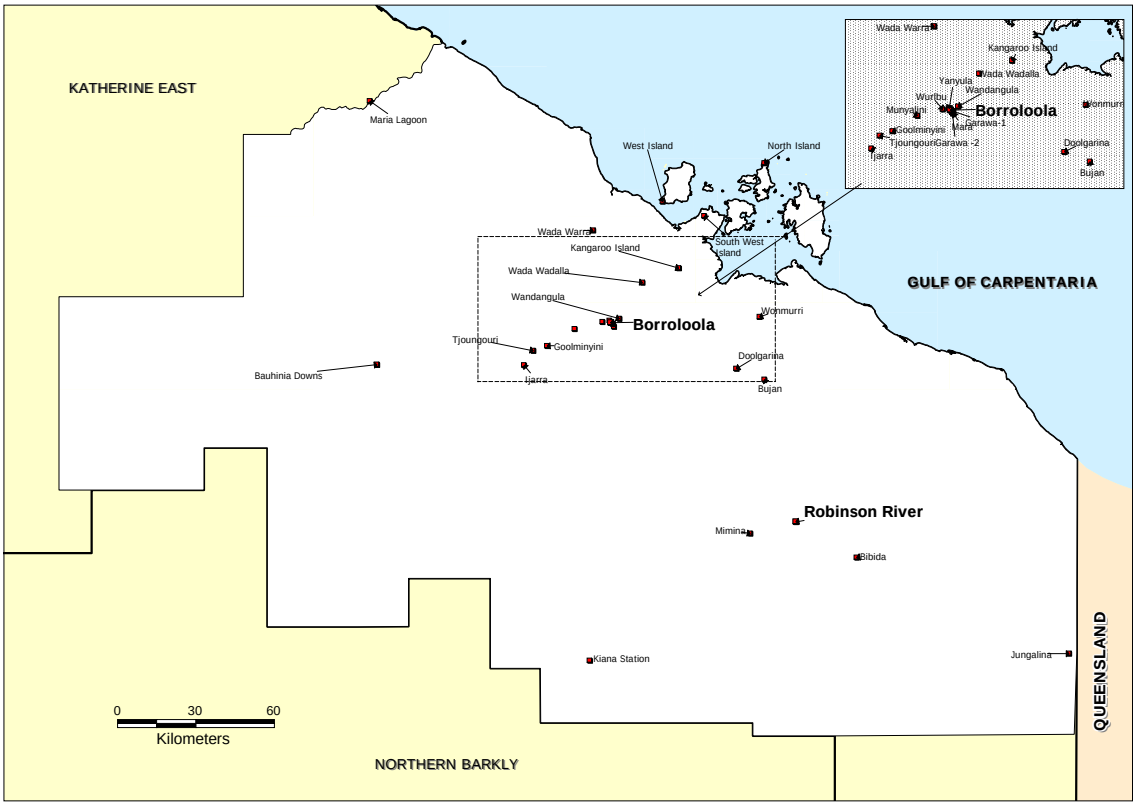
Robinson River has had a history of problems with administration due to the lack of local expertise, and the consequent vulnerability that goes with depending on non-Aboriginal staff. The community is *dry*, and has a strong cultural base.

Robinson River was selected as an RCI site in 1997. In October 1999 a meeting of the community decided to ask that the Congress manage the funds and assist the community to establish a health service. THS agreed that they would contribute what they were currently committed to (ie an AHW position, vehicle and supplies). AMSANT has submitted a proposal to OATSIH. Ongoing discussions between OATSIH and AMSANT are continuing. However there is still no resource operationalised.

Substance Misuse Programs

Borroloola is part of the pilot substance misuse intervention project that involves a project officer based in Darwin and a local worker whose CDEP wage is topped up from LWAP funds.

Figure 34: Map of South East Top End HSZ Showing Communities & Out-stations.



Milibuntharra, Sandridge, Wajtha, Mooloowa, Jimiyamilla, Uguie, Wallaburi, Mararani and Wundigalla are not shown on this map.

Priorities for Health Service Development

Highest priority areas as a result of our analysis are:

A. There is an urgency to operationalise the first round of the RCI funding. This includes:
   1. Robinson River;
   2. Miniyeri;
   3. Groote Eylandt – Milyakburra, Umbakumba and Angurugu;
   4. Dagaragu;
   5. Marthakal Homelands (Galiwin'ku)
   6. Binjari.

B. The next most in need population groups are:
   1. South East Top End HSZ (1/ 10)
      - Borroloola (5/27)
   2. Darwin HSZ (2/10)
      - Belyuen (10/23)
   3. Top End West HSZ (3/10)
      - Peppimenarti (2/23)
      - Palumpa (4/23)
      - Wadeye (16/23)
      - Daly River (18/23)
   4. Katherine East HSZ (4/10)
      - Jilkminggan (1/23)
      - Wugularr (6/23)
      - Bulman (9/23)
      - Ngukurr (13/23)
   5. South East Arnhem HSZ (4/10)
      - Numbulwar (12/23)
   6. West Arnhem HSZ (6/10)
      - Minjilang (7/23)
      - Warruwi (14/23)
      - Oenpelli (17/23)
   7. North East Arnhem HSZ (8/10)
      - Laynhapuy Homelands (3/23)
      - Yirrkala (8/23)
      - Ramingining (10/23)
      - Milingimbi (15/23)

   This list includes all those population groups that have 50% or less of their *Actual: Ideal Health Staff Costs*, but excludes non-remote locations, those who are part of a CCT, and those who are selected for support in the First Round of the RCI sites.

Recommendation 35

We propose that the PHC service needs identified above be used, (along with other criteria such as assessments of capacity to benefit) as a basis for allocation of funds for PHC services.

Other Identified Needs

We consider that there are some special needs that urgently need consideration. Specifically the funding base of Danila Dilba, Wurli Wurlinjang and Miwatj Health needs to be reviewed if these organisations are to play the role of Hub Centres in a Hub-Spoke Model. Danila Dilba especially needs consideration as it is the one service that constantly falls outside the remote classification (eg NTRHWFA criteria, RCI guidelines, Section 100) but has enormous demands placed on both its services (with a high proportion of visitors with chronic illness) and its leadership role (eg with AMSANT and the NTAHF). As can be seen by the rankings of need the Darwin HSZ is the second most in need.

CHAPTER 10 - SERVICE DEVELOPMENT ISSUES

Health Care Service Delivery

Homelands and Out-stations

It is clear from our work, that many out-stations/ homelands do not receive any health care service. There are some significant exceptions to this – Danila Dilba (Darwin), Oenpelli, Jabiru, Laynhapuy Homelands, Maningrida, Daly River, Ramingining, Gapuwiyak, Wurli Wurlinjang (Katherine), Mataranka, Barunga, and in the KWHB area. All of these have some organised program to visit people on out-stations/ homelands on a regular basis.

The logistics of providing such a service are complex, costly and logistically 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 larger towns or settlements. People are more likely to have access to more bush tucker than they have in more populous communities. The highly nutritious quality of bush 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 PHC service delivery provides support to the out-stations/ homelands by ensuring regular visits by health staff.

Thus a major finding of our work has been the large number of people with poor (or no) access to PHC services. To provide these people with a resident health care 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 in many areas.

One aspect highlighting the importance of community control, whether this is through formal mechanisms, or through the more central involvement of community leaders and AHWs 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, for example, often depends on knowledge about who went shopping where and with whom, and where the footie was last weekend.

Transport

Transport is a major problem in the NT. We recommend that transport needs be taken into account in PHC service development. This may be the provision of a driver, or funds for air travel. In some communities the role of driver might be combined with that of a handyman function for the maintenance of buildings, garden and equipment. The focus of transport would be primarily to increase access of local people to the health service, as well as getting people to specialist appointments for communities closer to regional centres. This is particularly relevant to communities within 200kms of regional centres who are not eligible for PATS support.

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). Whilst better PHC 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:

- The development of child health programs in PHC 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 the carers of children and PHC staff.
- Identifying barriers to access to nutritious food, and especially to help carers understand that different principles of nutrition apply to adults and children.
- Supporting community initiatives to deal with issues of substance misuse, and specifically to deal with children whose families are unable to care for them.

Child and maternal health programs are important in the light of recent understandings of the determinants of health (see Chapter 6), and with this in mind such programs need to be built on the women's leadership in communities. The main weakness of the Strong Women Strong Babies Strong Culture program is the process where THS have attempted to impose this as *the* model, rather than building on existing processes in communities.

Women's Health

Women's health has tended to focus on:

- Issues of birthing – antenatal care and the birthing process;
- Contraception;
- Child rearing issues;
- Issues related to STDs, and infertility;
- Cancers of the breast and cervix.

Danila Dilba have developed a program for women's health, Gumileybirra Women's Health[1].

[1] Danila Dilba *Annual Report 1999*, Darwin, 1999.

Strong Women Strong Babies Strong Culture is active in 11 communities around the NT. This program has been somewhat controversial due to it being subject to heavy promotion by THS as a success story. It is claimed that an evaluation showed 43% reduction in the number of low birth weight infants and 140 gram increase in the mean birth weight in one community. However, the evaluation was less certain as to cause of this outcome[2]. During the same period of the *Strong Women, Strong Babies, Strong Culture* program, a medical officer was appointed to this community that may have also had an impact on this outcome. The main cause of controversy, however, is the way THS have packaged this program to apply to all communities. It is structured as a selective PHC program that is in contradiction to the comprehensive PHC concept that is central to the model proposed in this report. That is, the program is structured vertically and tends to operate (at least in some communities) separately to the PHC service. This approach has sometimes cut across local PHC service strategies and split the community.

Despite these conflicts, there is no doubt that child and maternal health programs are of critical importance in the long term. It should be possible to develop a collaborative approach to supporting a less partisan program to support child and maternal health programs in communities. This could be achieved through a working group of the NTAHF.

Recommendation 36

That the development of child and maternal health programs be collaboratively developed through a Working Group of the NTAHF.

Male Health Programs

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 STDs, along with the other reasons people seek health care. There is an urgent need to:

- Create an environment in PHC service that is comfortable and accessible to men. For example, a separate men's entrance, clinic or building.
- 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 male health to be incorporated with environmental health courses, and environmental skills to be incorporated into AHW courses. Male health issues have been a strong focus of the Health Summits, especially at Banatjarl. It is clear that there is increasing energy from a growing number of men around these issues.

Miwatj Health have established a Men's Health clinic at Gapuwiyak which operates from a separate space to the rest of the clinic and employs male AHWs. The response from men in the community has been extremely encouraging.

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[2] Mackerras, D *Evaluation of Strong Mothers Strong Babies Program* Menzies School Health Research, Darwin, 1996.

Recommendation 37

That PHC services reorganise their facilities where possible to accommodate the needs of men's health and that resources be allocated to supporting men to address both their physical needs (in terms of chronic disease) and their emotional and spiritual needs.

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 (see Appendix 6).
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 accident prevention – such as advanced driver education programs.
- Rubbish disposal.
- Dust control.
- Youth programs.

Some of these programs may be delivered through PHCs 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. These decisions should be made with the involvement of the Aboriginal health leadership.

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 important roles in this area.

Nganampa Health have contributed significantly in this area through their housing for health[3] programs (UPK[4]). 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.

There have been suggestions that male AHWs in some communities may be able to play an environmental health role alongside a clinical men's health role[5]. These options should be pursued.

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 for 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 expressed as diabetes, high blood pressure and heart disease. Diabetes and high BP both damage the kidney, and contribute to the high rate of end stage renal disease.

Issues that need to be addressed strategically are:

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

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

- Nutritional advice to women about the needs in pregnancy, and the needs of young children, 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.
- 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 local people to play a facilitating role if such programs are to be sustainable.
- 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 joint health service staff- store managers' workshop. However, this collaboration has not been sustainable.

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[3] Pholeros, P et al *Housing for Health: towards a Healthy Living Environment for Aboriginal Australia.* Health Habitat, Sydney, 1993.

[4] Nganampa Health Council *Report of Uwankara Palyanyku Kanyintjaku: an environmental and public health review within the Anangu Pitjantjatjara Lands.,* Alice Springs, 1987.

[5] Tregenza, J *Op. Cit.,* 1995.

Methods of auditing store sales[6] 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 it's 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. We understand, however, that this process has not been sustained in the community concerned. The issue of availability of nutritious food in bush stores has been an issue of concern raised at the Health Summits.

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.

The cost of food is a further problem effecting 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)[7] estimated that at one out-station serviced by UHS, around 40% of peoples 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.

Chronic Disease in Aboriginal Communities

Over the past two decades Aboriginal people have increasingly been affected by a range on inter-related chronic diseases which are related to the transition from a hunter and gatherer lifestyle factors (high levels of mobility and exercise in getting food, and high quality food intake) to sedentary life through forced settlement, and dependency on poor quality food rations, and more recently highly processed supermarket foods and fast foods. Increased alcohol consumption has also been a factor. These diseases are diabetes, cardiovascular disease (high BP, ischaemic heart disease) and renal disease.

This increased disease load has been a major focus of Aboriginal health services, with effort being made to implement protocols within services for the better detection and treatment of these diseases.

Whilst diabetes and some vascular disease causes high levels of morbidity and disability, renal disease and especially ischaemic heart disease are responsible for high levels of mortality.

In regard to ischaemic heart disease an examination of PHC service work loads illustrates a low number of people who are being seen for this condition, whilst mortality data shows that it is either the first or second most common cause of death. There are two possible explanations for this:

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6 Lee, AJ et al *'Apparent dietary intake in remote Aboriginal communities.'* Aust J Pub Hlth, Vol 18, No 2, June 1994, p190-197.

7 Gault, A *'Urapuntja Health Service: Health Survey.'* IAD, Alice Springs, 1990.

1. Aboriginal people have a different type of ischaemic heart disease to non-Aboriginal people – that is, heart disease in Aboriginal people is silent, and that the first sign of the disease causes death; or
2. The health care system is failing to diagnose ischaemic heart disease in Aboriginal people.

Whilst the first suggestion has been suggested from time to time, there is no evidence that this is the case. The failure of health services is worth investigating thoroughly and excluded before the first explanation is accepted.

The diagnosis of ischaemic heart disease depends on:

1. people with symptoms presenting to health services;
2. health services recognising the symptoms as those of possible heart disease;
3. performance of various diagnostic tests to determine the presence of coronary artery disease.

Various medical interventions are then available for treating the identified lesions (eg bi-pass surgery).

There is no doubt that appropriate medical interventions are life saving for this condition.

In the 1950s-60s, many 40 and 50 year old non-Aboriginal men died of ischaemic heart disease. The National Heart Foundation at that time was not promoting healthy ticks on supermarket food. Instead they were promoting best practice in the clinical recognition and treatment of heart disease to doctors. Effective medical interventions had a marked impact on the number of deaths from ischaemic heart disease in that population, and the age at which deaths occurred.

Since the effective implementation of medical interventions, the National Heart Foundation has moved its focus to preventive strategies – specifically addressing risk factors of smoking, cholesterol, obesity, and lack of exercise. It is this type of strategy that is largely being promoted in Aboriginal communities, with little impact.

However, Aboriginal people's access to exercise electro-cardiograms and coronary angiography necessary for accurate diagnosis is very limited indeed. This needs to be urgently addressed. Once people experience this, and are kept alive as a consequence to talk with others about it, then maybe people will be more likely to change their personal behaviours.

In regard to the detection of high blood pressure and diabetes, the health system does much better and there is no doubt that good clinical management of these conditions will prevent, or at least delay the onset of renal failure and ischaemic heart and other vascular disease.

The current effort regarding eye health, for example, reflects the action being taken to, not only deal with diseases like Trachoma, but also identify and treat diabetic retinopathy.

One approach to dealing with these interrelated problems, is to conduct multi-disciplinary clinics, where people can be effectively assessed and treated by a number of professionals. This has been shown to greatly improve some people's involvement with their own health problems, as well as preventing complications. Professionals involved have included:

- AHWs;
- PHC medical practitioners;
- Nurses;
- Podiatrist;
- Physician
- Dietician
- Nephrologist.

This enables both the PHC team to become much more conscious of the issues, as well as more confident about what needs to be done, and the clients respond more positively because of less time waiting to be seen, better communication about what the nature of their problems is, and more appropriate advice offered. Further we should not underestimate the impact that such positive experiences of the health care system have on broader attitudes within the Aboriginal community and the consequent greater preparedness of people to access care early.

Renal Disease

However, renal disease is the main issue that the community has identified as an urgent priority. Both Health Summits organised by AMSANT have seen strong and impassioned interventions from community members about the catastrophic impact that end stage renal disease and the need to access treatment far from country has on people's family and community life.

The cause of this epidemic of renal disease in the NT 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, post streptococcal glomerulonephritis, and adult chronic disease such as diabetes and hypertension, both of which damage the kidneys.

Governments have been concerned about the growing numbers of Aboriginal people requiring renal haemodialysis, and the potential strain this puts on health budgets.

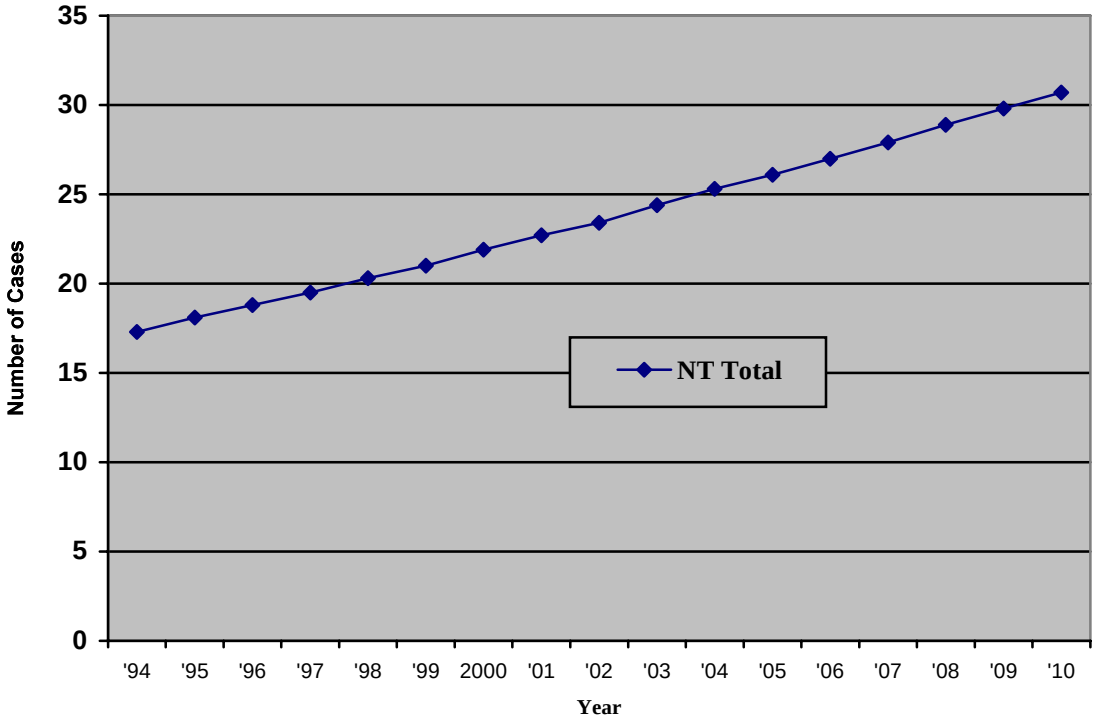
The graph in Figure 35 shows the projected increase in new cases of end stage renal failure expected in the NT until the year 2010. It shows a significant increase.

The graph in Figure 36 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.

This problem highlights the need to support health prevention programs aimed at improving water supplies, nutrition and general living conditions. Improved PHC aimed at the timely treatment of infections (urinary, skin and throat) and to offer treatment for diabetes, hypertension and impaired renal function is critical to improving outcomes. There is no doubt that early detection of renal disease, and appropriate medical intervention (especially the use of ace inhibitor drugs) can slow the progress of disease very significantly.

Figure 35: Projected Number of New Cases of End Stage Renal Disease from 1994 to 2010.

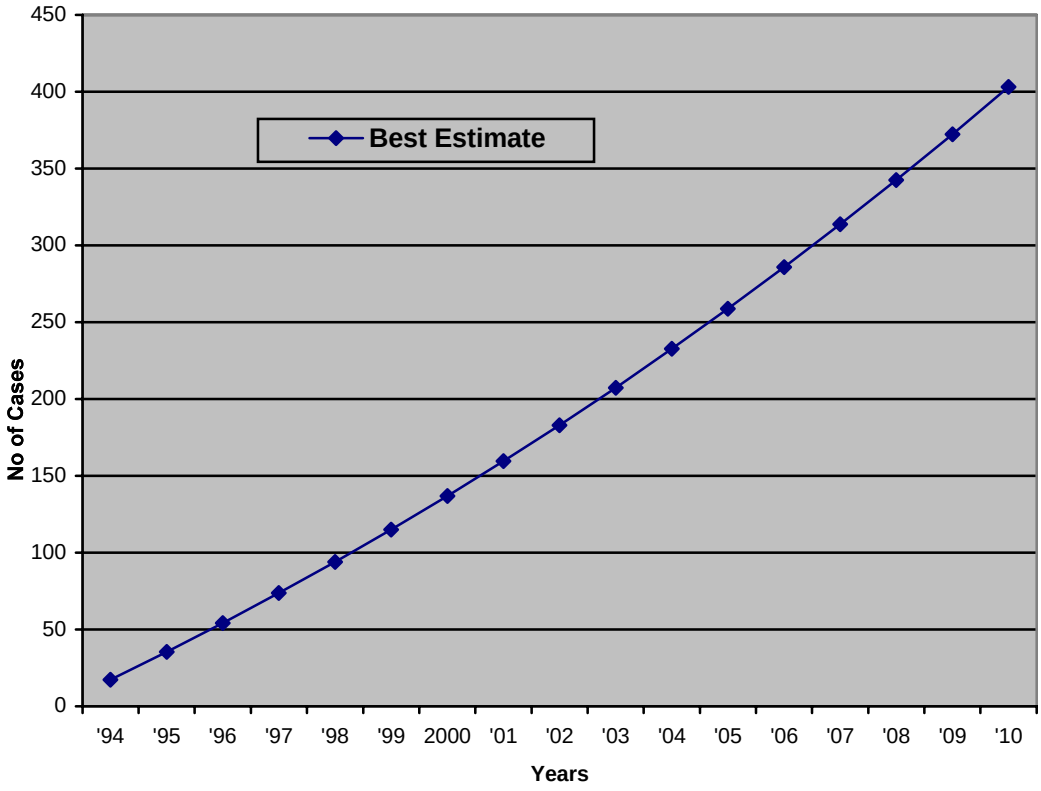


Source: Territory Health Services.

