"Health in the NT – Setting the scene"

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I would like to begin by acknowledging the traditional owners of the land on which we meet, the Larrakia people, and their elders past and present.

I want to start by going way back, in fact some forty years back, to the beginning of what is arguably the most significant period of health advocacy in the Northern Territory.

This history is actually quite fresh in my mind because last year we celebrated forty years of Aboriginal community controlled health services in the NT and twenty years since AMSANT was established.

This was nothing short of a revolution.

The first Aboriginal community controlled health service in the NT was the Central Australian Aboriginal Congress, or Congress. Congress was set up by community leaders in 1973 at a time when the health and social conditions of Aboriginal people were in an appalling state. Congress was born from community pressure. Aboriginal people took to the streets of Alice Springs in big demonstrations. One of Congress' first programs was supplying tarps to communities.

Congress led the way and was soon joined by other Aboriginal health services in different parts of the Territory.

The development of community controlled health services was in turn the result of action internationally in the health community to develop the concept of primary health care.

The Aboriginal community controlled health model developed over time and with it the practice of comprehensive primary health care.

As you will know, this model of care is far more than the delivery of health services, but includes health promotion, illness prevention, treatment, care and rehabilitation, community development and advocacy, including cross-sectoral activity to address the social determinants of health. It is delivered through multidisciplinary teams and is at its core evidence based. It also incorporates services relating to alcohol, tobacco and other drugs, early childhood development and family support, aged and disability, and mental health and social and emotional well being.

Despite the success of Aboriginal community controlled health services, they still struggled for resources and support from government. A strong advocacy voice was required and so it was that AMSANT was established after a 3-day meeting of

community controlled health services in Alice Springs in 1998. The organisation's key objectives were:

- greater community control
- more resources
- improved training, salaries, and conditions for Aboriginal Health Workers.

AMSANT's first major campaign was to have administrative responsibility for Aboriginal primary health care transferred from the Aboriginal and Torres Strait Islander Commission, or ATSIC, to the Commonwealth Health Department.

This was a very controversial move but was based on the carefully reasoned assessment that Aboriginal health funding would be forever constrained unless funds could be accessed from mainstream health funding.

This proved to be right on the money, literally.

AMSANT also set about to develop an agenda for advocating on Aboriginal health by directly engaging with the community. Several key conferences and historical summits followed.

In October 1998, more than 150 delegates attended the Central Australian Aboriginal Health Summit at Ilpurla Outstation. What was remarkable was that it was the first time a large group of Aboriginal community leaders had gathered to confer about the state of health in their communities.

Concern about Aboriginal health and control of services was gaining momentum.

The following year more than 200 delegates attended the Banatjarl Health Summit near Katherine. One year later another significant summit was held in Arnhem Land, at Gulkula.

The Gulkula Health Summit theme was 'Family is Life". It focused on family relationships and the crisis facing children and young adults. Male and female