The community has expressed a great deal of support for the development of dialysis options that can be done in people's community. Strong moves have been made in Katherine, Tiwi Islands, as well as Tennant Creek and Kintore in Central Australia. A trial of dialysis based on the Tiwi Islands is currently underway.

CARIHPC's Renal Working Group has focused on the needs in Central Australia, which are not fundamentally different to the Top End. This Group developed a Renal Plan that was submitted to THS, but has not been approved by THS. Momentum has waned largely due to a perception that this plan clashed with THS Chronic Disease Strategy, and a concern within THS about costs. We suggest that there is an opportunity to engage with the community on this issue. People know about renal disease, whereas the term *Chronic Disease* means little. Attacking renal disease means dealing with the issues around diabetes, hypertension and cardio-vascular disease that are the main chronic diseases experienced by Aboriginal people.

Figure 36: Projected Increase Of Total Number (Cumulative) Of Clients With End Stage Renal Disease From 1994 to 2010.



Source: Territory Health Services

The experience of the Renal Unit at the Royal Perth Hospital in managing a self-dialysis program for Aboriginal people in remote areas is worthy of investigation. This program depends on intensive training in the use of the equipment, the intimate involvement of a family member, and a hot line from the person's home direct to the Renal Unit in Perth for support. Whilst this program is not suitable for everyone, it does help some people. It also expresses to the community that their needs are being considered.

We understand that THS is waiting for an evaluation of the Tiwi arrangements before making further decisions about decentralised dialysis or self-dialysis programs. We are not against honest evaluation of programs. Indeed, there is an urgent need for much more stringent evaluation to occur. But to narrowly focus an evaluation on the Tiwi experience reduces the opportunity to find better and more creative ways of addressing this difficult problem. What works or fails to work for the Tiwi, cannot necessarily be applied to other populations. There are clearly self-dialysis programs operating around the country already, some involving Aboriginal clients. There is an urgent need to develop a strategy for dealing with this problem in multiple locations. There is little doubt that the current situation is costing lives, as many people on the dialysis program are unable to sustain the lifestyle away from their country and family that is currently necessary if they are to benefit from dialysis. We understand that the CRCATH is developing a research proposal to investigate the actual outcomes of programs elsewhere and to explore what options can be developed for the NT.

The Devitt, McMasters report[8] has documented the social and cultural issues involved in renal disease in Central Australia. This is an invaluable resource for gaining insights that should help inform decision makers about action required.

THS has embraced a Chronic Disease Strategy[9] in recent years. This has been criticised by AMSANT partly because it was developed without consultations with the community sector, but also because it fits the criteria of selective PHC which David Werner has described as one of the main reasons for the decline of comprehensive PHC. These perceptions have not been helped by the language used in the strategy being that of the World Bank. In its' theoretical underpinning the issues of comprehensive PHC service delivery are well discussed, but in the end the list of actions fit selective PHC practice. The *'best buys'* approach values the 'scientific' data gleaned from epidemiological and other analyses over the felt needs and perceived priorities of the community. Again this needs to be related back to the underlying causes of poor health status discussed in Chapter 6. If these issues are to be effectively addressed, then the issues identified by the community sector needs to be given greater weight.

However, there is no doubt that much of what the chronic disease strategy is promoting has been the intended practise of PHC services, though frustrated by inadequate resources.

Our main concern with this strategy is that it lacks any credible link with the community dynamic. Communities are vocal about the impact of *renal disease*; they are not talking about *chronic disease*. If THS, and the other NTAHF partners, are able to find a way of responding to the crisis around end stage renal failure, possibilities may be presented for productive relationships around preventive strategies for renal disease which actually include diabetes and the issues around cardio-vascular disease.

Why not start with what the community is concerned with?

Recommendation 38

That multi-disciplinary chronic disease clinics be organised within PHC services as the cornerstone of a strategy to address preventable chronic disease in Aboriginal communities.

Recommendation 39

That a strategy be developed under the guidance of the NTAHF to ensure that Aboriginal people have timely access to the methods of diagnosis and treatment of ischaemic heart disease that are available to other Australians.

Recommendation 40

We recommend that THS urgently reconsider its decision to delay implementation of decentralised dialysis or self-dialysis programs, and that such programs are implemented in multiple sites as part of a more comprehensive evaluation strategy as a matter of urgency.

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[8] Devitt, J & McMasters, A *'Living on Medicine: Social and Cultural Dimensions of End Stage Renal Disease among Aboriginal People of Central Australia.* Central Australian Aboriginal Congress, Alice Springs, 1996.

[9] THS *Preventable Chronic Disease Strategy – The Evidence: Best buys and key result areas in chronic disease control.* August, 1999.

Health Financing

One of the major issues that has emerged over the past 5-6 years is the question of the financing of Aboriginal health. It is beyond the scope of this report to detail a comprehensive overview of health financing issues.

However, the latest opportunity is incorporated in the Primary Health Care Access program announced in the 1999-2000 Commonwealth budget. This program is firstly dependent on the existence of regional Aboriginal health plans, and then offers MBS per capita equivalents for defined population groups. The details of this are still being worked out, but have similarities with the CCT. It offers up to 4 times the national average utilisation for MBS - twice for increased disease load, and twice for remoteness. It appears that individuals will still have to sign up to the health care service as well as to Medicare. Concern has been expressed about the enormous effort that this requires, that could be better utilised in providing health care. There have also been questions raised about the tendency of this program to move away from a needs-based system of increasing health care to Aboriginal people. Others have pointed out that the loadings for disease load and remoteness take into account some idea of need. However, it must be said that these are very crude estimates indeed. The basic national average utilisation of MBS is overwhelmed by both non-Aboriginal and urban utilisation rates of MBS, and thus itself does not indicate anything about need. The loading for remoteness does address one factor related to need, but in a very crude manner. Nevertheless, this program does offer the possibility of a significant increase of resources into Aboriginal health. We have already discussed the issue of Zones and how they might be used. With this program it is very tempting to see Zones as discrete population groups which could have their own fund holding arrangements, and operate in a similar way to the THB and KWHB. We suggest that will not be possible in all Zones, and that flexibility needs to be embraced to allow for a diversity of situations and to improve the equity of the program..

We have done some rough modelling to test the adequacy of this funding model. We have defined, as part of the assessment of health service needs in this report, the clinical staff: population ratios. We have extended this to consider 2 types of health service – a remote service and a Hub Centre. We have then considered what other types of staff are required (eg administrative staff), what their degree of remoteness (ie kilometres from main centre) means in terms of vehicles and travel costs, and what operational budgets will be required. We also have made assumptions about what roles the Hub Centres will have. These assumptions are broadly based on the Core Functions of PHC detailed in Chapter 12. In many ways the detail of this does not matter. Whether certain functions are based in Hub Centres or elsewhere will not fundamentally change the ball park costs. We stress that this is a rough test as to the adequacy of funding levels under the PHC Access Program. Clearly more work needs to be done to more accurately determine the costs, and to test the assumptions underlying the calculations. Further a process through which the partners in the NTAHF can agree on the assumptions needs to be developed.

We have chosen 4 types of health service in which to explore funding adequacies:

1. Hub Centre – population 5,000.
2. Community – population 500 people, 100 Kms from centre;
3. Community – population 500 people, 500 Kms from centre;
4. Community – dispersed into out-stations, population 800 people 250 Kms from centre.

Table 46: Comparison of PHC Modelling Costs, and MBS per capita Options.

Type of Community	PHC Service Costs ($)	MBS x1 ($)	MBS x 4 ($)
Hub Centre, pop 5,000	6,300,000	1,750,000	7,000,000
Pop 500, 100 Kms	825,000	175,000	700,000
Pop 500, 500 Kms	1,050,000	175,000	700,000
Dispersed, Pop 800, 250 Kms	2,120,000	280,000	1,120,000
Totals	**10,295,000**	**2,380,000**	**9,520,000**

This shows that the difference between the 4xMBS funding proposal and the costing of PHC services is only 7.5%. However, the difference between funding of particular services and their 4xMBS funding level is much more significant – ranging from up to 47% under funding to 11% overfunding. This reflects the inequitable nature of a per capita funding arrangement which fails to look realistically at the different costs required to achieve a similar level of service.

Thus the most important observation of these results is the inequitable nature of per capita funding arrangements. This observation is not affected by the modelling assumptions. It can be seen in Table 46 that a population of 500 people will get the same absolute funding whether 100 or 500 Kms from the larger centre. We have estimated that the per capita amount should vary from $570 to $1,164 just for clinical staff salaries.

Larger populations used as a basis for funding, rather than smaller configurations, allow for flexible adjustments to be made to take some account of these anomalies.

We have not commented on the actual amounts specified in Table 46, as this requires much more work to ensure that the assumptions underlying the PHC cost analysis are acceptable.

The other method that has been partly explored is the use of the UK system of Health Benefit Groups and Healthcare Resource Groups[10, 11]. Essentially this method estimates the proportion of a population that is at no risk of, say diabetes, low risk, high risk, etc. and it is then determined what health service interventions are required for each level of risk, and the total required is then worked out using a matrix system. This may have validity in high population areas, with very good levels of health data, as may be the case in the UK where the system was developed for the National Health System. However, in small populations, that are basically under serviced, and where the level of data is poor (and of questionable validity anyway, due to small numbers) this method is unlikely to provide a sound basis for funding Aboriginal health. Further, where there are inadequate PHC services, getting the data necessary to apply this funding arrangement will necessitate special research which could be seen as a waste of scarce resources which would be better spent on providing services.

Interpreter Services

We have discussed large number of Aboriginal languages spoken in the Top End in Chapter 4. The lack of interpreter services in the Northern Territory has been the subject of an Inquiry by the NT Anti-Discrimination Commissioner[12]. The provision of adequate interpreter services is an important aspect of the provision of health care services and has been recognised for non-English speaking immigrant Australians for the past 40 years. The expression of illness is a culturally determined phenomenon to a significant extent and interpretation of the signs and symptoms of illness involves numerous subtleties which cannot be easily communicated in a foreign language which English is for many Aboriginal people.

Recommendation 41

That an Aboriginal interpreter service be developed as a matter of urgency and that interpreter resources be made available to PHC services in communities as well as to the centre based hospital and specialist services.

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10 THS, *Using Health Benefit Groups & Healthcare Resource Groups to Inform Health Management: A THS Project.* NTG, Information Brochure, August, 1999.

11 THS, DHAC *Strategic Healthcare Investment Seminar: Summary of Proceedings,* Thursday 19 August 1999, Mecure Hotel, Sydney.

12 Lawrie, D *Report: Inquiry into the Provision of an Interpreter Service in Aboriginal Languages by the Northern Territory Government,* Office of the NT Anti-Discrimination Commissioner, Darwin, 1999.

BIBLIOGRAPHY

1. AAC, CRS A452/1, Item 52/451 Part 2, Cook to McEwen, 2 September, 1938.
2. *Aboriginal and Torres Strait Islander Health Program 98-99* Department of Health and Aged Care, 1999
3. Aboriginal Health Development Group *'Report to Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health.'* December, 1989.
4. ABS, *National Aboriginal and Torres Strait Islander Survey*, Canberra, 1994.
5. Ah Kit, J *Land Rights at Work: Aboriginal People and Regional Economies*. in NLC & CLC *Land Rights; Past, Present and Future*. 1996, p52.
6. Altman, J *Aboriginal Economic Development and Land Rights in the Northern Territory: Past Performance,* NLC, CLC *Current Issues and Strategic Options*, Land Rights: Past Present and Future Conference Papers, Northern and Central Land Councils, Canberra, 1996.
7. AMSANT *Possible funding arrangements for the development of Aboriginal primary health care services.* AMSANT Position Paper, August, 1998.
8. AMSANT *Possible funding arrangements for the development of Aboriginal primary health care services.* AMSANT Position Paper, Revised February, 1999.
9. *Annual Report for the Groote Eylandt and Bickerton Island Substance Misuse Program 1997-98*, Angurugu, 1998.
10. ATSI Health Council *Health Service Delivery for Remote Aboriginal Communities*, Remote Areas Issues Sub-Committee Draft Position Paper, Canberra, 1997.
11. ATSIC Information Package, Attachment B '*Proposed NAHS funding to 1994-95.'* Prepared for National Conference Aboriginal Health Services, Melbourne, 12-15 March, 1991.
12. ATSIC News, September 1999.
13. *ATSIC NT News,* 2nd ed. September, 1999.
14. ATSIC *Yilli Rreung Regional Plan*, June 1996.
15. Auer, J et al *'Just Change: The Cost-conscious Manager's tool Kit.*' SA Health Commission, Adelaide, 1993.
16. *Australian Phrasebook:* Lonely Planet Publications, 1998.
17. Bartlett B & Legge D *Beyond the Maze: Proposals for more effective administration of Aboriginal health programs.* NCEPH Working Paper No 34. Central Australian Aboriginal Congress, Alice Springs & NCEPH, Canberra, 1994.
18. Bartlett, B & Tilton E *Report* of the Consultancy for the *Development of an Independent Medical Service and an Aged Care Pilot Program based at Ti Tree.* Central Australian Aboriginal Congress, Alice Springs, 1998.
19. Bartlett, B *'21st Anniversary of Workers Health Centre.'* Address delivered to meeting October, 1997.
20. Bartlett, B *Origins of Persisting Poor Aboriginal Health: An Historical Exploration of Poor Aboriginal Health and The Continuities of The Colonial Relationship as an Explanation of the Persistence of Poor Aboriginal Health*. MPH Thesis, University of Sydney, 1998.
21. Bartlett, B, Duncan, P, Alexander, D and Hardwick, J *Central Australian Health Planning Study: Final Report,* PlanHealth/ OATSIHS, Canberra, 1997.
22. Bhatia, K & Anderson, P *'An Overview of Aboriginal and Torres Strait Islander Health: Present Status and Future Trends.'* Aboriginal & Torres Strait Islander Health Unit, Australian Institute of Health and Welfare, Canberra, 1995.
23. Boughton, B *What is the Connection between Aboriginal Education and Aboriginal Health?* A Discussion Paper of the CRCATH Indigenous Health and Education Research Programs, Systematic Review Project (IE0031), November, '99.
24. BUKAS '*Restoring Health Care to the Hands of the People.*' Proceedings of Seminars Sponsored by Bukluran Para Sa Kalusugan Ng Sambayanan (BUKAS) [Task Force People's Health]. Health Action Information Network (HAIN), Quezon City, Philippines, 1987.
25. Caldwell, JC & P *'The Cultural, Social and Behavioural Components of Health improvement: The Evidence from Health Transition Studies.'* In Robinson, G (Ed) *'Aboriginal Health: Social & Cultural Transitions'* Proceedings of a conference at the NT University, Darwin, 29-31 September, 1995.

26. CARPA *'CARPA Standard Treatment Manual.* 4th edition, Alice Springs, 1998.
27. Carter E et al *Borning:1987 Pmere Laltyeke Anwerne Ampe Mpwaretyeke Congress Alukura by the Grandmother's Law.* Central Australian Aboriginal Congress. Aust Aboriginal Studies No 1 1987.
28. Cawte, JE *'Cruel, Poor and Brutal Nations.'* University Press of Hawaii, Honolulu, 1972.
29. Cawte, JE '*Social and Cultural Influences on Mental Health in Aboriginal Australia: A Summary of Ten Years Research.'* Transcultural Psychiatric Research Review 13, 1976.
30. Census of Population Aboriginal and Torres Strait Islander Count, Cat. No 2722.0, ABS, Canberra, 1991.
31. CHASP (Community Health Accreditation & Standards Program) *'Manual of Standards for Community and Other Primary Health Care Services.'* Australian Community Health Association, Sydney, 1993.
32. CHASP *Manual of Standards for Remote/ Rural Community and Other Primary Health Care Services.'* Australian Community Health Association, Sydney, 1994.
33. CHASP, Nganampa, Menzies *'Manual of Standards for Rural and Remote Aboriginal Health Services.'* 1993.
34. CLC & NLC *Our Land, Our Life: Aboriginal Land Rights in the Northern Territory*, Darwin, 1995.
35. Codd, M. *'Developing a Partnership: A Review of the Council for Aboriginal Health.'* Canberra, March, 1993.
36. Collins, B *Learning Lessons: An independent review of Indigenous education in the Northern Territory* NT Dept. Education, 1999.
37. Commonwealth Department of Health & Family Services *'General Practice in Australia: 1996.'* AGPS, Canberra, 1996.
38. Congress Alukura & Nganampa Health Council *'Minymaku Kutju Tjukurpa: Women's Business Manual.'* Alice Springs, 1994.
39. Coombs H.C. *'Decentralisation Trends Among Aboriginal Communities'*, in an address to the 45th ANZAAS Congress, Perth, 1973.
40. Crawshaw, J & Thomas, D *'It's not enough to know about diseases: Report of the review of Aboriginal & Torres Strait Islander health care in the Darwin area.'* Danila Dilba, Darwin, 1992.
41. Cuneen, C *ATSIC Submission*, Institute of Criminology, University of Sydney Law Faculty, in consultation with Aboriginal and Torres Strait Islander Services in Western Australia and the Northern Territory, 1999.
42. Curry R, *Allied Health Therapy Services in Aged and Disability Care in Remote Aboriginal Communities of the Northern Territory: A Framework for Quality Service Provision* Top End Division of General Practice, Darwin, 1999.
43. Cutter, T *'Report on Community Health Model: Health by The People.'* Central Australian Aboriginal Congress, Alice Springs, 1976.
44. d'Abbs, P *Katherine West Coordinated Care Trial: Local Evaluation – Mid-Term Report* Menzies School of Health research, Darwin, July, '99.
45. DAA *'Annual Report 1986-1987.'* AGPS, Canberra, 1987.
46. Danila Dilba, *Annual Report* 1999.
47. Deeble J, Mathers C, Smith L et al. *Expenditures on Health Services for Aboriginal and Torres Strait Islander people,* Commonwealth of Australia, May 1998.
48. Devitt, J & McMasters, A *'Living on Medicine: Social and Cultural Dimensions of End Stage Renal Disease Among Aboriginal People of Central Australia.* Central Australian Aboriginal Congress, Alice Springs, 1996.
49. Duffy, M *Living in Eastern Arnhemland: Your Guide to the Region* Nhulunbuy Community Neighbourhood Centre, 1998.
50. Evans RG, Barere ML, Marmor TR *Why are Some People Healthy and Others Not? The Determinants of Health of Populations*. Aldine de Gruyter, NY, 1994.
51. Evatt Foundation *The State of Australia*, Southwood Press, 1996.
52. *Explore Australia 2000,* Penguin Books, Melbourne, 1999.
53. Finlay, H. Lonely Planet Australia Guide: Northern Territory, 1996.
54. Foley, G *'Aboriginal community controlled health services: A short history.'* Aboriginal Health Information Bulletin, No 2, 1982.
55. Garrak-Jarru Regional Council, *Annual Report - 1998-99.*, ATSIC, 1999.
56. Garrow, A & McConnel, F *Good, that's my country back.* Wurli Wurlinjang, Katherine, July 1999.

57. Gramsci, A *'The Modern Prince & Other Writings.'* International Publishers, New York, 1972, pp 118-123.
58. Harrison, Jo *Optional Standards of Care for Frail Aged Aboriginal People: Trainers Manual* Menzies School of Health Research, Alice Springs, 1995.
59. Harrison, Jo, *Optional Standards of Care for Frail Aged Aboriginal People: Trainers Manual* Menzies School of Health Research, Alice Springs, 1995.
60. *Healthy Stores Workshop*, Alice Springs, 1991.
61. House of Representatives Standing Committee on Family & Community Affairs, *Inquiry into Indigenous Health: Discussion Paper.* Canberra, September, 1999.
62. *Housing and Infrastructure Needs Survey*, ABS, Canberra, 1994.
63. Hunter, E *'Aboriginal Health and History: Power & Prejudice in Remote Australia.'* Cambridge University Press, Cambridge, 1993.
64. Ife, J *'Community Development: Creating Community Alternatives – Vision, Analyses and Practise.'* Longman, Melbourne, 1995 cited in Petersen, A & Lupton, D *'The New Public Health: Health & Self in the Age of Risk.' Allen* & Unwin, Sydney, 1996.
65. Indian Health Service *'Trends in Indian Health - 1989. Tables* Rockville, MD, Division of Program Statistics, Office of Planning, Evaluation and Legislation, Public Health Service, Department of Health and Human Services, 1989.
66. *Jabiru ATSIC Regional Council Plan*, ATSIC, 1997.
67. Jawoyn Association *Coordinated Care Trial: Nyirranggulung Regional Health Authority: Expression of Interest*, December, 1999.
68. Jawoyn Association *Five Year Plan: Nyarrang nyan-burrk bunbun yunggaihmih 'We're moving ahead'*, Katherine, 1997.
69. Jawoyn Association *Rebuilding the Jawoyn Nation : Approaching Economic Independence.* Katherine, 1994, Ch 2.
70. Jawoyn Association *Wakmiyn Wakai: A holistic approach to substance abuse in Katherine: A Submission to territory Health Services.* Jawoyn Association, Katherine, 1999.
71. Josif, P & Elderton, C 'Working Together? A Review of Aboriginal Health Workers: Recruitment & Retention in the Northern Territory's Top End.' NT Department of Health & Community Services, Darwin, 1992.
72. Kakadu National Park - *Draft Plan of Management 1996.*, Commonwealth of Australia, 1996.
73. Kettle, E 'Health Services in the NT – A History 1824-1970.' Vols 1 and 2, NARU, ANU, Darwin, 1991.
74. King, L & Ritchies, J *Promoting Health in the Northern Territory: A Review.'* WHO Regional Training Centre for Health Development, School of Medical Education, Faculty of Medicine, University of NSW, April 1999.
75. Kunitz, S.J. *'Disease and Social Diversity: The European Impact on the Health of Non-Europeans.'* Oxford University Press, 1994.
76. Land Rights News, Vol 2 No 44, Feb 1998; Vol 2, No 45, May 1998; Vol 2, No 43, September 1997; Vol 2, No 47, December 1998.
77. Langton, M, Epworth, D, & Shannon, V. *Indigenous Social, Economic and Cultural Issues in Land, Water and Biodiversity Conservation.* CINCRM, Darwin, 1998.
78. Langton, M. *Burning Questions: Emerging Environmental Issues for Indigenous Peoples in Northern Australia.* CINCRM, NTU Print, Darwin, 1998, Pp63-64.
79. Lawrie, D *Report: Inquiry into the Provision of an Interpreter Service in Aboriginal Languages by the Northern Territory Government,* Office of the NT Anti-Discrimination Commissioner, Darwin, 1999.
80. Lea, D & Wolfe, J Community Development Planning and Aboriginal Community Control.' NARU, ANU, Darwin, 1993.
81. Lee, AJ et al *'Apparent dietary intake in remote Aboriginal communities.'* Aust J Pub Hlth, Vol 18, No 2, June 1994, p190-197.
82. Letter to the Chief Minister of the NT from Minjilang Community, 27 May 1983.
83. Levy, R. *Native Title – A Catalyst for Sea Change.* Land Rights: Past Present and Future Conference Papers, Northern and Central Land Councils, Canberra, 1996.
84. Lewis D, *A Shared History Aborigines and White Australians in the Victoria River District*, 1997

85. Local Government Association of the NT: *Straight Talking. A guide to negotiating and consulting with remote area local government Councils.*
86. Mackerras, D *Evaluation of Strong Women's, Strong Babies, Strong Culture Program* Menzies School Health Research, Darwin, 1996.
87. Magnery, Y *Report on Establishing a Holistic treatment System in Tackling Substance Abuse, Katherine District, NT*. Jawoyn Association , 1999.
88. Marmot M & Wilkinson RG *Social Determinants of Health.* Oxford University Press, Oxford, 1999.
89. McGrath, A *Born in the Cattle.*, Allen & Unwin, Melbourne, 1987.
90. Medical Services, *'Life Tables, Registered Canadian Indians, 1960 -64.'* Ottawa, Department of National Health and Welfare.
91. Millar, WJ *'Mortality Patterns in a Canadian Indian Population.'* Canadian Studies in Population 9, 1982.
92. Ministry of National Health and Welfare *'Health Indicators Derived from Vital Statistics for Status Indians and Canadian Populations, 1978-1986'* Ottawa Ministry of National Health and Welfare, September, 1988.
93. Miwatj ATSIC Regional Plan, ATSIC, 1997.
94. National Aboriginal and Torres Strait Islander Survey, Australian Bureau of Statistics, 1994.
95. *National Aboriginal Health Strategy* Working Party Report, AGPS, Canberra, 1989.
96. National Health Strategy *'Enough to Make You Sick: How Income and Environment Affect Health.'* National Health Strategy, Research Paper 1, Canberra, 1992.
97. Nganampa Health Council *Report of Uwankara Palyanyku Kanyintjaku: an environmental and public health review within the Anangu Pitjantjatjara Lands.,* Alice Springs, 1987.
98. NLC *'Traditional owners again reject ERA proposal'* Media Release, 27/10/99.
99. NLC Web Site: *www.nlc.org.au.*
100. NLC, *Marine Agreements with Aboriginal People* (video), July, 1999.
101. Northern Land Council *Annual Report 1997-98.* Commonwealth of Australia, Darwin, 1998.
102. NT Department of Lands, Planning and Environment *'NT Aboriginal Communities.'* Darwin, October, 1998.
103. NT Government Website: www .nt.gov.au/
104. NT Office of Aboriginal Development *Annual Report '95/96* NT Government, Darwin, 1996.
105. NT Office of Aboriginal Development *Summary Document Implementation of Recommendations Royal Commission Into Aboriginal Deaths In Custody* 1993/94.
106. O'Neil, M *'Community Participation in Quebec's Health System: A Strategy to Curtail Community Empowerment.' International* Journal of Health Services, Vol 22, No 2, 1992, pp287-301.
107. OATSIH Aboriginal Health Profile NT Northern, 1996.
108. Ove Arup *The ATSIC National Aboriginal Health Strategy Health: NT Health Impact Assessments.* Brisbane, May, 1999.
109. Parry, S *'Disease, Medicine and Settlement: The Role of Health and Medical Services of the Northern Territory 1911-1939.'* PhD Thesis, University of Queensland, 1992.
110. Pederson, AP et al *'Coordinating Healthy Public Policy: An Analytic Literature Review and Bibliography.' Department* of Behavioural Science, University of Toronto, 1988.
111. Petersen, A & Lupton, D 'The New Public Health: Health & Self in the Age of Risk.' Allen & Unwin, Sydney, 1996
112. Pholeros, P et al *Housing for Health: towards a Healthy Living Environment for Aboriginal Australia.* Health Habitat, Sydney, 1993.
113. Plant, A, Condon, J and Durling G '*Northern Territory Health Outcomes: Morbidity & Mortality 1979 - 1991.'* NT Department of Health & Community Services, 1995.
114. Pomare EW *'Maori Standards of Health: A Study of the 20 Year Period 1955 - 1975* Auckland Medical Research Council of NZ, Special Report Series no 7, 1980.
115. Pomare EW *Hauora: Maori Standards of Health: A Study of the Years 1970 - 1984* Auckland Medical Research Council of NZ, Special Report Series no 78, 1988.
116. Pool I *'Mortality Trends and Differentials' in population of NZ* Economic and Social Commission for Asia and the Pacific, Bangkok, 1985.
117. *'Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, 1978.*' World Health Organisation, Geneva, 1978.

118. Public Accounts Committee: *Report on the Provision of Health Services in the NT* NT Government, Darwin.
119. Raymond, E *Wardaman Ethno-biology*. CINCRM & Parks & Wildlife Commission of the NT, NTU, Darwin, 1999.
120. Reid, J & Trompf, P '*The Health of Aboriginal Australia.'* Harcourt Brace Jovanovich Group, Sydney, 1991.
121. *Report of the House of Representatives Standing Committee on Aboriginal Affairs.* Canberra, 1980.
122. *Report of the Royal Commission into Aboriginal Deaths in Custody.* AGPS, Canberra, 1991.
123. Rotem, A & Freeman, P *Essential Primary Health Care Services – Northern Territory*, THS, 1999.
124. Saggers, S and Gray, D, *'Aboriginal Health and Society: The traditional and contemporary Aboriginal struggle for better health.'* Allen & Unwin, 1991.
125. Scimgeour, D *'Community Control of Aboriginal Health Services in the Northern Territory.'* Menzies Occasional Papers, Darwin, Issue no 2/97.
126. Scrimgeour, D *'Community Involvement in Health Services for Indigenous Peoples of Canada, Norway and New Zealand.'* Menzies School of Health Research, Alice Springs, 1994, pp5-6.
127. Scrimgeour, D *Report of Review of Nganmarriyanga Community Health Service* Menzies School of Health Research, 1992.
128. Scrimgeour, D *Rethinking Community Control: A Core Services Approach to Health Care in Remote Aboriginal Communities.* Paper presented to Rural Health Conference, Perth, 1997.
129. Smith, D. (Ed.) *Aboriginal Autonomy* University of Cambridge Press, 1994.
130. Stead, J *The Aboriginal Land Rights Act (NT) 1976 - Successes and Failures.* in NLC & CLC *Land Rights; Past, Present and Future*. 1996.
131. Taylor, J & Bell, M *Population Mobility and Indigenous Peoples: the View from Australia.* Int J Pop Geog Vol2 No2, pp 153-169, June, 1996.
132. *The Little Red, Yellow & Black Book*, Australian Institute for Aboriginal and Torres Strait Islander Studies, 1994.
133. *The Remote Community Initiative – Top End Implementation Plan: Round #1 Sites.* OATSIH NT: Brails: 03/08/99.
134. Thomson, NJ *'Inequalities in Aboriginal Health'* (MPH thesis, University of Sydney, 1989) p 39; Gray, A *Discovering Determinants of Australian Aboriginal Population Health'* Working Paper, NCEPH, ANU, 1989, p11.
135. THS *Territory Health Services Annual Report 1998-99*, NT Government, Darwin, 1999.
136. THS *Aboriginal Health Initiatives*, (Undated).
137. THS *Annual Report 1997/98* Darwin, September 1998.
138. THS *Creating A Healthier Future* Darwin, November 1998.
139. THS *Doing It Better for the Bush*, Darwin, Dec '97.
140. THS *NT Aboriginal Mental Health Policy and Action Plan* 1998
141. THS *NT Cattle Stations Health Policy*, Darwin (Undated).
142. THS *Preventable Chronic Disease Strategy – The Evidence: Best buys and key result areas in chronic disease control.* August, 1999.
143. THS *Strategy On Petrol And Other Inhalant Substance Abuse*, 1998.
144. THS *The Aboriginal Public Health Strategy and Implementation Guide 1997-2002*, Darwin, 1998.
145. THS, *Aboriginal Health Policy*, Darwin, 1996.
146. THS, *Strategy Twenty First Century Strategic Intent* Territory Health Services, 1999.
147. THS*'Northern Territory Cattle Stations Policy.* Territory Health Services, undated.
148. THS, *Using Health Benefit Groups & Healthcare Resource Groups to Inform Health Management: A THS Project.* NTG, Information Brochure, August, 1999.
149. THS, DHAC *Development of a Strategic Computer-Based Model for Increasing Allocative Efficiency,* November 1999.
150. THS, DHAC *Strategic Healthcare Investment Seminar: Summary of Proceedings,* August 1999, Mecure Hotel, Sydney.
151. THS, DHAC *Using Health Benefit Groups and Healthcare Resource Groups to Inform Management: Information Brochure,* August 1999.

152. Tregenza, J & Abbott, K *'Rhetoric and Reality: Perceptions of the roles of Aboriginal Health Workers in Central Australia.'* Central Australian Aboriginal Congress, Alice Springs, 1995.
153. Tucker, WH '*The Science and Politics of Racial Research.'* University of Illinios Press, Ulbana, 1994.
154. Wakerman, J, Bennett, M, Healy, V, Warchivker, I *'Review of Northern Territory Government Remote Health Services in Central Australia.'* Menzies School of Health Research, August, 1997, p176.
155. Werner D *Globalisation and Primary Health Care* Keynote Address, PHA Conference, Darwin, 1999.
156. Werner, D & Sanders, D *Questioning the Solution: The Politics of Primary Health Care and Child Survival, with an in-depth critique of Oral Rehydration Therapy.* HealthWrights, Palo Alto CA, 1997.
157. West, M *Rainbow Sugarbag and Moon,* Museum and Art Gallery of the NT, Darwin, 1995
158. West, M, Carew, M & the Artists *Maningrida: The Language of Weaving.* Australian Exhibitions Touring Agency, 1995.
159. WHO *Alma Ata Declaration of PHC*, Alma Ata, USSR, 1978.
160. Wolfe, J *That Community Government Mob: Local Government in Small Northern Territory Communities* ANU, North Australia Research Unit, Darwin, Monograph, 1989.
161. Working Group *National Aboriginal Health Strategy*, Canberra, 1989.
162. World Bank *World Development Report 1993: Investing in Health.* Oxford University Press, NY, 1993.
163. Yilli Rreung ATSIC Regional Council Annual Report, ATSIC, 1997.
164. Young, E & Doohan, K *Mobility for Survival: A process analysis of Aboriginal population movement in Central Australia.'* ANU North Australia Research Unit, Darwin, 1989.
165. Young, E *'Aboriginal Population Mobility and Service Provision: A Framework for Analysis.'* Chapter 15, p 186-196 in Meehan, B & White N (Eds) '*Hunter-Gatherer Demography: Past and Present.'* Oceania Monograph 39, Sydney, 1990.
166. Young, E Doohan, K *Mobility for survival: A process analysis of Aboriginal population movement in Central Australia*, North Australia Research Unit Monograph, ANU, Darwin, 1989.
167. Young, E. *Outback Stores: Retail Services in North Australian Aboriginal Communities*. North Australia Research Unit, ANU, Darwin, 1984.
168. Yunupingu, G. (Ed.) '*From the Bark Petition to Native Title*'; Our Land is Our Life, University of Queensland Press, 1996.

APPENDIX 1 - TEMPLATE FOR DATA COLLECTION

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 Darwin, Katherine or Nhulunbuy.

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.

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.

APPENDIX 2 - AIMS OF THE TOP END ABORIGINAL HEALTH PLANNING STUDY

The aims of this consultancy have been stated under the tender brief as:

1. Identify health care priorities and provide practical solutions to improving access to health care and particularly primary health care.
2. Inform current and future funding decisions between THS, HFS and ATSIC.
3. Identify practical health interventions that will have the greatest possible impact on improving health outcomes.
4. The Planning Study will cover the following issues:
    - Management Issues
    - Workforce issues
    - Coordination of visiting staff
    - Operational costs
    - Coordination of administrative arrangements
    - IT development and application
    - Capital and environmental infrastructure
    - Access to MBS and PBS
    - Provision of services to out-stations/ homelands
    - Health Services/ Programs
    - Access to Primary Health Care services
    - Community health priorities
    - Population health programs
    - Health promotion and prevention programs
    - Screening
    - Clinical/ Chronic Disease Management
    - Current and emerging chronic disease
    - Treatment protocols
    - Patient recall system
    - Specialist services
    - Option for Community Control/ Participation
    - Identifying current and future opportunities for community participation and control.

Implementation
The plan will include implementation proposals that will provide for local planning in communities.

APPENDIX 3 - STEERING COMMITTEE

The TERIHPC was the steering committee for this study and consisted of:

Pat Anderson - AMSANT
Wes Miller - AMSANT
Jamie Gallacher - AMSANT and TERIHPC Secretariat
David Ashbridge, Trish Angus, Jenny Cleary - THS
Rose Rhodes, Cheryl Rae - THS
Marian Kroon - OATSIH
Roger Brailsford - OATSIH
John Kelly, Gerry Thomas - ATSIC

APPENDIX 4 - CONSULTATIONS CONDUCTED

Adams, Mick	Miwatj Health
Adena, Simon	Numbulwar Homelands Council
Alleman, Peter	Numbulwar Numburindi Community Government Council
Aloisi, Debbie	Binjari Council
Anderson, Clare	AMSANT
Anderson, Nikki	Lonely Planet Publications
Anderson, Pat	Danila Dilba & NTAHF Chairperson
Angelo, Denise	Diwurruwurru-Jaru Aboriginal Corporation, Katherine
Ashbridge, David	THS
August, Sandy	Miniyeri
Barclay, Bill	THB
Barnes, Tony	Australian Bureau of Statistics
Bell, Andrew	KWHB
Bell, Stephanie	Central Australian Aboriginal Congress
Berry, Joanne	THS, Barunga
Boffa, John	Central Australian Aboriginal Congress
Boland, Jeanette	THS, Adelaide River
Bond, David	Bawinanga Aboriginal Corporation
Boughton, Bob	Menzies School Health Research
Bourchier, Michael	Australian Bureau of Statistics
Boxxall, Tony	Gumatj Association, Marngarr Council
Brailsford, Roger	OATSIH
Braybrook, Vivien	Gunyangara Health Centre
Bridge, Catherine	East Kimberley Aboriginal Medical Service
Brown, Nell	Barunga Community Government Council
Brown, Sarah	Oenpelli
Bryce, Stephen	Gapuwiyak Health Centre
Bullimore, Terry	Kardu Numida Council
Bunn, Linda	Danila Dilba
Burch, Joy	NTRHWFA
Cameron, Liz	Binjari
Campbell, Gil	ARDS
Castine, Graham	Kalano Association
Cleary, Jenny	THS
Connors, Chris	THS
Costello, Kelvin	OATSIH
Crawley, Jenny	THS, Wugularr
Cresswell, Harvey	Wurli-Wurlinjang Health Service/ KWHB
Crouch, Jan	THS
Crundle, Ian	THS
Curwin-Walker, Peter	Nganmarriyanga Community Inc
d'Espaignet, Edouard	THS
Daly, Dawn	Nauiyu Nambiyu Health Centre
Daly, Lana	Nauiyu Nambiyu Health Centre
Davies, Anne	Nauiyu Nambiyu Health Centre
de Boer, Jac	Murin Association
de Boer, Lyn	Murin Association
Dempsey, Karen	THS, Darwin
Desatge, Charlotte	THS, Barunga
Devitt, Jeannie	CRCATH, Danila Dilba

Dixon, Patsy	Robinson River
Djamalaka	Ngalkanbuy Health Centre, Galiwin'ku
Dobrowska, Dana	THS, Darwin
Dowden, Michelle	Ngalkanbuy Health Centre, Galiwin'ku
Downing, Rev Jim	ARDS
Durnan, Deborah	IAD
Farley, Ces	THS, Darwin
Fazakerley, Ruth	Gapuwiyak Health Centre
Fisher, Peter	Anglicare
Fletcher, Janet	THS, Ngukurr
Fox, Dorothy	THS, Darwin
Gallacher, Jamie	AMSANT, & NTAHF Secretariat.
Garrard, Jocelyn	THS, Katherine
Gigante, Matthew	Minjilang Out-station Resource Centre
Gless, Gwenda	Minjilang Health Centre
Godfry, Hazel	Robinson River
Goodwin, Chris	THS, Darwin CCC
Govern, Mae	THS, Katherine
Guilfoyle, Patricia	Nganmarriyanga Clinic
Hagger, Mark	Binjari Council
Hall, Kez	THS, PHSU
Handicott, Geoff	Ngadunggay Homelands Resource Centre
Harris, Vanessa	KWHB
Harrison, Chris	THB
Higgens, Bernard	NLC
Hodgson, Robin	Diwurruwurru-Jaru Aboriginal Corporation, Katherine
Ingram, Innes	THS, Batchelor
Joshua, Ruth	AHW, Ngukurr
Jungawunga, George	Bulman
Kamfoo, Nellie	Bulman
Katona, Jacqui	Jabiluka Association
Kemmis, Lesley	THS, Darwin
Kemp, David	Menzies School of Health Research
Knight, Robert	Ngaliwurru-Wurri Association
Kroon, Marion	OATSIH
Lange, Sean	NLC
Lawler, Libby	KWHB
Lawrence, Lyn	THS, Darwin Urban
Lee, Anthony	Barunga Community Government Council
Lennon, Steve	AIMSS
Lewis, Michelle	Lonely Planet Publications
Liddell, Neil	THS, Nhulunbuy
Liddle, John	Congress
Lindenmayer, Peter	THS, Nhulunbuy
Lindsay, Ronnie	Bulman
Lloyd, Jane	NPY Women's Council
Mackinolty, Chips	Darwin
Maddison, Mike	THS, Mataranka
Maher, Helena	CARIHPC
Maher, Liam	Djabulukgu Association
Mans, John	Warruwi
Martin, Ronnie	Bulman
Martin, Virginia	THS, Nhulunbuy
Mason, Debra	Demed Association

Massey, Kathy	Anglicare, Groote Eylandt
Masters, Jed	NT Aids Council
Matthews, Helen	THS, Maningrida
McGregor, Bluey	Milingimbi & O/S Progress Resource Association
McIvor, Roger	Marthakal Homelands Resource Centre
McLeod, Bev	Warruwi
McMillan, Stuart	ARDS
Miller, Wes	Wurli-Wurlinjang
Mitchell, Neville	Gumatj Association, Marngarr Council
Morgan, David	Anyinginyi Congress
Morgan, Libby	Anglicare
Morley, Jo	HLG, Katherine
Morrison, Beverley	THS, Barunga
Munro, Ian	Bawinanga Association, Maningrida
Murdoch, Sue	Jabiru Alcohol Counsellor
Murphy, Lynn	THS, Numbulwar
Myers, Tony	AIMSS
Nadji, Sharon	Djabulukgu Association
Namburududi, Samuel	Numbulwar Homelands Resource Centre
Newton, Sid	Marngarr Council
Nunggumajbarr, Bobby	NLC
Ohem, Darryl	THB
Pierce, Mick	Wardaman Association
Pollock, Gilbert	Ramingining Homelands Resource Centre
Popple, Mike	Wugularr
Priestly, Errol	KADA
Quinlan, Paul	THS, Nhulunbuy
Rae, Cheryl	THS, Darwin
Rainger, Tracey	Ngaliwurru-Wurli Association
Realfe, Pauline	THS, Darwin
Rhodes, Rose	THS, Darwin
Richards, Phil	Barunga – Manyallaluk Community Government Council
Rivalland, Paul	Oenpelli
Robinson, John	Danila Dilba, Darwin
Rowland, Valerie	THS, Darwin
Runyu, Jane	Wugularr
Sainsbury, Peter	Robinson River
Sandery, Paul	THS, Katherine
Schafer, Serena	Yugul Mangi Community Council, Ngukurr
Scrimgeour, David	Menzies School of Health Research (previously)
Scrymgour, Marion	KWHB
Setter, Tony	LHHS
Shadforth, Kathleen	Robinson River
Sharp, Barbara	THS, Darwin
Shoobridge, David	Nauiyu Nambiyu
Sigston, Roger	CAAPS
Simmons, Dave	Miwatj Health
Simon, Teresa	Robinson River
Sloane, Mat	HLG, Darwin
Snape, Edna	Wugularr
Stowe, Kathy	THS, Katherine
Sullivan, Paul	A&IAAFR
Tedcastle, Bob	Murin Association
Thorpe, Margaret	THS, Ramingining

Tilmouth, Tracker	Consultant, Jabiluka Association
Tilton, Edward	AMSANT
Tosh, Margaret	Robinson River
Turner, Eric	OATSIH
Tyzak, Chris	THS, Palmerston
Valadian, Bernard	Aboriginal Development Foundation
Varney, Tracey	Bagot Community Health Centre
Walshe, Michael	Michael Walshe & Associates
Webb, David	Djabulukgu Association
Weeramanthri, Tarun	THS, Darwin
Wellard, Caroll	THS, Ramingining
Wellings, Peter	National Parks & Wildlife Services
Whelan, Kirk	OATSIH
White, Bob	FORWAARD
White, Jo	THS, Numbulwar
Wilfred, Ester	Robinson River
Williams, Bill	THS, Woodycupaldiya
Winsley, Kathy	Belyuen
Woodward, Robbie	Peppimenarti Grant Controller
Wordsworth, Peter	THS, Barunga
Yarmirr, Daisy	Minjilang

APPENDIX 5 – POPULATION PROJECTIONS

Table 47: Top End Indigenous Populations by Area 1981-2016

Area	1981	1986	1991	1996	2001	2006	2011	2016
Arnhem Land	7,196	7,762	9,649	10,860	12,691	14,521	16,352	18,182
Tiwi	1,477	1,652	1,629	1,805	1,939	2,072	2,206	2,339
SE Top End	803	1,219	1,859	2,133	2,666	3,200	3,733	4,266
Top End West	1,238	1,479	2,208	2,471	3,291	4,112	4,932	5,752
Katherine East	1,809	2,186	2,253	2,707	3,155	3,603	4,051	4,499
Katherine West	1,619	1,708	1,800	1,890	1,995	2,101	2,206	2,312
Darwin	4,499	6,462	7,298	9,038	12,077	15,117	18,156	21,196
Total Top End	**18,641**	**22,468**	**26,696**	**30,904**	**37,815**	**44,725**	**51,636**	**58,546**

Source: ABS Census Data 1981-96

Table 48:Top End Indigenous Population 1981-1996 & Population Estimates 2001-2016 Males by Age Category

Age Range	981	1986	1991	1996	% (1)	2001	2006	2010	2016
<4	1,378	1,568	1,941	2,044	3	2,373	2,703	3,032	3,361
5 14	2,742	3,062	3,478	4,084	3	4,750	5,417	6,083	6,749
15 24	1,920	2,538	2,838	3,275	5	4,045	4,816	5,586	6,357
25 44	1,998	2,544	3,361	4,005	7	5,346	6,687	8,028	9,369
45 54	569	665	791	973	5	1,203	1,434	1,664	1,894
>55	588	573	718	814	3	918	1,023	1,127	1,231
Total	9,195	10,950	13,127	15,195	4	18,637	22,078	25,520	28,961

Source: ABS Census Data 1981-96

Table 49: Top End Indigenous Population 1981-1996 & Population Estimates 2001-2016 Females by Age Category

Age Range	1981	1986	1991	1996	% (1)	2001	2006	2010	2016
<4	1,255	1,526	1,850	1,866	3	2,169	2,472	2,774	3,077
5 14	2,627	2,908	3,391	3,905	3	4,538	5,171	5,805	6,438
15 24	2,107	2,701	2,973	3,273	4	3,877	4,481	5,084	5,688
25 44	2,171	2,931	3,755	4,558	7	6,228	7,899	9,569	11,240
45 54	645	735	779	1,082	5	1,326	1,571	1,815	2,059
>55	641	717	821	1,025	4	1,230	1,434	1,639	1,844
Total	9,446	11,518	13,569	15,709	4	19,368	23,028	26,687	30,346

Source: ABS Census Data 1981-96

Table 50:Top End Indigenous Population 1981-1996 & Estimates 2001-2016 Percentage of Indigenous Persons in Age Categories

Age Range	1981	1986	1991	1996	2001	2006	2010	2016
<4	14	14	14	13	12	11	11	11
5 14	29	27	26	26	24	23	23	22
15 24	22	23	22	21	21	21	20	20
25 44	22	24	27	28	30	32	34	35
45 54	7	6	6	7	7	7	7	7
>55	7	6	6	6	6	5	5	5

Source: ABS Census Data 1981-96

APPENDIX 6 - OTTAWA CHARTER

OTTAWA CHARTER FOR HEALTH PROMOTION

The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November, 1986, hereby presents this CHARTER for action to achieve Health For All by the year 2000 and beyond.
This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialised countries, but took into account similar concerns in other regions. It built on the progress made through the Declaration of Primary Health Care at Alma Ata, the World Health Organisation's Targets for Health For All document, and the recent debate at the World Health Assembly on intersectoral action for health.

HEALTH PROMOTION

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

PREREQUISITES FOR HEALTH

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Improvement in health requires a secure foundation in these basic prerequisites.

ADVOCATE

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

ENABLE

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills, and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to men and women.

MEDIATE

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by non- governmental and voluntary organisations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

HEALTH PROMOTION ACTION MEANS:

BUILD HEALTHY PUBLIC POLICY

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse and complimentary approaches including legislation, fiscal measures, taxation and organisational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy maker as well.

CREATE SUPPORTIVE ENVIRONMENTS

Our societies are complex and inter-related. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasised as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organises work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanisation - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

STRENGTHEN COMMUNITY ACTION

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

DEVELOP PERSONAL SKILLS

Health promotion supports personal and social development through providing information and enhancing life skills, By doing so, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

REORIENT HEALTH SERVICES

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in the health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace and expanded mandate which is sensitive and respects cultural values. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environment components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organisation of health services, which refocusses on the total needs of the individual as a whole person.

MOVING INTO THE FUTURE:

Health is created and lived by people within the settings of everyday life; where they learn, work, play and love. Health is ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

COMMITMENT TO HEALTH PROMOTION

The participants in this conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and most importantly with people themselves;
- to recognise health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The conference urges all concerned to join them in their commitment to a strong public health alliance.

APPENDIX 7 - COMMUNITY 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.

1. Tiwi HSZ

These communities are located in the Jabiru ATSIC region, the Tiwi Land Council region, OPN Darwin Rural District. There are two islands that are located on Aboriginal land granted under the Aboriginal Land Rights Act (1976) with tenure held by the Tiwi Land Council.
There are four skin groups and twelve clan groups. ATSIC report states that culture and language are uniform.
The THB oversees the Tiwi CCT.

Bathurst Island

Nguiu

Location: 80 km N of Darwin on the SE corner of Bathurst Island. It is a 15-20 min flight to Darwin.
Population: 1200.
History: the Catholic Church established here in 1911 and still maintains a strong presence on the island.
Communications: national telephone network.
Access: all year round by air and barge.
Current Health Services: CCT – staff are employed by the THB.
Staff: RNL3B x1, RNL3A x 2, AHWs x 12, MO x 2, Office Manager, Office workers x 3 (CDEP), 1 groundsman (CDEP), 3 cleaners (CDEP).
Clinic: old Catholic mission hospital approx 30 years old. Renovations by army 1996, THS repairs 1997, requires substantial repairs to maintain and has major security problems. There is separate gender space and a CCTIS computer system.
Vehicles: 1 new van, 1 2yr old van, 1 dual cab with cage, 1 x 4wd troop carrier modified to an ambulance.
Staff Accommodation: 2 new units, 1 duplex, and 2x 3br house.
Airstrip: sealed.

Out-stations

- Wurankuwu (Ranku)

It is permanently occupied (Category 1) with a population 100. Visiting Services: weekly - MO and RN alternate. Clinic and phone. 50 Km from Nguiu. Airstrip is not sealed and prone to flooding. There are intentions to relocate the airstrip to a more suitable site. Barge ramp. Bush holiday multiple out-stations (Category 5) along the island for one month get a twice-weekly bush clinic run.

Melville Island

Milikapiti – Snake Bay.

Location: 120 km N of Darwin on the northern coast of Melville Island. It is a 35 min flight to Darwin.
Population: 480.
History: began as a government settlement.
Communications: national telephone network.
Access: all year by air, unsealed road to the community - can be impassable in severe rain. The road to Pirlangimpi is closed in the wet. There is a weekly barge.
Current Health Services: Tiwi CCT – resident staff employed by the THB, visiting staff contracted to THS.
Staff: RNL3B x 1, RNL3A x 1, AHWs x 4, THS DMO 6 days a month.
Clinic: 30 year old building in shocking condition, unsafe and unsound having had no maintenance for 5 years, no separate gender space. CCTIS computer system.
Airstrip: sealed.

Pirlangimpi – Garden Point.

Location: 125 km N of Darwin on the NW coast of Melville Island. It is a 35 min flight to Darwin.
Population: 350.
History: the Catholic Mission established here in 1940 as a community for 'Stolen Generation' Aboriginal children.
Communications: national telephone network.
Access: all year by air, the road to Milikapiti is closed in the wet. Weekly barge landing - boat access all year round.
Current Health Services: Tiwi CCT - resident staff employed by the THB, visiting staff by THS.
Staff: RNL3B x 1, AHWs x 2.5. THS DMO 3days a month.
Clinic: 10-year-old building in reasonable condition, no separate gender space. CCTIS computer system.
Airstrip: gravel with lighting in good condition. Occasionally closed for a day or two at a time.

Out-stations

- Taracumbi
- Paru.

Both are permanently occupied (Category 1), with a combined population of around 20, and receive no health services.

2. Darwin HSZ

Darwin

These communities are located in the Yilli Rreung ATSIC and in the Darwin/ Daly NLC regions, THS Darwin Urban/ Rural District. Darwin is serviced by Danila Dilba Medical Service, THS Community Care Centres at Darwin, Casuarina and Palmerston and private GPs.
Population: Indigenous population of 8,420.
Languages: the main language/cultural group is the Larrakia who are the traditional owners of Darwin.
History: It is the main public service administration centre for the NT.
Communications: national telephone network.
Current Health Services: Danila Dilba Medical Service
Danila Dilba provides services specifically to Aboriginal and Torres Strait Islander populations of the Darwin, Palmerston and Litchfield local government areas however up to 2/3 of their clientele are from outside those areas. People live in private and public housing and town camps.
Staff: Director, administrator, clinic manager, AHWs x 12, MOs x 3, RN x1, 4.5 transport officers, receptionist x 3.5, cleaners x 2, educators x 5, project officer, lecturer and clinical supervisor.
Clinic: Owned by Danila Dilba in fair condition, 2 buildings leased.
Vehicles: 8 cars and 1 van leased, 3 passenger vans purchased by capital grants in fair condition, 2 other vehicles in poor condition (1992).
THS Community Health Centres also provided some health services to Indigenous people in Darwin through their centres in Darwin, Casuarina and Palmerston.

Town Camps

Darwin Town camps include:

- Knuckey's Lagoons (11 Mile)
- Palmerston Town Camp
- Railway Dam
- Kulaluk
- Fish Camp
- Humpty Doo
- Tree Point
- Bagot
- Minmarama Park

Bagot (with a population of around 280) has its own health service run through the a Service Agreement between THS and the Community Council. There is no health committee.
Staff: AHWs x 2.5. Private GPs x 3 rotate times from 9-12 x 5 days a week.
Clinic: new, no separate gender space.

Vehicles: 2 - a Camry which was a gift from Transport and Works, the other is a 7 year old van.

The other camps are serviced by Danila Dilba (except Humpty Doo and Tree Point) and are visited by a male and female AHW and a MO less frequently. In some places, visits are suspended during the wet due to access problems. Humpty Doo is visited by the Palmerston Community Care Centre when particular clients are referred to them. Tree Point receives no service. These outstations have a total population of around 360. They are all permanently occupied (Category 1).

Adelaide River

Location: on the Stuart Highway 113km S of Darwin. It is a 1-hour drive to Darwin.
Population: 350
History: it is an historical Territory settlement that grew up at a major river crossing. The town developed as a stopover for travellers and has continued to find its raison d'etre and economic viability through serving the travelling public. During World War II, Adelaide River was well within the militarised Top End of the Territory, with several airstrips and military camps in the vicinity.
Land Tenure: gazetted town.
Communications: national telephone network.
Access: all year.
Current Health Services: THS. There is no health committee.
Staff: RNL3B x 1, RNL3A x .5(shared with Batchelor), private GP visits from Batchelor half a day a week, AO x .31, 1 trainee AHW.
Clinic: in good condition, no separate gender space.
Vehicles: 1x4wd, 1 sedan.
Staff Accommodation: industry housing.

Out-stations

- Wairia
- Gulngarring

Both are permanently occupied (Category 1) with a combined population of 60. They receive no services.

Belyuen

Location: on the Cox Peninsula 130km SW of Darwin. It is 1.5 hrs by road, 10mins by air, and 10mins drive to ferry and 15mins ride to Darwin; the ferry landing is owned by Telstra and difficult to get stretchers onto the boat. There is one out-station Bulgul which is permanently occupied (Category 1) and receives no services.
Population: 260.
Languages: Wadjiginy, Emniyangal.
History: the Aboriginal population was moved here from Bagot when the army took over the Bagot compound in 1940-41. In 1972 the Commonwealth Government secured tenure for 16 sq miles. The Belyuen Community Government Council was incorporated in 1975.
Land Tenure: ALT.
Communications: national telephone network.
Access: All year by road, some sections of the road are unsealed and can be limited in the wet.
Current Health Services: SA with THS, Multi Purpose Centre. There is no health committee. Commonwealth funds aged care program.
Staff: AHWs x 2F, 1M and 1 F trainee; DMO visits 1 day a fortnight.
Clinic: THS building that needs R&M; had 8 leaks in the wet and A/C is broken. Also dangerous hump outside the clinic needs removal. No separate gender space/entry or computer.
Vehicles: 1 Troop Carrier that had approval for conversion to an ambulance but this was withdrawn after the agreement had been signed after concerns regarding the condition of the vehicle.
Staff Accommodation: nil.

Airstrip: not licensed, 2km away from community which is 200 metres too short for the new aero medical planes to land on - 2 recent evacuations by the aerial medical services have been conducted by truck and boat.

Out-stations

- Bulgul

This id permanently occupied (Category 1) with a population of 20. It receives no visiting service.

Batchelor

Location: 100km S of Darwin. It is a 1-hour drive and 30min flight to Darwin.
Population: 850
History: township was developed as a uranium-mining centre in the 1950s.
Communications: national telephone network.
Access: all year.
Current Health Services: THS and a private GP. There is no health committee.
Staff: RNL3B x 1, RNL3A x 2.5, AHWs x 1. Private GP 3.5 days a week, AO x.75, AO x .25 (paid by GP).
Clinic: in good condition, no separate gender space.
Vehicles: 1x4wd.
Staff Accommodation: Industry housing.

Out-stations

- Woolaning
- Acacia Larrakia
- Iron Stone

They are all permanently occupied (Category 1) with a combined population of 170. Woolaning receives monthly RN & AHW visits from Batchelor.

3. Top End West HSZ

These communities are located in the Yilli-Rreung and Jabiru ATSIC regions, the Darwin/Daly NLC region and the THS Darwin Rural District.

Nauiyu Nambiyu (Daly River)

Location: 220km SW of Darwin, 2-3 hours by road, 45 mins by air.
Population: 400.
Languages: Ngangikkurrungurrurr, Nangowmeri, Marrathiel and Malak Malak.
History: the Catholic Church established a mission here in the 1950s.
Land Tenure: Freehold. Lease from Catholic Church that automatically renews every 12 years unless the trustees decide otherwise.
Communications: national telephone network.
Access: may be inaccessible in the wet for up to 3 months.
Current Health Services: the Council has a SA with THS; NTRHWFA proposed doctor. There is no health committee. The Council receives a grant from THS to run a nutrition program at Daly River.
Staff: AHW x 1(THS Agreement), AHW x 3 employed through CDEP and topped up by the health service when on call, AHWx2 trainees, RN L3Bx 1, RNL3Ax 1, DMO visits fortnightly x 1 day. I RN is also coordinator of the Aged Care program.
Clinic: good condition, no separate gender space/entry, computer.
Vehicles: 1x4wd.
Staff Accommodation: 1x3br house in good condition.
Airstrip: all weather, occasional flooding at the end of the strip.

Out-stations of Nauiyu Nambiyu

- Woolliana
- Malak Malak
- 5 Mile (Little Hill, Waltwhitby)

They are all permanently occupied (Category 1) with a combined permanent population of 165. However, a drug and alcohol program is conducted at Five Mile, and the population here swells to up to 50 during programs. There is a small school at Woolliana, and health service staff visit regularly from Nauiyu Nambiyu.

Tourism is active in this area, and this increases the demand on the health service.

Palumpa

Location: 240km SW of Darwin, 30km from Peppimenarti and 54km E of Wadeye. It is 4.5+ hours drive and one hour flight to Darwin (350km), 45 mins drive to Wadeye.
Population: 300.
Languages: Koori, Mooringoora.
History: the community was established as an out-station of the Port Keats cattle company 17 years ago. Its population has expanded rapidly.
Communications: telephone, fax, satellite phone.
Access: unsealed access roads are cut off during the wet for up to 3 months.
Current Health Services: Combination – THS and the Council has a SA with OATSIH. There is no health committee.
Staff: RN x 1. DMO visits 1 day per fortnight.
Clinic: new – November '97, no separate gender entry/space but one room is shared as men's health/doctor's room.
Vehicles: 1x 2years(October) troop carrier that is in good condition.
Staff Accommodation: 1 house.
Airstrip: closed for short periods after rain. Will drive to Wadeye for larger airlift to Darwin.

Out-stations

There is no funding for out-station visits or medical supplies but often people from Woodycupaldiya (40km) use the service on a visiting basis. Outstations of Merrepin (1/2 hour by air), Nemaluk and Wudapuli tend to relate to either Palumpa or Peppimenarti (see below).

Peppimenarti

Location: 320km SW of Darwin. It is 4.5+ hours drive and 1 hour flight to Darwin.
Population: 350
Languages: Ngangikkurrungurrurr, Nangowmeri, Marrashabin, Marradun.
History: the community was established as an out-station of Daly River mission in 1972.
Land Tenure: secure.
Communications: national telephone network.
Access: unsealed access roads are cut off during the wet for up to 3 months.
Current Health Services: the Council has a SA with THS. There is no health committee.
Staff: RNL3B x 1, AHWs nil, DMO visits fortnightly.
Vehicles: 1995 troop carrier.
Staff Accommodation: 1x3br house in good condition.
Airstrip: unsealed.

Out-stations

The outstations that relate to Palumpa and Peppimenarti are:

- Merrepen (Matapan)
- Nemarluk
- Emu Point
- Wudapuli

These are all permanently occupied (Category 1) and have a combined population of 150. Emu Point associates particularly with Peppimenarti, but the others relate to both Peppimenarti and Palumpa. None receive visiting services.

Nardidi (Nadirri) is a Murin Association out-station and relate to Wadeye, but use Peppimenarti health services. Paradale (Perrederr) is a Yantjarrwu outstations and relate to Woodycupaldiya, but use Peppimenarti health services.

Pine Creek

Location: 90km N of Katherine. It is in THS Katherine District. It is 1 hour to Katherine.
Population: 100 Aboriginal, 461 non-Aboriginal plus tourists.
History: 550.
Communications: national telephone network.
Access: all year.
Airstrip: at Katherine.
Current Health Services: THS.
Staff: AHWs x1, RN x 2, Private GP from Katherine 1 day a week.
Clinic: good condition but has no separate gender entry/space or computer.
Vehicles: 1x4wd.
Staff Accommodation: 1x 2br flat in fair condition.

Out-stations

- Pine Creek Compound;
- Kybrook Farm.

Both are permanently occupied (Category 1) with a combined population of 75, and receive no visiting health service.

Wadeye – Port Keats

Location: 500km SW of Darwin, 7 hours by road, 50 mins by air, there is a barge (16 hours, monthly) from Darwin.
Population: 2,200
Languages: Murinpata, Murincair, Muringar, Murinjabin, Murinamoor, Jamajung.
History: the Catholic Church established a mission here in 1935.
Land Tenure: secure – Aboriginal land.
Communications: national telephone network.
Access: road can become impassable at the river crossings and may be cut off for up to 5 months. Barge access as well.
Current Health Services: THS delivered service. Was previously a SA service (until 1.3.1996). NTRHWFA proposed doctor. There is no health committee. The Council receives a grant from THS to run a environmental health program.
Staff: AHWs x 4.7, AHW x 1.5, AHW x 1.25, AHW x 2 trainees, RNL3A x 5, AOx2, 2 cleaners, 1 driver – CDEP; DMO visits 2 days a week.
Clinic: good condition, no separate space.
Staff Accommodation: 4x 2 br units in good condition (lack of accommodation).
Airstrip: good, new bitumen.

Out-stations

- Ditchi (Dithi, Ditji)
- Fossil Head
- Kubuyirr
- Kudantiga
- Kultchill (Kulthil)
- Kuriyippi
- Kuy
- Nadirri (Nadidi)
- Nangu
- Ngardinitchi (Ardinitchi, Ngardinith)
- Ngarinthi (Wumarr)
- Ngunthak
- Old Mission
- Table Hill
- Tchindi
- Wumirdin
- Yederr

Many of these outstations have had their communications recently upgraded for radiophone usage and VJY will be out of use by Dec '99. None of the out-stations receive a regular visiting health service. There is no direct communication to the clinic but there is a radiophone to the Murin Association.

Five outstations are permanently occupied (Category 1), four are occupied most of the time (Category 3), 1 is unoccupied during the wet (Category 4), 2 are occupied on weekends and/ or holidays (Category 6), 2 are permanently unoccupied (Category 7), and 3 are unoccupied temporarily due to sorry business or other cultural matter (Category 2). The combined population is 255.

All of these are serviced by gravel roads to Wadeye of varying quality. Many rely on two-way radios rather than telephones. However, telephones are becoming increasingly standard.

The following outstations have no airstrip:

- Ditchi (Dithi, Ditji)
- Kudantiga
- Kultchill (Kulthil)
- Kuriyippi
- Nangu
- Ngardinitchi (Ardinitchi, Ngardinith)
- Ngarinthi (Wumarr)
- Ngunthak
- Old Mission
- Table Hill
- Wumirdin

Outstations receive visiting services in extreme emergencies only. As seen above many do not have an airstrip. Tchindi and Yederr have access to airstrips, but they are more than 10 km away.

Nadirri (Nadidi), Kuy, Ngarinthi (Wumarr), Ngunthak, Old Mission, Tchindi, Wumirdin and Yederr have boat access to Wadeye.

All of these outstations have gravel and/ or dirt access roads which are impassable at times during the wet season.

Ditchi (Dithi, Ditji) , Kubuyirr, Kudantiga, Kuriyippi, Ngardinitchi (Ardinitchi, Ngardinith), Ngarinthi (Wumarr), Old Mission, Wumirdin, and Yederr have no telephone and rely on 2 way radio for communication. The rest, except Kultchill (Kulthil), Nangu and Table Hill have telephones.

An alcohol awareness program run by A&IAAFR operates at Ngardinitchi (Ardinitchi, Ngardinith).

Woodycupaldiya

Location: 380 km SW of Darwin. 5 hours drive and 50 mins flight to Darwin, 2-4 hours drive to Daly River. School.
Population: 30
Languages: Marrathiel.
History: established as a family out station from Daly River in 1983. There is no store.
Land Tenure: secure – Land Trust.
Communications: national telephone network.
Access: dirt access road to Daly River gets cut off in the wet.
Current Health Services: THS
Staff: AHW x 1, DMO visits 6 weekly.
Clinic: new health clinic, no separate gender entry/space or computer.
Vehicles: 1x 4wd.
Staff Accommodation: 2-bedroom house owned by the Resource Centre and furnished by THS.
Airstrip: unsealed which becomes inaccessible for short periods in the wet.

Out-stations

- Banakula
- Chuluk
- Deleye
- Jurong Springs
- Kelerrk (Kwombom)
- Kuwuma (Kuama, Kwarma)
- Leichart
- Mulingi (Mulingne)
- Paradale (Perrederr)
- Nordik
- Sabina (Mungalindi)
- Uminuluk (Tommy's Out-station)
- Un-Marr (An-Marr, Mardinga, Mardingna, Marygar, Marengar)
- Wudaduk (Murradum)

Seven of these are permanently occupied (Category 1), one is unoccupied due to cultural matters (Category 2) three are occupied for more than half the time (Category 3), two are not occupied during the wet season (Category 4) and one is occupied less than half the time (Category 5).

The combined population of the outstations is 100. All have access to other centres via unsealed roads, many of which are often washed out in the wet.

Chuluk, Deleye, Mulingi (Mulingne), Sabina (Mungalindi), Paradale (Perrederr) and Un-Marr (An-Marr, Mardinga, Mardingna, Marygar, Marengar) have an airstrip. Wudaduk (Murradum) uses the Un-Marr airstrip, but the others lack access.

There are telephones at Banakula, Chuluk, Deleye, Kelerrk (Kwombom), Mulingi (Mulingne), Nordik, Sabina (Mungalindi), Un-Marr (An-Marr, Mardinga, Mardingna, Marygar, Marengar) Paradale (Perrederr) and Wudaduk (Murradum). Others rely on radios.

Banakula, Deleye, Kelerrk (Kwombom), Kuwuma (Kuama, Kwarma), Mulingi (Mulingne), Sabina (Mungalindi), and Wudaduk (Murradum) receive a monthly visiting clinical service. The others must travel to Woodycupaldiya, Palumpa or Peppimenarti for any access the health services.

4. West Arnhem HSZ

These communities are in the Jabiru ATSIC and the West Arnhem NLC regions and the THS Darwin Rural District.

Jabiru

Location: 250 km E of Darwin, 2.5-3 hrs drive, 40-60 mins by air.
Population:
Languages: Guluninku, Mialli.
History: Jabiru is now a mining town (Ranger Uranium mine).
Land Tenure: situated in Kakadu National Park.
Communications: telephone, fax, 2 way radios in hilux.
Access: road can be closed for short periods. Deaf Adder road closed early in wet. Cannon Hill, people boat to Mudginberri then drive to Jabiru.
Current Health Services: Combination - SA between THS and Djabulukgu Association. There is an NTRHWFA RAG for a doctor. THS employ other staff except for a private GP who has an arrangement with ERA to visit the mine weekly. There is no health committee.
Staff: AHWs – 1M, 1F; RN x 4.2, doctor and private GP.
Clinic: THS hospital-like building that is not used as such, THS fund the running costs of the building. There is no separate gender space.
Vehicles: 1 hilux – this was a part grant from THS, 4wd station wagon (doctor's vehicle which was previously leased through Ranger royalties).
Staff Accommodation: the service is currently leasing a doctor's house from ERA, AHWs rent town council houses. Accommodation is a major problem here. 3 leased 5 required.
Airstrip: large all weather sealed landing strip.

Town Camps and Outstations

- OO9
- Cannon Hill
- Deaf Adder (Golondjorr)
- Djirbiyak (Whistle Duck)
- Hunters (Kurrajong)
- Kapalga
- Manaburduma
- Mudginberri (Madjinbardi)
- Mumukala
- Nourlangie
- Paradise Farm
- Patonga-Airstrip
- Patonga-Homestead
- Red Lily (Gina, Ginda)
- Spring Peak
- East Alligator

Thirteen of these are permanently occupied (Category 1), one is not occupied during the wet (Category 4 and is not occupied at all (Category 7). One of these is a Town Camp of Jabiru.

The combined population is 325.

All receive visiting health services fortnightly from Jabiru.

None of these out-station shave airstrips, although one is 5km from an airstrip.

Manaburduma, Mudginberri (Madjinbardi), Cannon Hill (East Alligator), Mumukala, Paradise Farm, Patonga-Airstrip, Patonga-Homestead, Nourlangie, Red Lily/Gina, and Hunters (Kurrajong) have a telephone, whilst the others rely on radios.

The outstations are up to 100kms from Jabiru, and most have significant distances of unsealed road to traverse.

Minjilang (Croker Island)

Location: NE side of Coburg Peninsula, 230km NE of Darwin and a 35min-hr flight.
Population: 250
Languages: Iwaidja, Marrgu, Gunwmggu, Maung and Walang.
History: the Methodist Overseas Mission established this community in 1940 when 'Stolen Generation' children were brought to here from all over the NT . In 1967 the children were fostered out to Darwin and Minjilang was handed over to the traditional owners.
Land Tenure: secure – lease arrangement under negotiation with traditional landowner.
Communications: satellite phone and national telephone network.
Access: airstrip 7km from town on unsealed gravel road across a flood plain that closes occasionally, boat/barge access.
Current Health Services: SA with THS.
Staff : AHWs x 2, RNL3B x 1, DMO x 1 day per fortnight.
Clinic: in good condition but no separate gender space or computer.
Staff Accommodation: 1 new 2br house.
Airstrip: 7km from town on unsealed gravel road across a flood plain- access cut off in wet. Closes occasionally.

Out-stations

The outstations relating to Minjilang include those on Croker Island as well as those on the Mainland.
Croker Island outstations include:

- Adjamarragu
- Allamirra
- Irgul
- Keith William's Outstation
- Mariah
- Marramarrani
- Sandy Bay
- Walga
- Wanakutja
- Wilgi (Waningi, Wilji)

Of these five are permanently occupied (Category 1), two are not occupied during the wet (Category 4) and three are only occupied on weekends and holidays (Category 6). The combined population of these outstations is 80.

All use the airstrip at Minjilang and seven have access to a phone, with the other two relying on radio. All are fairly close to Minjilang, but roads are poor and cut off in the wet. Boat access is available to coastal outstations.

A DMO visits Black Point and Cape Don 6 weekly but there is no visiting service or schools at the out-stations.

Mainland Outstations include:

- Annesley Point
- Araru Point (Araru)
- Gul Gul
- Gumeragi (Gumaragi)
- Murganella
- Tiger's Outstation
- Black Point
- Cape Don

Of these seven are permanently occupied (Category 1) and one is used at weekends and holidays (Category 6). The combined population is 95.

Cape Don and Black Point have airstrips, whilst others do not. Five of these out-station s have a phone, whilst the others rely on radios.

A DMO visits Black Point every 6 weeks, and visits Cape Don irregularly. Others receive no visiting health service.

Oenpelli – Kunbarllanjnja

Location: 330kms E of Darwin and 60km NNE of Jabiru on the East Alligator river. It is 3.5-4 hours drive and 45mins flight to Darwin and 20mins flight to Jabiru.
Population: 1000
Languages: Kunwinjku.
History: the community was settled in 1906 as a cattle station and then was handed over to the Anglican CMS in 1926. The Aboriginal community council was established in 1972.
Communications: There is phone, fax at Oenpelli also a satellite phone. O/S has phones and radios through to Demed.
Access: the river is tidal and isolates the community in the wet. The road is cut December-April.
Current Health Services: Combination – THS, OATSIH fund Demed for an OS nurse and then Demed purchase the service from THS by a contract. A doctor is employed by the Council. Prior to this arrangement Oenpelli had a SA with THS. There is a health committee that includes people from Demed and Kunbarllanjnja Council. OATSIH fund a management-training course which is actually a Local Government course but which includes health information. CDEP is also used to employ staff. The Council receives a grant from THS to run a nutrition program.
Staff : AHWs: 2 female, 1 male; Nurses: 3 female, 1 male; Doctors: 1 female. All are located at Oenpelli but one RN & AHW are employed to service O/S. Other employees include a cleaner, driver and receptionist and 4 other people do odd jobs – these are funded by CDEP.
Clinic: a Hospital which was built ?early'70s complete with leprosy baths, ward type arrangement. There are areas for emergency, men's health, women's health, AHW room, reception, drug store, staff room, baby clinic, offices and a morgue. It was possibly funded by the Commonwealth but it is now a THS asset. THS are going to provide funding for the clinic refurbishment as it is greatly in need of such. It easily gets grotty, maintenance has been difficult – recently there was a leaking roof that poured water into the emergency room, near wires etc and producing copious amounts of mud on the floor.
Vehicles: 1 Troop carrier converted to ambulance 12/12 good condition, has cupboard in back so can only transport 3 people; another troop carrier; OATSIH funded a hilux for O/S program.
Staff Accommodation: staff rent 4 good houses from Lands and Housing but one staff is housed in a very small flat. The council is going to build a doctor's house.
Airstrip: may not be used by larger planes in the wet so evacuations will be taken to Jabiru.

Out-stations:

- Gamargan (Gamargawan)
- Goomadeer
- Gudjekbin (Gudjerbinj)
- Gumarirnbang (Gumarinbarn)
- Gurrhgurr (Table Hill)
- Kikiyown (Kikikyowh)
- Kungarrewarl (Clancy's)
- Malgawa
- Mamadawerre
- Mandilbarreng (Mandalbareng)
- Mangardubu (Mangardabu)
- Manmoyi
- Marlwon (Kikikyowh, Lady Dreaming)
- Mikginj Valley (Mikinj)
- Nabarlek
- Namugardubu

Nine of these are permanently occupied (Category 1), one is temporarily unoccupied due to cultural matters (Category 2), one is occupied less than half the time largely due to lack of services (Category 5), three are used only on weekends and holidays (Category 6), one is permanently unoccupied (Category 7) and one is being planned but not yet occupied (Category 8).

The combined population is 360.

A nurse visits each out-station once a month and a doctor visits each out-station every 10 weeks. All of the outstations, except Mandilbarreng (Mandalbareng) receive these visiting health services. None of the out-stations has a clinic and no pharmaceutical or other clinic supplies are kept at the outstations. However Gumarirnbang (Gumarinbarn) have a room dedicated for clinic use.

Gamargan (Gamargawan), Gudjekbin (Gudjerbinj), Gumarirnbang (Gumarinbarn), Gurrhgurr (Table Hill), Malgawa, Mamadawerre, Manmoyi, Marlwon (Kikikyowh, Lady Dreaming), and Namugardubu (Namagarrarbu) have airstrips but are only able to be used during daylight.

Goomadeer and Mikginj Valley have old airstrips which are unused. The rest have no airstrip. The outstations are from 40 to 250kms from Oenpelli. Roads are of varying condition, but are generally dirt roads which get cut off in the wet.

Goomadeer Kikiyown (Kikikyowh), Mikginj Valley (Mikinj) and Nabarlek have no phone or radio. Gurrhgurr (Table Hill), Kungarrewarl (Clancy's), Mandilbarreng (Mandalbareng) have no telephone and rely on radio. Others have telephones.

There are schools at Gumarirnbang (Gumarinbarn), Mamadawerre, Manmoyi, and Namugardubu (Namagarrarbu). As well, Gudjekbin (Gudjerbinj) has an unrecognised school.

Warruwi

Location: it is located on the eastern side of South Goulburn Island 300km NE of Darwin and 150 km NE of Jabiru, 1-hour flight to Darwin.
Population: 340
Languages: Maung, Galpu.
History: originally established in 1916 as a Methodist mission but since the early '70's has been managed by the Warruwi Community Inc.
Communications: phone, fax, satellite phone.
Current Health Services: SA with THS. RN has admin load, bookkeeping done by Council town clerk. The establishment of a Health Board has been discussed here with a suggestion of joining up with and wanting to join up with Minjilang (unconfirmed).
Staff : AHW x 3, RNL3B x 1, DMO visits fortnightly.
Clinic: new. Separate male /female space.
Vehicles: 1.
Airstrip: often closed in the wet.

Out-stations

- Amadji Balk (Amatjatbalk)
- Arla (Aria)
- Ararlagu (Illiaru)
- Ngarlu Ngarlu
- Injalatparri
- Ngijipin (Ngijbin)
- Wigu
- Arnorran
- Waminara Bay

Three of these outstations are permanently occupied (Category 1), three are temporarily unoccupied due to cultural matters (Category 2), one is occupied less than half the time due to lack of services (Category 5), and two are occupied only on weekends and holidays (Category 6).

The combined population is 55.

Only Ararlagu (Illiaru) has access to an airstrip. Arnorran has access to a phone, but the others rely on radios. All are less than 1 hour by road to Warruwi, but the roads are unsealed and difficult at times in the wet. There are no routine health visits to these out-stations.

There are two other outstations in this Zone which do not obviously relate to the major communities. These are:

- Inngirnatj
- Waidaboonar (Waidabonoor)

One is only occupied during weekends and holidays (Category 6), and the other is temporarily unoccupied due to cultural matters (Category 2). One of these has a day only airstrip and telephone.

5. Maningrida HSZ

Maningrida is in the Jabiru ATSIC region, the West Arnhem NLC region and the THS Darwin Rural District.

Maningrida

Location: on the Arnhem coast at the mouth of the Liverpool River. It is 550km (6-10 hours drive) E of Darwin, 300km by air 50 mins –1.5 hours flight to Darwin (some planes take 3 hours as it is part of a milk run). The road is unsealed and may be cut off in the wet. It is 150km to Ramingining and a 4-hour drive from Oenpelli (250km).
Population:
Languages: Mabarnard/ Djukurridjii, Kunbarlang, Nakkara, Burarra, Kuninjku, Gorrgon, Djinang, Gupapuyngu.
History: the community was established in 1957 as a trading centre.
Communications: national telephone network.
Access: road and coastal barge, it is not accessible by road in the wet.
Current Health Services: combination –THS. Doctors are employed by the Bawinanga Aboriginal Corporation. The Council receives a grant from THS to run an environmental health program.
Staff : 1x RNL3B, 7xRNL3A, 4 x AHW, 1 x AHW trainee (Abstudy), MO x 2; AHWx1 on long service leave, 3 males employed on CDEP who want to undertake training next year.
*Clinic :*OATSIH has funds for new clinic.
Vehicles: 2 x 4wd, 2wd ute.
Staff Accommodation: 5 x 1 br flats, 2 x 2 br units, 4x 3 br houses.
Airstrip: sealed with navigational lights.

Out-stations

- Ankabadbirri
- Barrihdjowkkeng
- Benamanka Gunora
- Bolkdjam
- Buluhkaduru
- Damdam
- Gamardi
- Gamarru Guyurru (Gamarru Guyurru)
- Gochan Jiny-jirra
- Gorrong-Gorrong
- Gupanga
- Guyun
- Ji-balbal
- Ji-bena
- Ji-malowa
- Ji-marda
- Kabalyarra
- Kakodbebuldi
- Korlobidahada
- Kumurlulu
- Kurrurldul
- Mandedjkadjang
- Mankorlod
- Marrkolidjban
- Miwirnbi
- Milmilngkan
- Mumeka
- Nadilmuk
- Nakkalamndjarda
- Namarladja
- Nangak
- Djinkarr
- Wurdeja
- Yaminyi
- Yikarrakkal (Kubum)
- Yilan
- Berraja
- Birriba
- Djakalabona
- Garrabu
- Naqarla
- Ndjudda

Twenty Nine of these are permanently occupied (Category 1), two are temporarily unoccupied due to cultural matters (Category 2), ten are occupied only on weekends and holidays, and one is in the process of being developed and is not yet occupied (Category 8).

The combined population is 815.

A nurse visits the outstations monthly and a doctor visits every 3 months. Emergency visits are made when indicated.

Gamardi, Gamarru Guyurru, Ji-balbal, Ji-marda, Malnjangamak, Mankorlod, Marrkolidjban, Mumeka, Nangak (4kms away), Yilan have access to an airstrip. Ankabadbirri, Barrihdjowkkeng, Bolkdjam, Damdam, Gamardi, Gamarru Guyurru, Gochan Jiny-jirra, Ji-balbal, Ji-bena, Ji-malowa, Ji-marda, Kakodbebuldi, Korlobidahada, Kurrurldul, Malnjangamak, Mandedjkadjang, Miwirnbi, Mumeka, Nangak, Djinkarr, Wurdeja, Yikarrakkal (Kubumi) and Yilan have telephones. Others rely on radios or have no communication system.

Again the roads are unsealed and sometimes impassable in the wet.

Gamardi, Gamarru Guyurru, Ji-malowa, Ji-marda, Kakodbebuldi, Korlobidahada, Malnjangamak, Mankorlod, Marrkolidjban, Mumeka, Wurdeja, Yikarrakkal (Kubumi), and Yilan have a school.

Malnjangamak access services at both Maningrida and Ramingining. Gamarru Guyurru access services at both Maningrida and Milingimbi.

6. North East Arnhem HSZ

These communities are in the Miwatj ATSIC region the East Arnhem NLC region and the THS East Arnhem District.

Nhulunbuy

Nhulunbuy, a mining town, is the largest community in the region with about 4000 residents and is the administrative centre of the region for the NT and Federal Governments. It is situated on the east coast of Arnhem Land on the Gulf of Carpentaria about 600km west of Darwin. The town was built on a special town lease on Aboriginal land specifically to service the Nabalco bauxite mine, which began operations in 1971. The town takes its name from Nhulun (Mt Saunders), a prominent feature in the middle of the town.
The airport is 13km from the town by bitumen road. The town is also connected with Aboriginal communities in the region by road (usually only passable during the Dry). The Bulman Track connects Nhulunbuy and Katherine - a 700km journey - but is impassable during the Wet season.
Nhulunbuy has a 30-bed hospital with emergency, surgery and obstetric facilities as well as a private medical centre.
Population: 140 (Aboriginal population only counted)
Languages: Gumatj
Communications: national telephone network.
Access: no road access in the wet.
Current Health Services: ACCHS - Miwatj Health.
Staff : 5 & 1 trainee doctors; 3 AHWs.
Services: there is a clinic at Miwatj; one doctor is based at Gapuwiyak, one does 2 days a week with Laynhapuy, 6 mornings a fortnight at Gunyangara, Galiwinku and Numbulwar.
Clinic: no separate gender entry. There is a computer system that is currently being changed over from Health Planner to Ferret.
Vehicles: 4x4wd, 1x station wagon, 2x4wd utes.
Staff Accommodation: staff accommodation is rented.

Town Camps and Outstations

- East Woody (Galaru)
- Ruwakpuy (Bremer Island, Dhambaliya)

These are permanently occupied (Category 1). Miwatj Health visits one community regularly. They have a combined population of 35.

Galiwin'ku - Elcho Island

Galiwin'ku is the major community on Elcho Island; the island is about 3km off the Arnhem Land coast, 500km East of Darwin(1.5 hour flight) and 150kms west of Nhulunbuy(30-45 min flight). Situated on the south-west of the island, it is the service centre for a number of homelands on Elcho, adjoining islands and the mainland.
It is the largest Aboriginal community in North East Arnhem Land. The total population of community and homeland people is close to 2000, more than 60 per cent of who are under the age of 40. During the wet seasons the community supports approximately 1600 people and the homelands have approx. 400 people. In the dry season the community decreases to approx. 1300 and the homelands increase to 700 people approx. There are about 50-100 non-Aboriginal people living on the island
The first language of many of the people is the Yolngu language Djambarrpuyngu, although up to 16 language groups live in the area.
Galiwin'ku was set up as a mission station in 1942 by the Methodist missionary Harold Shepherdson and there is still a strong Christian influence along with strong Yolngu culture. Alcohol is not allowed on the island or on any adjoining islands. Concerns have raised by the council and Resource centre about the lack of health service to the Homelands as well as the private financial burden imposed on people when they have to seek medical assistance.
Galiwin'ku is also one of the most frequently visited communities in the Miwatj region, not only government people but also anthropologists, artists, musicians, Christian groups, writers and researchers.
Population: 1400
Communications: Local, phone, fax, satellite phone, cars have 2 way radios to the clinic. Some out-stations have telephones.
Access: all year by air. Access is limited. There is a very poor unsealed access road from Galiwin'ku and is unpassable on the north half of the island in the wet. There is a weekly barge service.

Current Health Services: combination – the Council has a SA with THS, there is a RAG for the doctor, Miwatj provide a doctor 2/7 a week and Rural Health Support, Education and Training (RHSET) fund an educator. Marthakal Homelands is an approved RCI site. The Council receives a grant from THS to run SWSBSC program.
Staff : there is a flexible rostering system based on 10 AHWs funded for 60 hours a fortnight. 3 of these are male (tend to be harder to retain). All are registered. 3 NURSES one of whom are male; 1 female doctor based at Galiwinku funded by NTRHWFA ($60,000 the other $60,000 has to be raised through Medicare). Miwatj provide a male doctor 2/7.
Clinic: The current clinic was built in 1970 by the Army and no one (THS, Lands and Housing or the Community Council) knows who is responsible for the on going maintenance and capital works - it needs constant R&M. There is confusion over who is responsible for this as THS state Lands and Housing is responsible. THS has given the clinic capital money for maintenance and repairs. The clinic has space for men's, women's, babies health, an emergency room and kitchen and there is separate entry for male/female.
Vehicles: 1 troop carrier/ambulance 6/12 old; another troop carrier used by AHW on call, round town, bush trips, 1 caged hilux used round town and a doctors car provided by NTRHWFA and used for clinic and doctor's private use.
Computers: They have been using Miwatj health planner system for 5 years – has been good as has made finding files much easier (went from alphabetical to numerical system) but needs good and constant data entry. They are now changing over to Ferret. Miwatj provide maintenance support.
Staff Accommodation: Heritage listed owned by council and built by the church. There has been no maintenance for a long time and need minor capital works as has white ants. Council owns a prefabricated house 5-10 years old and another 3 bedroom house is provided by Lands and Housing but THS provided the furnishing for this.
Airstrip: good sealed airstrip, with all weather access. Lighting for 24 hour operation.

Other Funding: RHSET has funded a community health educator's position for the last 3 years which rans out in July. Submissions had been presented to THS but there was been disagreement about whether the $ went to the council or to the Health Service. RHSET has since provided funding to continue the position.
Communications: Local, phone, fax, satellite phone, cars have 2 way radios to the clinic. Some homelands have telephones.

Marthakal Homelands

Marthakal Homeland Resource Centre is currently responsible for 34 Homelands in the area with approx 50% occupancy all year round. Most of the homelands are small islands with little or no access ie airstrips, roads or sea access.
Elcho Island - due to the combination of the poor access road and the proximity to town, these homelands do not appear to be occupied all year round.
Mainland - These tend to be permanently occupied but have very basic living conditions.
Wessel Islands -the main issue for this location is the remoteness and cost of access to Galiwinku.

Marthakal has a significant transportation cost in servicing the homelands due to their remoteness from Galiwinku and/or the limited and sometimes poor access. Some of the Homelands do not have airstrips. There is a very poor unsealed access road from Galiwin'ku. The road is unpassable on the north half of the island in the wet. Some airstrips are also closed due to rainfall. Seas are often rough during heavy cyclonic rainfall.
Many homelands people are still living in town due to a lack of access to services at the homelands. Many people who are frail, ill or disabled live in Galiwin'ku because their families fear the consequences of not being closer to medical services.
Current Health Service: nil. Has been approved as an RCI site.
Staff: nil
Clinic: no facilities in any of the communities.
Communication: ten Homelands have satellite phone, not all are operable at any given time. Two Homelands have radios that may or may not work.
Emergency situation: homelands with airstrips will make contact with Marthakal Homeland Resource Centre or give a message to Galiwin'ku Health Clinic, the current practice is that they pay for own charter.
Staff Accommodation: nil.

Homelands

Western Mainland and Islands

The Homelands here are:

- Bularring (Bularriny, Bularrinyur)
- Garriyak (Garriyakngurr)
- Mapurru
- Nikawu (Nikawungyura)
- Nganmarra
- Djiliwirri
- Gamarrwa

One of these is permanently occupied (Category 1), two are temporarily unoccupied due to cultural matters (Category 2), one is occupied more than half the time (Category 3), two are occupied less than half the time (Category 5) and one is permanently unoccupied (Category 7). The combined population is 50.

Garriyak (Garriyakngurr) and Mapurru have unsealed airstrips. All have boat access.

There is a school at Mapurru. There are telephones at Garriyak (Garriyakngurr) and Mapurru with the others either relying on radios or having no communication technology.

Garriyak (Garriyakngurr) have only makeshift dwellings and must cart water by wheelbarrow for 500metres.

Eastern Mainland and Islands

- Dholtji
- Gikal
- Gonguruwuy
- Gallirra
- Gurundu
- Mallarrami
- Mata Mata
- Mudhamul (Muthamul)

One is permanently occupied (Category 1), four are temporarily unoccupied due to cultural matters (Category 2), one is not occupied during the wet (Category 4), one is only occupied at weekends and holidays (Category 6) and one is not occupied at all (Category 7). The combined population is 55.

Mata Mata has a short, unsealed airstrip, and the airstrip at Mudhamul (Muthamul) is being repaired. Mata Mata and Gonguruwuy have telephones. Others either rely on radios or have no communication system.

Gonguruwuy and Mudhamul (Muthamul) have been selected for infrastructure development by the ATSIC-Army Community Assistance Project.

There is a school at Mata Mata.

North Homelands

- Gulmarri (Galumarri)
- Nyekala
- Rorruwuy

One of these is permanently occupied (Category 1), one is temporarily unoccupied due to cultural matters (Category 2) and one is not occupied at all (Category 7). The combined population is 30.

Rorruwuy has an unsealed airstrip which needs repair. Rorruwuy has a school and a telephone. The others rely on radio or have no communication system.

Nyekala has been selected for infrastructure development by the ATSIC-Army Community Assistance Project.

Elcho and Northern Islands Homelands

- Dhayirri (2nd Creek)
- Dhudupu
- Galawarra
- Ngayawilli
- Dhambala

Two of these are permanently occupied (Category 1), and three are occupied more than half the time (Category 3). The combined population is 65.

None have airstrips or telephones. Galawarra and Ngayawilli have been selected for infrastructure development by the ATSIC-Army Community Assistance Project.

Central Homelands

- Banthula, (Bamdhula, Bant'tla)
- Dharawa (Dharrwar)
- Djurranalpi
- Ganpurra (Ganpura, Bapulu)
- Gitan
- Gawa
- Galingar
- Martjanba
- Nanyinburra
- Wunpurri
- Yirringa
- Watdagawuy

Four of these are permanently occupied (Category 1), three are temporarily unoccupied due to cultural matters (Category 2), three are occupied more than half the time (Category 3), one is only occupied on weekends and holidays (Category 6) and one is not occupied at all. We have no information about one location. The combined population is 140.

Martjanba has a very short airstrip, with the others having none. Banthula, (Bamdhula, Bant'tla), Dharawa (Dharrwar), Djurranalpi, Ganpurra (Ganpura, Bapulu) and Gawa have telephones with the others relying on radios or having no communication system. Dharawa (Dharrwar) has been selected for infrastructure development by the ATSIC-Army Community Assistance Project.

There is a school at Banthula, (Bamdhula, Bant'tla), Djurranalpi and Gawa.

Gapuwiyak – Lake Evella

Gapuwiyak is home to more than 650 people, but is the centre of a population of up to 800 Yolngu living in the community and in surrounding homelands. The community's name means "salty water" and it is located on the shores of Lake Evella. The lake was named by Harold Shepherdson and TT Webb, Methodist Church missionaries, after their wives Eve and Ella. Gapuwiyak was originally a Galiwin'ku out-station but was permanently settled by 1968.
The community is off the Bulman Track but is connected by road with it and with Nhulunbuy and smaller Arnhem Land communities during the Dry. They are impassable during the Wet.
Gapuwiyak is run by a community council, which is responsible for community affairs as well as the usual NT local government activities like roads, garbage collection, water and power. The barge only comes in twice a month to a landing on the Buckingham River 23 km away from the community.
Location: It is 40km inland adjacent to Lake Evella and the Buckingham River. It is 220km west of Nhulunbuy - a 3 hour drive and a 25 min flight.
Population: 500
Languages: the main languages spoken are the Yolngu languages Djambarrpuyngu, Dhalwangu, Manharmgu and Djapu.
Communications: phone fax, O/S program has satellite phone.
Current Health Services: combination - THS (previously SA), OATSIH funds the Homelands program, Miwatj employ a doctor. There is no health committee. The Council receives a grant from THS to run SWSBSC program and the Education centre receives a grant from THS to run a nutrition program.
Staff : MO x 1, RNL3A x 2, AHWs x 3 ; RNL3A x 1, AHWx1 (Homelands).
Clinic: originally a small bush clinic for which there was money for additions for some years. Transport and Works responsible for this and recently organised a contractor who came in and half finished the job which he left then another contractor came in and half finished what was half finished so it is now three quarter finished. Another new contractor is about to start. Transport & Works have lost about $500,000 on this. Once finished it will be reasonably spacious and functional but at this stage they have no funding for equipment or furniture. There is a completely separate men's health clinic. Since this was established male attendance has risen by 600%.
Vehicles: -1 homelands troop carrier fitted with supplies, equipment and satellite phone; clinic ford transit, 2wd van/ambulance – will take a stretcher; old battered troop carrier used by male AHW.

Staff Accommodation: AHWs live in Aboriginal housing which is of poor standard. Nursing accommodation is a problem. When the service was SA Health Centre the Council had to supply housing so they rent off the Council. The accommodation is small and old and the worst standard out of all non-Aboriginal staffing in the community. THS is currently building a duplex which would house 2 families which is not the best solution. The service has had 6 different relief charge nurses in the last 12 months. The doctor has 3 bedroom house on a separate block of land.
Airstrip: not sealed and occasionally closed in wet.

Homelands

- Balma
- Burrum (Bulakator)
- Dhupuwamirri (Mare)
- Donydji (Doindji, Donidji)
- Mirrnatja (Mirrngatja)
- Raymangirr (Ramangirr)
- Yalakun (Yarringurr, Yarri)
- Baygurrtji (Baykurrtji, Bagurritji)
- Barrnyinura (Barge Landing, Bunhunara, Bunhungara)
- Dhamiyaka
- Dhunganda (Djugunda)
- Garrata
- Naliyindi (Nalyindi, Naliyinji)
- Warranyin

Seven are permanently occupied (Category 1), one is temporarily unoccupied due to cultural matters (Category 2), two are unoccupied during the wet (Category 4), three are occupied less than half the time (Category 5) and one is only occupied on weekends and holidays (Category 6). Combined population is 170.

Occupied homelands are visited by an AHW & RN half a day a fortnightly. The doctor visits irregularly. Visits occur via road in the dry and air in the wet. Out-stations have red first aid boxes which are refilled on visits. Dhupuwamirri (Mare), Donydji (Doindji, Donidji), Mirrnatja (Mirrngatja) and Raymangirr (Ramangirr) have clinics. Naliyindi (Nalyindi, Naliyinji) and Dhunganda (Djugunda) receive no visiting service.

Balma, Burrum (Bulakator), Donydji (Doindji, Donidji), Mirrnatja (Mirrngatja), Raymangirr (Ramangirr), Yalakun (Yarringurr, Yarri), Baygurrtji (Baykurrtji, Bagurritji), Garrata and Naliyindi (Nalyindi, Naliyinji) have an airstrip. Dhupuwamirri (Mare) also has an airstrip, nut it is not accessible in the wet. Seven homelands have no telephone.

Yalakun (Yarringurr, Yarri) and Raymangirr (Ramangirr) have a school.

Gunyangara – Marngarr (Ski Beach, Drimmie Head)

Gunyangara is a small community on the shores of Melville Bay about 10km from Nhulunbuy. It is an island joined to the mainland by a causeway and 10 mins drive to Nhulunbuy.
It is the home of Gumatj people and has a population of between 200 and 450, depending on the season. It originally started as a Gumatj out-station from Yirrkala but has grown from the mid-1980s onwards. Gunyangara is managed by Marngarr Community Government Council and is also the home of the Gumatj Association, which receives royalties from the mine and runs homeland support and a crocodile farm. It is serviced by Nhulunbuy.
Population: 300
Languages: Gumatj.
Access: all year round.
Current Health Services: combination, both OATSIH and THS have SAs with the Marngarr Council – there is no health committee.
Staff : RN x 1. Miwatj doctor visits 6 mornings a fortnight.
Clinic: to be refurbished, no separate gender space/entry.
Vehicles: 1x4wd.
Staff Accommodation: nil.

Homelands

- Dhanaya
- Daliwuy
- Galupa (Kings Village, Yudu Yudu)
- Wallaby Beach
- Ninikay (Nyinyikay)

Two are Permanently occupied (Category 1), one is occupied less than half the time due to lack of services, and two are either a transient camp only or occupied on weekends & holidays only. (Category 6). The combined population is 80.
Ninikay (Nyinyikay) has an airstrip. All receive visiting health services when occupied.

Milingimbi

Milingimbi is an island community half a kilometre from the mainland in the Crocodile Islands which lies off the northern Arnhem Land coastline about 440kms east of Darwin and 180km west of Nhulunbuy. The island measures about 5 by 1lkms, is quite flat and is surrounded by mangroves. It is a 40 min flight to Nhulunbuy.
The community is run by a community council. Milingimbi is a dry community.
Population: 800
History: The land is originally Burarra land, but people from the other language groups were encouraged to settle there by Methodist missionaries more than 60 years ago.
Languages: Gupupungu, Liyagawumirr, Djambarrapuynga, and Burarra - the western Arnhem Land language.
History: the Methodist Mission established the community here in 1923.
Communications: national telephone network.
Access: Air, it is possible to go overland through Arnhem Land and then barge over to the island during the Dry, but people don't usually try the trip because it's a pretty tough drive. The freight barge comes in every two weeks.
Current Health Services: THS, there is no health committee. The Council receives two grants from THS to run a SWSBSC and an environmental health program
Staff : RN x 2, RN x1(relief) , AHWs x 5(1 is male), DMO visits from East Arnhem 1.5 days per week.
Clinic: in good condition, has a computer but no separate gender space.
Vehicles: 2x4wd.
Staff Accommodation: 3x1br flats in fair condition.
Airstrip: sealed all weather.

Homelands

- Bayagida (Rapuma, Yabooma Island, Galungali)
- Bodia
- Dhipirrinjura (Dipirri, Dhipirringura)
- Gunuruguru (Gumurugu)
- Langarra (Howard Island)
- Murrunga (Mooronga Island, Garrandjirrgura)

Five are permanently occupied (Category 1) and one is unoccupied during the wet.

The combined population is 265.

There are no regular visiting services to the homelands.

Bodia, Dhipirrinjura (Dipirri, Dhipirringura), Gunuruguru (Gumurugu), Langarra (Howard Island) and Murrunga (Mooronga Island, Garrandjirrgura) have an airstrip. All but one have telephones.

Bayagida (Rapuma, Yabooma Island, Galungali), Gunuruguru (Gumurugu), Langarra (Howard Island) and Murrunga (Mooronga Island, Garrandjirrgura) have a school.

Ramingining

Ramingining is about 400kms east of Darwin, 200km W of Nhulunbuy and 22kms inland from the Arnhem Land coastline and from Milingimbi. It is 8 hours drive from Gove and 30mins-2 hours flight to Nhulunbuy.
Ramingining has a community council and a Homelands Resource Centre. It is a dry community.
Population: 800
Languages: Gupapuyngu, Djambarrpuyngu, Manharrngu, Lyagawumirr and Ganalbuyngu.
Land Tenure: secure.
History: the community originated in the early 1970s with the movement of people of about a dozen clan groups from a nearby placed called Nangalala or Ring.
Communications: national telephone network.
Access: Roads connecting the community with the Bulman Track and the Top Road are only open during the Dry. The barge brings freight twice a month.
Current Health Services: combination – THS whilst OATSIH has a SA with the Homelands Resource Centre who contract THS to provide a visiting homeland service. There is no health committee.
Staff : RN x 2; RN x 1, AHW x 1 and AO.5 funded by OATSIHS for homeland service; DMO visits 1-2 days per week .
Clinic: in fair condition, has a computer but no separate gender space.
Vehicles: 4wd x 3 – 1 funded by OATSIH.
Staff Accommodation: 1x2br house in reasonable condition.
Airstrip: all weather, not sealed but good drainage. Only after heavy rains it is soft in places and temporarily out of use.

Homelands

- Galawdjapin (Galatjapan)
- Gatji (Gartji, Gadiji)
- Wulkabimirri (Wulkubimirri)
- Yathalamarra (Yathalmarra)
- Mulgurram (Mulgurrum, Mangu)
- Balingura (Balinyur)
- Borogomarra (Djakalajiripurra, Mangbirr)
- Bundatharri (Bundadharri)
- Garanyadjine (Jimmy's, Grajin)
- Gilirri (Galerra)
- Gupulul (Gulpuyul, Gulpulul)
- Malngangamak (Malnjangarnak, Malnyanganak)
- Murwangi (Arafura Station)
- Ngangalala (Ring)
- Mungberri

Seven are permanently occupied (Category 1), one is unoccupied due to cultural matters (Category 2), four are occupied less than half the time due to lack of services (Category 5), two are occupied only on weekends and holidays (Category 6) and one is permanently unoccupied.
The combined population is 235.

Six of the homelands have telephones, whist the remainder rely on radios or have no communication system.

Wulkabimirri (Wulkubimirri), Yathalamarra (Yathalmarra), Malngangamak (Malnjangarnak, Malnyanganak) and Ngangalala (Ring) receive regular health service visits.

Malngangamak (Malnjangarnak, Malnyanganak) accesses services at both Ramingining and Maningrida.

Yirrkala

Yirrkala is on the Arnhem Land coast about 18km to the south-east of Nhulunbuy. The community is the centre of Laynhapuy Homelands Resource Centre, which services more than 20 Homeland communities with building, infrastructure and health services. It owns Laynhapuy Aviation, among the first Aboriginal-owned air transport services in the country, which flies the workers and teachers and other visiting government officers to the homelands.
The community is dry, alcohol is only allowed through a permit system.
Population: 750
Language: the community's Yolngu people speak mainly Dhuwaya. Many still speak their clan languages, including Rirratjingu, the language of the traditional owners of most of the land the community stands on.
Communications: national telephone network.
History: Yirrkala began as a Methodist mission in 1935, but has been run by the Yirrkala Dhanbul Community Association since the 1970s following the withdrawal of the Uniting Church from community administration.
Access: sealed road to Nhulunbuy and airport also boat landing.
Current Health Services: THS, there is no health committee. The Council receives a grant from THS to run SWSBSC program.
Staff: RN x 2, AHW x 1, doctor(Hospital) visits 1-2 days per week.
Clinic: in good condition.
Vehicles: 2wd x 1.
Staff Accommodation: nil – staff reside in Nhulunbuy.
Airstrip: Gove airport nearby.

Laynhapuy Homelands

Current Health Services: combination, SAs with THS and OATSIH and the Laynhapuy Homelands Association Inc. There is no health committee.
Staff: RN x 2, AHW x1, Miwatj doctor 2 days a week.

- Baniyala (Banyala)
- Barraratjpi
- Barrkira
- Bawaka
- Birany Birany (Biranybirany)
- Bukudhal (Bukudal)
- Buymarrwuy (Buymarr)
- Dhalinbuy (Dhalingboy)
- Dhuruputjpi (Dhurupupi, Maywundji, Mayundji)
- Djarrakpi (Djarrapi)
- Gan Gan (Gangan)
- Garrthalala (Garrttbalala, Garrtbalala)
- Gurkawuy (Gurkawuy No 2, Gurkhawuy)
- Gurrumuru (Gurrumurru)
- Gutjangan (Bremer Island North)
- Rurrangala (Rurranali, Dhuwalkitji)
- Wandawuy (Wulwulwuy)
- Yanungbi (Yangunbi)
- Yudu Yudu (Yuduyudu)
- Yinimala

Sixteen of the Homelands are permanently occupied (Category 1) and four are temporarily unoccupied due to cultural matters (Category 2). The combined population is 755.

Baniyala (Banyala), Barrkira, Dhalinbuy (Dhalingboy), Djarrakpi (Djarrapi), Gan Gan (Gangan), Garrthalala (Garrttbalala, Garrtbalala), Gurrumuru (Gurrumurru) and Wandawuy (Wulwulwuy) have an unsealed airstrip.

All but four of the Homelands have telephones.

Baniyala (Banyala), Barrkira, Bukudhal (Bukudal), Dhalinbuy (Dhalingboy), Gan Gan (Gangan), Garrthalala (Garrttbalala, Garrtbalala), Gurrumuru (Gurrumurru), Gutjangan (Bremer Island North) and Wandawuy (Wulwulwuy) have clinics.

There is a school at Dhalinbuy (Dhalingboy), Gan Gan (Gangan) and Gurrumuru (Gurrumurru).

7. South East Arnhem HSZ

These communities are located in the Miwatj ATSIC and in the Ngukurr/ Anindilyakwa Land Council regions.

Alyangula

Location: Groote Eylandt, 640 km E of Darwin and 50km from the east coast of Arnhem Land. It is 35-50 mins flight to Gove.
Population: 100 (only Aboriginal population counted).
Languages: English, Filipino, Thai, Tongan, Italian, West Samoan, Yugoslav, French
History: Alyangula is a manganese mining town.
Communications: national telephone network.
Access: all year round.
Current Health Services: THS/Private GP
Staff : : RN x 1; 1 Admin Officer; non THS resident GP.
Clinic: good condition.
Vehicles: 1x2wd station wagon.
A*irstrip:* at Angurugu.

Angurugu

Location: on the west coast of Groote and is approximately 16 kilometres from the mining township of Alyangula and is 500m -1 kilometre from the airport serving all Groote Eylandt. The mine and the Groote Eylandt Airport are both located within 500m of Angurugu. It is a 30-50 min flight to Nhulunbuy and about one hour by jet to Darwin.
Population: 800
Languages: Anindilyakwa, Nunggubuya.
History: Angurugu was first settled in 1942 after the CMS transferred its mission from Emerald River, the first Groote Eylandt mission that was begun in 1921. CMS was responsible for the community's administration until 1979. It is now fully governed by an elected Aboriginal community council.
Land Tenure: Anindilyakwa Land Trust.
Communications: national telephone network.
Access: The main road connecting Alyangula to Groote Eylandt Airport, the mine and Angurugu is sealed and accessible during all weather. The roads to homelands are unsealed and often closed in the wet.
Current Health Services: THS, there is no health committee.
Staff : RN x 3, AHWs x 5.5, 1 Admin Officer; DMO x1 shared with Milyakburra and Umbakumba,
Clinic: the clinic which has recently has renovations has separate gender space and is owned and maintained by THS. There is a computer and lap top. All after hours work is done from Alyangula.
Vehicles: 4wd x 2, 1 mini bus
Staff Accommodation: There are three houses here but staff are accommodated at Alyangula.
Airstrip: The airport is a major regional facility handling domestic Ansett and Qantas flights as well as local light aircraft traffic.

Homelands.

- Dulumba Bay
- Wurrumenbumantja (Leske Pools, Wurrumenbumanja)
- Bartlaumba (Bartalumba Bay)
- Mulkulla (Malkala, Malkula Creek)
- Yedikba (Emerald River)
- Ngadumiyerrna (Ngadumiyerrka, Ngadumi Terrn, Little Paradise)
- Yanbagwa (Yanbakwa)

All homelands are permanently occupied with a combined population of 135. All are within 45km of Angurugu, but these roads are unsealed and impassable at times during the wet.

Milyakburra

Milyakburra is the community on Bickerton Island, which is just off the west coast of Groote Eylandt. The island was used by the Macassans as a base for trepanging and, earlier this century, well-known NT identity Bill Harney had a camp at East Bay. The island is low-lying but undulating and covered in eucalypts. Housing is extremely limited. The community is run by an incorporated council and has a school.
There is a CDEP scheme operating here The army was engaged as project manager for the construction of a new sewerage system in 1998. It also built a football field, relocated the rubbish tip, and upgraded the barge landing and trained some locals in housing maintenance. This was funded by the NAHS.

Location: island 13 km west of Groote and 8 km E of mainland. It is 15 mins by air to Nhulunbuy and 10 minutes by air from Groote Eylandt.
Population: 220.
Languages: Anindilyakwa, Nunggubuya.
History: the community resettled here in 1987 as part of their homeland movement. It was for a time used as a rehabilitation centre for young petrol sniffers.
Land Tenure: Anindilyakwa Land Trust.
Communications: national telephone network.
Access: by boat all year, freight barge once a month.
Current Health Services: THS.
Staff : there are no resident staff here.
Clinic: there is a small clinic here which does not have separate gender space or entry nor computer.
Vehicles: nil.
Staff Accommodation: nil.
Visiting Services: RN & AHW visit 1 day a fortnight, DMO visits 1 day a fortnight.
Airstrip: the registration classification does not allow any night evacuations.

Umbakumba

There is no housing for non-Aboriginal employees who travel daily to and from Alyangula or Angurugu. Umbakumba is not a dry community; alcohol is allowed.
Location: on the beachfront and behind dunes on the NE coast of Groote, 50km of unsealed road to Angurugu. It is a 1 hour drive to Alyangula and 45 mins to Angurugu. It is a 30-50min flight to Nhulunbuy and 60 mins to Darwin.
Population: 450
Languages: Anindilyakwa.
History: The Anglican church had a mission here from 1958-1966 after which the welfare branch took it over. Umbakumba now has a Community Government Council and has a school.
Land Tenure: secure.
Communications: national telephone network.
Access: unsealed road may be closed in the wet.
Current Health Services: THS.
Staff : one resident AHW.
Clinic: the clinic is owned and maintained by THS. It is in poor condition. It has no separate gender space nor computer. All after hours work is done from Alyangula.
Vehicles: no health vehicle.
Staff Accommodation: nil.
Visiting Services: AHW and an RN visit 5 days a week, DMO visits 1day/week from Angurugu.
Airstrip: The airstrip is dirt and not often used.

Homelands

- Thompson Bay (Mawulyumanja, Mawulyumanttja)
- Marble Point (Darrangmurmanja)
- Scott's Point
- Alyingberrma (Alyingbarruma, Qantas Base)
- Picnic Beach

Three of these homelands are permanently occupied (Category 1), one is occupied most of the time (Category 3) and one is not occupied at all (Category 7). The combined population is 80.

There are no visiting services.

Numbulwar

Numbulwar is on the Gulf Coast of Arnhem Land, 250km south of Nhulunbuy and 900(570km)km south-east of Darwin. It is a 6-8 hour drive to Katherine and 1 hour flight to Nhulunbuy. There are 10 homelands and there is movement between Numbulwar and Ngukurr, Borroloola and Groote Eylandt. It is built among sand hills at the mouth of the Rose River and is a dry community.
Population: 900
Language: Nunggubuyu, Ritharmgu, Anindilyakwa and Kriol.
History: the community was started up by the CMS as the Rose River Mission in 1952 but has been self-governing since the 1970s under the Numbulwar Numburindi Council.
Communications: national telephone network.
Access: Numbulwar is connected by road to the south with Ngukurr and then through to Mataranka and to the north with the Bulman Track. It is one of the worst in the Territory and becomes impassable in the wet for several months. Freight arrives by barge twice monthly.
Current Health Services: combination - THS, whilst Council receives a grant for AHWs. Council decided to move 1 AHW to respite. The Council receives two grants from THS to run a nutrition program and an environmental health program.
Staff : RN x 2, AHWs x 3, DMO visits 1-2 days a week. There are no cleaners, receptionists or drivers.
Clinic: in good condition.
Vehicles: 2x4wd.
Staff Accommodation: 2x 1br flats in fair condition, 2x 3br houses in good condition.
Airstrip: all weather airstrip unusable in wet weather. Access road to airstrip cut in wet several times each year.

Homelands

- Alharrgan (Cape Barron)
- Amalilpil (Amlibil)
- Andanangki (Andananki, Andananggki)
- Dharrni (Dharri, Wuyindhangayn)
- Marrkalawa
- Marraya (Marraiya)
- Miwul
- Ngilipitji (Ngulipitji)
- Waldnarr (Harris Creek, Waldharr)
- Wumajbarr (Wumarrdjbarr)
- Wuyagiba
- Yilila
- Yimidarra (Wundu, Policeman's Crossing)
- Rocky Point
- Edward Island (Ngulugi)
- Amaya (Turtle Village)

Three of these homelands are permanently occupied (Category 1), two are occupied for more than half the time (Category 3), three are occupied less than half the time (Category 5), three are occupied only at weekends and holidays, and four are homelands being planned (Category 8). The combined population is 160.

Andanangki (Andananki, Andananggki), Ngilipitji (Ngulipitji), Wuyagiba and Waldnarr (Harris Creek, Waldharr) have airstrips. The roads are unsealed and many are impassable in the wet.

There are no telephones, but Alharrgan (Cape Barron), Amalilpil (Amlibil), Andanangki (Andananki, Andananggki), Dharrni (Dharri, Wuyindhangayn), Marrkalawa, Ngilipitji (Ngulipitji), Waldnarr (Harris Creek, Waldharr), Wumajbarr (Wumarrdjbarr), Wuyagiba and Yimidarra (Wundu, Policeman's Crossing) have radios.

There are no visiting health services.

8. Katherine East HSZ

These communities are located in the Garrak-Jarru ATSIC, THS Katherine District and in the Katherine NLC region.
The major language groups for the region are Jawoyn, Ngalpon, Mayaiii, Wagiman, Wardaman, Rembarmga, Dagoman, Yangman, Mangarrayi, Gagaju, and Kunwinjku.

Katherine

Population: 1,040 (Aboriginal population counted only)
Communications: national telephone network.
Access: all year.
Current Health Services: ACCHO - Wurli Wurlinjang
Staff : MO x 2.3 (usually 3.3), RN x 1(midwife), AHWs x 19(includes 4 trainees), 4 Managers, 12 administration(includes drivers), 2 educators, nutritionist
Clinic: recent expansion required and nearly completed.
Staff Accommodation: there is a lack of reasonable accommodation in Katherine particularly post flood.

Town Camps

- Mialli Brumby (Mialli, Kalano)
- Rockhole (Rochole)
- Warlpiri Transient Camp
- Jodetluk (Gorge Camp, Maude Creek Camp)
- Prior Court
- Redgum
- Wallaby

All of these Town Camps are permanently occupied (Category 1), although two were destroyed by authorities after the 1997 Katherine floods. The combined population is 495.

All Town camps are all visited weekly by AHWs from Wurli Wurlinjang health service.

Out-stations

- Banatjarl (King Valley)
- Werenbun (Barnjarn, Edith Falls Road)
- Gimbat (Edith Falls)

All are permanently occupied (category 1) with a combined population of 35.

All are part of the Jawoyn Association. There are no clinics and no visiting health services are available. Banatjarl (King Valley) is a cattle station and the population here swells during mustering time.
There are no telephones, and people rely on radios.

There is an unsealed airstrip at Mary River near Gimbat.

Barunga (Bamyili)

Location: 80 km ESE of Katherine, 1 hour by road.
Population: 340
Languages: Jawoyn, Mara, Mialli, Ngalkbon, Dalabon, Rembarrnga, Ngalakan and Mangarrayi
History: established as a government settlement, now has a local government council.
Land Tenure: secure
Communications: national telephone network
Access: sealed road to Katherine.
Current Health Services: THS.
Staff : RN x 1, AHWs x 2. also Manyallaluk AHW works 3 days at Barunga. DMO visits 1.5 days a fortnight from Katherine.
Clinic: good condition has separate men's and women's rooms. Has a PC, 1x server and 4 terminals.
Vehicles: 4wd x 1, 1 twin cab.
Staff Accommodation: 1x3br house in good condition, 3 flats
Airstrip: no night lights. Evacuations are by road.

Out-stations

- Manyallaluk (Eva Valley)

Manyallaluk is permanently occupied (Category 1) with a population of 85. There is a clinic and a telephone There is also a resident AHW employed 2 days a week with a nurse visiting weekly and a doctor half a day a fortnight.

The clinic is in good condition but there is no separate gender space, vehicle or computer. It is 35km by dirt road from Barunga – 1/2hr drive.

The Barunga Council are keen to get an alcohol rehabilitation facility happening here through ATSIC.

Specialist visits are infrequent. The chronic disease system was trialed here and as a consequence is well resourced in regard to IT. There is better management of chronic disease now with fewer call outs. PATS is an issue for this community as there is no available transport to Katherine Hospital so often clients go to Darwin instead.

Wugularr (Beswick)

Location: on the banks of Waterhouse Creek approx 120 km SE of and 1.5 hours drive from Katherine on the Central Arnhem Highway and 31 km E of Barunga. Access is via the Stuart Highway for the first 51 km then onto the Barunga road, which is sealed except for the final 10km. Access can be cut at the Waterhouse river for brief periods during the wet, there is no access by air.
The community of Wugularr was devastated in the Katherine floods, however unlike Katherine they have been unable to replace major infrastructure. It has only been in the past few months that the morale of the community has lifted. Prior to this the community has been plagued with problems that includes 29 youth suicide attempts from Dec-Jan(1998-1999). A post suicide strategy has been to arrange for a bus to take 30 students daily to Katherine high school.
Population: 500
Languages: Jawoyn, Ngalpon, Mialli, Rembarrnga, Dalabon.
Land Tenure: secure
History: established as a training centre in the cattle industry. Now has a community government council.
Communications: national telephone network, satellite phone.
Access: road can be cut off in the wet at river crossing.
Current Health Services: THS.
Staff : : RN x 1, AHWs x 1, 2 trainees who are on CDEP. DMO visits for 1 day each fortnight.

Clinic: the building has 2 cubicles and 1 room for consultation and an emergency room. It does not have separate entry or gender space but the emergency room doubles as a male treatment area when not in use. There are no separate toilets, baby's clinic area or staff room. There is no computer or desk for study purposes.
Vehicles: 4wd x 1.
Staff Accommodation: 1x3br house in good condition, 1 demountable for relief staff.
A*irstrip:* not in operation all year round. Evacuations are by road.

Out-stations

- Bishop's Bore

The only out-station is Bishop's Bore which is permanently occupied (Category 1) with a population of 10. There are no visiting health services.

Bulman (Gullin Gullin, Yulngu)

Location: 312 NE of Katherine. It is a 3.5-4 hours drive and a 30-60 min flight to Katherine.
Population: 250
Languages: Rembarrnga.
Land Tenure: secure tenure within Arnhem Land.
Communications: national telephone network.
Access: unsealed access road to Katherine approx 200km which can be unpassable for extended periods in the wet. Also unsealed road to Nhulunbuy which is generally closed in the wet.
Current Health Services: THS. The Council receives two grants from THS to run a nutrition program and an environmental health program.
Staff : RN x 1 , AHWs x 2, DMO visits for 1 day per fortnight.
Clinic: good condition but has no separate gender space nor computer.
Vehicles: 4wd x 1.
Staff Accommodation: 1x3br house in fair condition.
Airstrip: unsealed which can become inoperable for short periods in the wet.

Out-stations

- Weemoll
- Baghetti
- Barrapunta (Emu Springs)
- Gulpuliyul
- Mount Catt
- Momob (Bulman Gorge)
- Morbon (Blue Water)

Five of these outstations are permanently occupied (Category 1), one is occupied for more than half the time (Category 3) and one is not occupied during the wet (Category 4).

The combined population is 150. The population of Weemoll tends to increase during the wet, with people form other outstations moving there. One of these sites is an important ceremonial ground where the population can swell to 600 people during ceremonies.

The RN and AHWs based at Bulman alternate visits, doing fortnightly mobile runs that are dependant on the weather as well as the condition of the roads which can be boggy for a long time.

Mataranka

Location: 106km SE of Katherine on the Stuart Highway. It is a popular tourist destination that serves population increases from 250- to over 1000 during the Dry.
Population: 630
Communications: national telephone network.
Access: may be cut off in the wet.
Current Health Services: THS.

Staff : RN x 1, 1RN relief during the tourist season.
Clinic: a new community health centre has outside and inside waiting areas, male and female entrances, male and female toilets including disabled.
Vehicles: 4wd x1, 2wd x 1.
Staff Accommodation: 3x1 br flats in poor condition. The old clinic will be renovated for accommodation.
Visiting Services: DMO 1 days a fortnight.
Airstrip: the only airstrip is at Daly Waters. Evacuations are by road meeting halfway with the Katherine ambulance.

Town Camps and Out-stations

- Morgan (Mulga)
- Mataranka Transient Camp (Mataranka Town Camp)
- Jomet (Urpalarwn, Birdum, Larramah)

All are permanently occupied (Category 1) with a combined population of 70.

Jilkminggan

Location: 140km SE of Katherine, 3 km N of Roper Highway. It is 1.5 hours drive to Katherine and 30 mins to Mataranka. Clients can only access PATS if they are greater than 200km from a major centre. There is a twice daily bus from Mataranka to Katherine. This results in many cancelled specialist and theatre bookings missed.
Population: 175
Languages: Mangarrayi, Alawa, Roper, Creole
Land Tenure: secure.
History: excision from Elsey station.
Communications: telephone, no fax
Access: sealed road to Mataranka via the Roper Highway and Stuart Highway to Katherine. Short length of gravel access road to Roper Highway can be cut off briefly after heavy rain.
Current Health Services: THS
Staff : nil.
Clinic: 5 year old three room structure - no separate gender space nor computer or fax.
Vehicles: nil.
Staff Accommodation: nil.
Visiting Services: RN (Mataranka) and DMO visits fortnightly .
Airstrip: Elsey Station.

Outstations

- Mole Hill (Goondburoon)

This is the only out-station. It is permanently occupied with a population of around 30. It receives no visiting health services.

Miniyeri (Miniyerri, Hodgson Downs)

Location: 275 km SE of Katherine, 40km S of the Roper River. It is 3 hours drive and 50mins flight to Katherine.
Population: 350.
Languages: Alawa.
Land Tenure: Secure.
Communications: national telephone network.
Access: There are unsealed external roads with poor access and may be cut off 6-8 weeks in the wet.
Current Health Services: THS but this is a recommended RCI site.
Staff : trainee AHW, RN x 1. DMO visits 1 day fortnight.
Clinic: satisfactory condition, no separate gender space nor computer.

Vehicles: 4wd x 1.
Staff Accommodation: 1x 3 bedroom house in good condition.
A*irstrip:* unsealed and not lit.
Access: There are unsealed external roads with poor access and may be cut off 6-8 weeks in the wet.

Out-stations

- Bringung (Brinung)
- Flicks Hole (Flicks Waterhole)
- Minamia (Cox River)
- Roper Valley Station
- Hodgson River Station

Two of these are permanently occupied (Category 1), one is temporarily unoccupied due to cultural matters (Category 2), and two are occupied less than half the time (Category 5). They have a combined population of 105.

There are no visiting health services.

Ngukurr

Location: 320km SE of Katherine on the banks of the Roper river. It is 3.5 hours drive and 40-60mins flight to Katherine. It gets cut off for 3 months a year. It is a dry community.
Population: 1000
Languages: Ngalakan, Roper Kriol, Alawa, Mara, Nunggubuyu.
History: established by the CMS in 1908.
Land Tenure: secure.
Communications: national telephone network.
Access: cut off by the rivers usually Jan-March.
Current Health Services: THS. The Council receives a grant from THS to run a nutrition program.
Staff : RN x 2, (Currently only one) AHWs x 5.5. DMO visits 3 days a fortnight.
Clinic: this clinic has separate entry and women's room.
Vehicles: 4wd x 2.
Staff Accommodation: 3 x 3 br house in good condition (2 for permanent staff and one for relief). These belong to the Department of Lands and Housing but THS maintain.
Airstrip: all weather.

Out-stations

- Urapunga (Rittarungu)
- Nulawan (Nallawan)
- Badawarrka (Badawarrku, Baddanarrka, Baddanarrka)
- Costello (Castello, Jilwili)
- Awumbunyji
- Boomerang Lagoon
- Jowar (Joyar)
- Lake Katherine
- Larrpayanji
- Mumpumampu (Mumbu Mumbu, Mialurra, Mumba Mumba)
- Nummerloori (Namaliwirri, Namaluri)
- Ruined City (Burinju)
- Wanmarri
- Turkey Lagoon (Bananda)

Three of these outstations are permanently occupied (Category 1), tow are temporarily unoccupied due to cultural matters (Category 2), and nine are only occupied on weekends and holidays. The combined population is 260.

Most of these out-stations get cut off in the wet. All out-stations aside from Urapunga are visited by health service staff at Ngukurr annually and on an if needs basis. Other visits are made annually by the health service where there are non-Aboriginal residents employed in the fishing industry (including Taiwanese Crabbers) at Port Roper.

Urapunga (Rittarungu), Nulawan (Nallawan) and Costello (Castello, Jilwili) have an airstrip, although all require upgrading or repairs. The roads tend to be poor, are unsealed, and most are cut off in the wet.

Urapunga (Rittarungu) has a clinic. Urapunga (Rittarungu), Nulawan (Nallawan), Badawarrka (Badawarrku, Baddanarrka, Baddanarrka), and Costello (Castello, Jilwili) have telephones, with the rest relying on radios or having no communication technology.

Wardaman Communities

Binjari (Binjarri, Wylunba)

Location: 18 km west of Katherine
Population: 225.
Languages: Wardaman, Alawl and Jawoyn
History: this community was established as part of an excision of a pastoral property.
Land Tenure: freehold land with restrictions.
Communications: telephone, fax, no computer.
Current Health Services: the Council has a SA with THS and it is also a recommended RCI site. Families pay a levy of $4 a week for medical supplies which either come through the Katherine Hospital pharmacy or by script at the local chemist. The Council is currently preparing a submission for extra nursing hours for a second staff member and a nine seater bus so the 2nd nurse can transport clients to other services in town. The Council receives a grant from THS to run a nutrition program.
Staff : THS fund $32,000 for AHW position but is used to pay 2 nurses who alternately work 4 days a week from 9-2. GP comes from Katherine on Tuesday mornings.
Clinic: new but got flooded when they lost all their charts. Got flood emergency money to employ a worker to update same. No separate gender space/entry.
Vehicles: nil.
*Staff Accommodation: n*il.
Airstrip: nil.

Other Wardaman Communities

- Dillinya (Dry Creek)
- Djalibang (Innisvale)
- Wurrkleni (Johnson Waterhole)
- Djarrung (Djurrung)
- Dungowan Station
- Birrimba

Two are permanently occupied (Category 1), one is occupied more than half the time (Category 3), two are occupied less than half the time (Category 5) and one is being planned (Category 8).

The combined population is 45.

None have airstrips, and generally the infrastructure is poor. Dillinya (Dry Creek) and Djalibang (Innisvale) have a telephone. The others rely on radios or have no communication system. There are no visiting health services to these outstations. Generally people use Wurli Wurlinjang and the hospital in Katherine. Some at Wurrkleni use the health service at Binjari.

9. Katherine West HSZ

These communities are located in the Garrak-Jarru ATSIC, THS Katherine district and in the Victoria River NLC region. This area is often referred to as the Victoria River District. Traditional Aboriginal languages include Jaminjung, Kadjerong, Nungali, Wardaman, Ngaliwurru, Ngarinman, Miriwung, Bilnara, Karangpurru, Mudbara, Malngin, Gurindji and Warlpiri. Land use includes ALTs, pastoral leases, national park / conservation areas and military areas.

There is a history of pastoral leases being owned by absentee landlords and overseas companies eg Vesteys and Bovril. In 1966 the Gurindji walked off Wave Hill station and were followed by Aborigines working on other stations in the area. It was 11 years of struggle before land was handed over. Other successful land claims have been at Yarralin (240 square kilometres formerly part of Victoria River Downs) and Fitzroy station.

More recent history has included Kerry Packer's failed bid to purchase Victoria River Downs (VRD) station(this was blocked by the NTG) to be later purchased by Robert and Janet Holmes a Court's Heytesbury Pastoral Company. Heytesbury also own Mt Sanford, Mooloolo, Wallamunga, Birrindudu stations in this area and Anthony Lagoon and Eva Downs in the Barkly as well as 2 others in the Kimberley. Kerry Packer owns the neighbouring station Humbert River.

Timber Creek has an Aboriginal organization, Ngaliwurru-Wuli Association which was formed in 1986, which services local Aboriginal communities. It currently receives a THS non government grant for Environmental health.

Historically THS managed and administered health staff, clinics and visiting DMO services from Katherine. The most recent development for health services in this area has been the formation and incorporation of the KWHB, which has l8 Board members, in February 1998. In July 1998 it became a fund holder for a CCT.

Early changes have been a 70% increase in funding into the area, additional staffing, doubling of PHC doctor visits, sessional payments for specialists, program development, development of community based health committees, mobile PHC service to non Aboriginal cattle stations and out-stations, advocacy, MOUs with community government councils.

There is still a major need for adequate and appropriate health facilities, better identification of funding for infrastructure. The KWHB would also like to see a development of mental health services with strategies to promote social, emotional and physical well being.

Timber Creek

Location: 284km W of Katherine and 2.75hr drive to Katherine.
Population: 560
Languages: Ngarinyman, Ngaliwurru, Nungali, Jaminjung.
Communications: national telephone network.
Current Health Services: THS.
Staff : : RN x 3, AHWs x .5, DMO visits 2 days a week. There is a medical officer's position vacant – recruitment will start soon. It will be funded by a RAG to the KWHB and the employee will be accommodated by OATSIH.
Clinic: new health clinic with no separate gender/entry space, has a computer and lap top.
Vehicles: 1x4wd, 1x2wd.
Staff Accommodation: 1x2br demountable in fair condition.
Other: This service visits Bulla & Amanbidji. The Council receives a grant from THS to run a environmental health program.

Out-stations

- Policeman's Hole
- Muringung (Darby's Camp, 1 Mile Camp)
- Myatt (Jerry's Camp, 5 Mile)
- Gilwi (12 Mile Camp)
- Line Creek
- Barrac Barrac (Mayamum, Mayamumosin)
- Bob's Yard (Iuwakam, Kutjulum Burru)
- Fitzroy Station
- Airdroom Bore
- Bubble Bubble (Dhamberral, Djamboral)
- Bucket Springs (Binjen Ningguwung)
- Doojum
- Bamboo Springs (Jirrngow)
- Marralum (Marralam, Legune Station)
- Kneebone

Eleven of these outstations are permanently occupied (Category 1), one is occupied most of the time (Category 3), and three are occupied less than half the time (Category 5). They have a combined population of 315.

Fitzroy Station and Marralum have an airstrip, but the others use either Timber Creek or Kununurra. They are up to 350kms from Timber Creek, but the roads are passable all year round. Some use services at Kununurra, WA.

Some outstations close to the WA border receive visiting services from EKAMS. The KWHB is extending service delivery to provide visiting services to outstations.

Policeman's Hole, Myatt (Jerry's Camp, 5 Mile), Gilwi (12 Mile Camp), Barrac Barrac (Mayamum, Mayamumosin), Fitzroy Station, Bubble Bubble (Dhamberral, Djamboral), Bamboo Springs (Jirrngow) and Marralum (Marralam, Legune Station) have telephones. Others rely on radios or have no communication technology.

Mialuni (Amanbidji)

Location: 464km W of Katherine and 184km SW of Timber Creek. It is an 8 hr drive to Darwin, 5 hours to Katherine, 2 hours to Timber Creek. It is a 25 min flight to Timber Creek and 45-60 min flight to Katherine.
Population: 100
Languages: Ngaringman, Mirriwoong.
History: it is on a freehold pastoral property.
Land Tenure: Nagurunguru ALT.
Communications: national telephone network.
Access: intermittently closed off in wet for up to 4 months.
Current Health Services: THS
Staff : nil, visit from Timber Creek –doctor monthly, nurse fortnightly.
Clinic: new clinic with no separate gender entry/space nor computer.
Vehicles: nil.
Staff Accommodation: nil.
Airstrip: good.

Bulla (Gudabijin)

Location: 348 km W of Katherine and 1680 km from Darwin. Just off the Victoria sealed highway. It is 3.5-4 hours to Katherine and 35 min drive to Timber Creek. It is a 12 min flight to Timber Creek and 45-60 min flight to Katherine.
Population: 120.
Languages: Ngaringman, Murrinpatha.
Communications: national telephone network.
Access: road often closed between Katherine in the wet.
Current Health Services: THS.
Staff : part time resident AHW, nurse and doctor visit from Timber Creek.

Clinic: clinic in good condition with no separate gender entry/space or computer.
Vehicles: nil.
Staff Accommodation: nil.
Airstrip: gravel which is not all weather and is short restricting the size of aircraft landing/taking off.

Yarralin

Location: 380 km SW of Katherine, 15km W of VRD and 140km to Timber Creek. It is a 1 hour flight to Katherine and 18 mins to Timber Creek. It is a 4 hour drive to Katherine, 2 hours to Pigeon Hole, 20 mins to VRD and 1 hour to Timber Creek.
Population: 300
Languages: Ngaringman, Gurindji, Bilinara, Mudbura.
Land Tenure: secure.
Communications: national telephone network.
Access: road often impassable in the wet.
Current Health Services: KWHB
Staff : RN x 2, AHWs x 1, DMO visits one day a week.
Clinic: new health clinic with no separate gender/entry space, has a computer and lap top.
Vehicles: 1x4wd.
Staff Accommodation: 2x2 br flats which are new, 1x3 br new house and one old clinic in good condition.
Airstrip: gravel airstrip can be cut off during heavy rain.

Out-stations

- Lingarra
- Pigeon Hole (Bunbidee)
- Kalumbulani (Camfield)
- Yinguwunarri (Old Top Springs, Yinguwinarri, Inganawi, Old Top Springs)

Two of these are permanently occupied (Category 1), and two are not occupied during the wet (Category 4). The combined population is 145.

There is a gravel airstrip (not all weather) at Pigeon Hole (Bunbidee).

Pigeon Hole (Bunbidee) receives a visiting health service from Mialuni (Yarralin). Others receive no visiting service.

Daguragu

Location: 460 km SW of Katherine and 8 km N of Kalkarindji. It is a 5 hour drive and 50-90 min flight to Katherine.
Population: 250.
Languages: Gurindji, Warlpiri, Mudbura, Kriol.
History: Daguragu has a rich history of self-determination; it is the "birth place" of Aboriginal Land Rights in the NT. On the 22 August 1966, Aboriginal people decided to "walk off" Vestey's properties in the district, in particular from Wave Hill station. They established Daguragu community as distinct from the government settlement at Kalkarindji.
The community uses Kalkarindji for school, store and airstrip. There is a shortage of accommodation here.
Land Tenure: Dagaragu ALT.
Communications: national telephone network.
Access: Wattie Creek crossing may be closed in the wet
Current Health Services**:** KWHB and it is an approved RCI site.
Staff : resident at Kalkarindji –nurse and AHW visit daily.
Clinic: to be replaced, currently no separate gender entry/space nor computer.
Vehicles: nil.
Staff Accommodation: nil.

Airstrip: at Kalkarindji – access road to Kalkarindji and airstrip can get cut 4-5 times a year.

Out-stations

- Bardu Wardu (Birdiwater)

This is only occupied on weekends and holidays (Category 6).

Kalkarindji (Libanungu)

Location: 478 km SW of Katherine. It is a 5 hour drive and 1.5 hour flight to Katherine.
Population: 400.
Languages: Gurindji, Warlpiri, Kriol, Kartangarrurru.
History: government settlement.
Land Tenure: is an open town. Dagaragu ALT.
Communications: national telephone network.
Access: sealed road to Katherine but may be cut off in the wet.
Current Health Services: KWHB.
Staff : RN x 2, AHWs x 2, resident doctor who is employed by the KWHB and accommodated by THS.
Clinic: should be replaced, currently no separate gender entry/space, has computer.
*Vehicles:*1 x 4wd, 1 x 2wd twin cab.
Staff Accommodation: 3 x 1 br flats in fair condition, 1 x 4 br house in good condition.
Airstrip: all year.

Out-stations

- Liku (Mountain Springs, Booneroo, Wave Hill)
- Mamadi (Gudiwudi, Inverway)
- McDonalds Yard (Bunuru, Pururu)
- Mt Maiyo (Mulluyu)
- Nelson Springs
- Puturru (Gills Creek)
- Cattle Creek (Yamarti)
- Mistake Creek
- Jutamaling (Swan Yard)
- Limbunya Homestead
- Blue Hole

Four of these outstations are permanently occupied (Category 1), four are not occupied during the wet (Category 4), and three are subject to an excision application (Category 8). Their combined population is 85. Some of these outstations relate to WA communities.

Mamadi (Gudiwudi, Inverway) has an airstrip, but others are between 20 and 115km from the nearest airstrip. Roads in this area are unsealed, and some are impassable in the wet. Only Mistake Creek has a telephone, with the others relying on radio, or having no communication technology.

Lajamanu

Location: 555km SW of Katherine. It is a 6 hour drive and 1-2 hour flight to Katherine and 100mins flight to Darwin.
Population: 800
Languages: Warlpiri, Gurindji.
History: a government settlement was established here in the 50s.
Land Tenure: Aboriginal Land which belongs to Gurindji and Warlpiri.
Communications: national telephone network.
Access: road may be closed in the wet (100km of gravel road to Kalkarindji).
Current Health Services: THS, KWHB employ a doctor here.
Staff : : RN x 3, AHWs x 3, doctor, administration officer.
Clinic: in good condition, has a women's room but no separate gender entry, has computer and laptop.

Vehicles: 1x4wd.
Staff Accommodation: 1 3br house in fair condition.
Airstrip: good standard airstrip which can sometimes be closed after heavy rain.

Out-stations

- Duck Ponds (Mirririnyungu, Kulingalimpau, Murrinyu)
- Jangalpangalpa
- Jiwaranpa (Jiwan, Talbot Wells, Jwarnpa, Kamara, Kamira)
- Lul-Tju (Lul'Tju)
- Mirridi (Mirrirdi)
- Mungurrupa (Mungkurrupa, Tanami Downs)
- Ngarnka
- Parntna
- Parrulyu
- Picininny Bore (Tjabalajabala)
- Pinja (Pileaja, Pielegja)
- Yartalu Yartalu (Bogaree, Granites)

Seven are permanently occupied (Category 1), two are temporarily unoccupied deu to cultural matters (Category 2), and three are occupied more than half the time (Category 3). The combine population is 225.

The communities are located up to 400km from Lajamanu. Roads are unsealed and often on very poor condition. There are no visiting services. Jiwaranpa (Jiwan, Talbot Wells, Jwarnpa, Kamara, Kamira) and Yartalu Yartalu (Bogaree, Granites) can access services in an emergency form the Tanami and Granites mine. This was negotiated as part of the Traditional Owners agreement with the mine negotiated by the CLC.

KWHB contract THS who employ 2 RNs who provide a mobile service to pastoral leases (and some of the out-stations). They have 3-4 runs which are done by vehicle, (some places are inaccessible in the wet -there is a small amount in their budget for flights) and they spend ½-1 day at each station. Their work is mostly health promotion and education with some screening. They do sessions on use of the medical kits which are dispersed if they are located more than 60km from a health centre. The staff are currently working towards getting St Johns instructors certificates so they can offer accredited senior 1st Aid and accident action courses on site at the stations. They visit the following pastoral leases:
Auvergne, Birrindudu, Bullo River, Bunda, Camfield, Coolibah, Delamere, Fitzroy, Gilnockie, Humbert River, Innesvale, lnverway, Keep River Ranger Station, Kidman Springs Research facility, Killarney, Kirkimbie, Legune, Limbunya, Montejinni, Moolooloo, Mount Sanford, Newry, Nicholson Station, Old Top Springs Roadhouse, Riveren, Rosewood, Spirit Hills, Victoria River Downs, Victoria River Roadhouse, Wallamunga, Waterloo, Wave Hill.

They irregularly visit Marralam, Policeman's Hole, Bubble Bubble, Bob's Yard and Doojum.

10. South East Top End HSZ

These communities are located in the ATSIC Garrak-Jarru Regional Council, the Borroloola/Barkly NLC region, THS Katherine District.

Borroloola

Location: 670km SE of Katherine. It is a 6-7 hours drive and 2.5 hour flight to Katherine. It is a 1.5 hour flight to Darwin.
Population: 800
Communications: national telephone network.
Access: major sealed road.
Current Health Services: combination, THS and a private GP.
Staff : AHWs x 1, RN x 4 and administration officer.
Clinic: the clinic is in good condition. It has no separate gender space but has a computer.
Vehicles: 4wd x 2, 2wd x 1 dual cab.
A*irstrip:* all weather with lights.

Town Camps

- Garawa (Garawa 1, Borroloola town camp)
- Garawa 2 (Borroloola town camp)
- Mara (Dulu, Mala camp)
- Yanyula (Yanula)

All of these are permanently occupied (Category 1), with a combined population of 360. These are part of the Narwimbi Land Trust.

Out-stations

- Bauhinia Downs (Gurdanji, Bingbinga)
- Goolminyini (Devils Springs)
- Ijarri (Tarwailah, Ijarra, Crocodile Creek)
- Kiana Station
- Numultja (Kiana Station)
- Milibunthurra
- Munyalini (Minyalini, Campbell Springs, Calvert hills)
- Wandangula (Wanda Ngula, Police Lagoon)
- Sandridge
- Wada Warra (Bone Lagoon, Bing Bong, Wurrunburra Assoc)
- Wada Wadalla (Wada Wadala, Blackfellow Creek, Bone Lagoon)
- Wajtha (Old Tarwalla, Cow's Lagoon)
- Wurlbu
- Yungurie (Ryan's Creek, Tjoungouri, Tjungouri)
- Maria Lagoon

Thirteen of the mainland outstations are permanently occupied (Category 1), one is occupied most of the time (Category 3) and two are occupied less than half the time (Category 5). The combined population is 275.

Bauhinia Downs (Gurdanji, Bingbinga) and Kiana Station have an airstrip, although neither are reliable in the wet. Goolminyini (Devils Springs), Kiana Station, Wada Warra (Bone Lagoon, Bing Bong, Wurrunburra Assoc), Wandangula (Wanda Ngula, Police Lagoon, Wurlbu and Yungurie (Ryan's Creek, Tjoungouri, Tjungouri) have a telephone. The rest rely on radios or have no communication technology.

There is a school at Kiana Station. Kiana Station receives a visiting service from Borroloola. Others receive no visiting health service.

Island Outstations

- Jimiyamilla (Black Craggie Island)
- Mooloowa (Cape Vanderlin)
- North Island (Barranyi)
- South West Island (Wathunga)
- Uguie (Clarkson Bay, Vanderlin Island)
- West Island (Wurdijiya, Yathunga, Mumathumburu)
- Yameeri (Kangaroo Island, Looganwarra)

Five of these places is permanently occupied (Category 1) and two are occupied less than half the time (Category 5). They have a combined population of 85. They are part of the Wurralibi Land Trust.

None of these out-stations have an airstrip, and access to Borroloola is by road and boat.. South West Island (Wathunga) has a telephone and Mooloowa (Cape Vanderlin) and Uguie (Clarkson Bay, Vanderlin Island) have radios.

None receive visiting health services.

Robinson River (Mungoobada)

Location: It is located 200 km from Borroloola which is a 2.5 hours drive and 820kms and 8 hours drive to Katherine. It is a .5 hours flight to Borroloola and I hour flight to Katherine.
Population: 200
Languages: Garawn is the major language group.
Communications: national telephone network.

Access: there is an unsealed airstrip 5 km from town along an unsealed read. Airstrip recently regraded it is good even in wet but not useable at night. Road to Borroloola also impassable during heavy rain. There are 6 river crossings between RR and Borroloola.
Current Health Services: THS and is also a recommended RCI site.
Staff : Nil (THS fund a permanent AHW position). A nurse from Borroloola visits for 1 day weekly, a doctor goes fortnightly.
Clinic: 1 large multi purpose room including waiting area, 1 consulting room including drug cupboard, office, no cold storage area nor separate gender space. There is no computer.
Vehicles: nil.
Staff Accommodation: 2 bed unit owned and maintained by THS.
Visiting Services: there is a visiting RN, GP visits from Borroloola.
A*irstrip:* there is an unsealed airstrip 5 km from town along an unsealed read. Airstrip recently regraded it is good even in wet but not useable at night.

Mungoobada Out-stations

- Walluburi
- Wundigalla

Mabunji Out-stations

- Jungalina (Wollogorang, Branch Creek)
- Maranari
- Wonmurrie (Wonmurri, Manangoora)
- Bidida (Yangulinyina, Surprise Creek)
- Budjanga (Budjana)
- Bunjanga (Bujan, Bujana)
- Doolgarina (Jibabana)
- Mimina

Seven of the outstations are permanently occupied (Category 1), two are occupied more than half the time (Category 3), and one is occupied only on weekends and holidays (Category 6). The roads in this area are unsealed and often impassable in the wet. Their combined population is 85.

None have an airstrip. Budjanga (Budjana) has a telephone, but the others rely on radios or have no communication technology. There are no visiting health services.

Mabunji Out-stations

The Mabunji Outstations have been serviced by the Mabunji Resource Centre in Borroloola, although they relate culturally to Robinson River, and use its resources. There are plans to transfer these outstations to the Mungoobada Resource Centre.

APPENDIX 8 - COMMONWEALTH AGED CARE FUNDING

The following organisations are funded for Aged Care Projects.

1. Tiwi HSZ

Nguiu THB.
Milikapiti Community Government Council.
Aged Care Pilot Project – Tiwi Islands Aged Care.

2. Darwin HSZ

Commonwealth Aged Care Program (CACP) - Darwin Gwalwa Daraniki Ass Inc
Home & Community Care (HACC) THS Dementia Worker (Casuarina)
HACC THS Respiratory Nurse (Casuarina)
HACC THS Spinal Nurse (Casuarina)
HACC THS Care Coordination Project
HACC THS Taxi Subsidy Scheme(Casuarina)
HACC Aboriginal and Islander Medical Service
HACC Aboriginal Resource and Development Services Darriba Nurri
HACC Belyuen Community Council Co-ordination Service
HACC Belyuen Community Council Vehicle Project

3. Top End West HSZ

CACP Daly River Nauiyu Nambiyu Community Government Council
CACP Peppimenarti Community Council Inc
CACP Wadeye Kardu Numida Inc
HACC Wadeye Kardu Numida Association Kardu Numida HACC Service
HACC Pine Creek Community Council Pine Creek Transport Services
HACC Daly River Nauiyu Nambiyu Association Nauiyu Nambiyu Nutrition Service

4. West Arnhem HSZ

CACP Jabiru - Djabulukgu Ass Inc
HACC Djabulukgu Association Co-ordination Service
HACC Djabulukgu Association Meals Project
HACC Oenpelli Gunbalanya Council Inc - Oenpelli Gunbalanya Nutrition and Home Help Program
HACC Warruwi Community Council Mardbulk Home Care Service

5. Maningrida HSZ

Aged Care Pilot Project – MHB.

6. North East Arnhem HSZ

CACP Laynhapuy Homelands Laynhapuy Homelands Ass Inc
HACC Galiwin'ku Community Inc
HACC Gapuwiyak Community Inc Meals and Home Help Service
HACC Milingimbi Community Inc Milingimbi Meals Service

7. South East Arnhem HSZ

CACP Numbulwar Numburindi Community Government Council
Aged Care Pilot Project – Angurugu Community Council

8. Katherine East HSZ

HACC Bulman (Gullin Gullin) and Weemoll Community Council Madrul Centre HACC Project
HACC THS Katherine Community Connections
HACC Beswick Wugularr Community Council Wugularr (Beswick) HACC Services
HACC Barunga Community Council Barunga Community HACC Project
HACC Binjari Community Council Binjari Community HACC Project
HACC Katherine Kalano Community Association Kalano HACC Services
HACC Lajamanu Community Council

9. Katherine West HSZ

CACP Lajamanu Community Government Council
CACP Yarralin Walangeri Ngumpinku Resource Centre

10. South East Top End HSZ

HACC Borroloola Rrumburriya Malandari Council, Boonu Boonu Women's Centre
Aged Care Pilot Project – Rrumburriya Malandari Council

APPENDIX 9 - EXPENDITURE ON HEALTH SERVICES FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Table 51 compares the health expenditure per person by the NT government on Indigenous and non Indigenous people with health expenditure by all States and Territories combined. On average, the NT spends $3221 per Indigenous person compared with $963 per non Indigenous person - over three times more, on average, for Indigenous people. By comparison the average expenditure on Indigenous people for all States and Territories combined is $1753 per person compared with $785 per person for non Indigenous people.

Table 51: Estimated expenditure per Indigenous and non Indigenous person for the NT government and the total for all States and Territories, by type of service, 1995/96

	Northern Territory			Australia		
	Indigenous	Other	Ratio	Indigenous	Other	Ratio
	$ per person	$ per person	Indig: Other	$ per person	$ per person	Indig:Other
Hospital – inpatients	1,237	419	3.04	924	474	1.95:1
Hospital – outpatients	371	109	2.95	267	119	2.24:1
Mental health institutions			3.39	28	23	1.19:1
Nursing homes	4	2	1.85	33	26	1.27:1
Community health	669	148	4.52	291	74	3.90:1
Patient transport	316	50	6.28	81	23	3.48:1
Public health	272	86	3.16	57	21	2.69:1
Administration and research	353	149	2.37	74	24	3.15:1
Total	**3221**	**963**	**3.34**	**1753**	**785**	**2.23:1**

Source: Deeble (1998)

* Note: This is State/ Territory expenditure only.

In the NT, as in all States and Territories, expenditure on hospital inpatients is the largest single expense at an average of $1,237 per Indigenous person compared with $921 per Indigenous person nationally. The NT government spends another $669 per Indigenous person on community health services (half the amount spent on inpatients) and half as much again on outpatients ($371) and patient transport ($316). These relative proportions are not the same nationally. Less than a third of the national expenditure on inpatients is spent on community health and outpatients ($291 and $267 respectively). Less than 10% of inpatient expenditure is spent on patient transport.

The higher expenditure on inpatients in the NT compared to the other States and Territories is related to the higher admission rates for Indigenous people at 517 persons per 1,000 (Table 52). In other States, the admission rate for Aboriginal and Torres Strait Islander people, even after adjusting for underreporting, is 510 per 1,000 in SA, 505 per 1,000 in WA, 487 per 1,000 in Qld and 388 per 1,000 in NSW.

Table 52 Acute hospital admission rates for Indigenous and non Indigenous people: reported and adjusted to estimated under-identification, 1995/96

	Acute admission rates per 1000 population					
	Indigenous		Non indigenous		Ratio	
State/Territory	Reported	Adjusted	Reported	Adjusted	Adj Adm	Cost
NSW	258	388	283	277	1.40	1.62
Victoria	266	353	287	286	1.23	1.78
Queensland	413	487	292	289	1.69	2.12
Western Australia	505	505	250	250	2.02	2.67
South Australia	460	510	311	310	1.64	1.81
Tasmania	-	380	265	260	1.46	1.56
ACT	106	106	230	230	0.47	0.76
NT	517	517	163	163	3.17	3.34

Source: Deeble (1998)

Table 53 shows the State and Territory expenditure per person on Indigenous and non Indigenous people by State and Territory. NT has the highest per capita expenditure for both Indigenous and non Indigenous people. NT expenditure on Indigenous people is a third higher than the average per capita expenditure on Indigenous people in WA and over double the rate of SA, Qld, NSW and Victoria.

Table 53: State and Territory expenditure per person by State and Territory, 1995/96

State/Territory	Indigenous $	Non indigenous $	Ratio
NSW	1334	825	1.62:1
Victoria	1326	747	1.78:1
Queensland	1518	716	2.12:1
Western Australia	2152	807	2.67:1
South Australia	1500	827	1.81:1
Tasmania	1227	788	1.56:1
ACT	659	869	0.76:1
NT	3221	963	3.34:1
Australia	**1753**	**785**	**2.23:1**

Source: Deeble (1998)

Nearly 80% of health expenditures on services to Aboriginal and Torres Strait Islander people are managed by the States and Territories. The Commonwealth spends almost another $500 per Indigenous person nationally to give a total average expenditure of $2232 per person ($1753 + $472). See Table 54. In the NT the Commonwealth contribution is $661 per Indigenous person to give a total of $3882, when the NT government contribution is added.

Table 54 Estimated expenditure per person on services to Aboriginal and Torres Strait Islander people by State and Territory, 1995/96.

	Gross expenditure ($) per Indigenous person			
	State	Commonwealth		Total
State/Territory		AMS	Other*	
New South Wales	1334	139	226	1699
Victoria	1326	318	226	1870
Queensland	1518	147	226	1891
Western Australia	2152	370	226	2748
South Australia	1500	500	226	2226
Tasmania	1227	121	226	1574
ACT	659	94	226	979
Northern Territory	3221	435	226	3882
Australia	**1753**	**246**	**226**	**2232**

Source: Deeble (1998)

* This figure includes MBS and PBS expenditures as well as estimates expenditure on Indigenous peoples from nationally funded programs such as Blood Transfusion Service.

Table 55 compares the average estimated benefits paid per Indigenous and non Indigenous person through the MBS and PBS. Only a quarter of the benefit paid per person for non Indigenous people is paid for Indigenous people ($450 compared to $115) for both MBS and PBS combined. Indigenous people have very few specialist consultations – only 12% of the benefit paid for non Indigenous people. Payments for GP consultations, pathology and imaging is about a third of the payment for non Indigenous people.

Table 55: Estimated benefit payments for Indigenous and non Indigenous people through Medicare and the Pharmaceutical Benefits Scheme per person, 1995/96

	Indigenous	Non Indigenous	Ratio
MEDICARE	$	$	
GP consultations	44	130	0.35:1
Specialist consultations	7	50	0.12:1
Pathology	15	48	0.31:1
Imaging	16	49	0.33:1
Other Medical	6	54	0.11:1
Total Medicare	**88**	**331**	**0.27:1**
PBS			
General	3	19	0.16:1
Concessional/ pensioner	19	77	0.25:1
Other (safety net etc.)	5	27	0.18:1
Total PBS	**27**	**123**	**0.22:1**
All Medicare and PBS	**115**	**450**	**0.26:1**

Source: Deeble (1998)

The low utilisation of MBS is partly due to the way doctors have historically worked in the NT (ie salaried), or their absence, but also represents the inadequate level of health care delivered at the community level. The NTG expend more on community health than other state jurisdictions, but this is because THS have tended to provide PHC services in Aboriginal communities that are provided elsewhere through GPs. Poor access to PHC is nevertheless particularly revealed from the low access to Specialist services. This inadequate level of PHC service in communities, also probably results in higher utilisation of expensive hospital services in the NT.
The higher NT expenditure of non-Indigenous people compared with other jurisdictions is difficult to explain due to the demographics of that population – that is young, and often transient which means that those who get sick often return to where they came from. Does this represent some underlying inefficiencies?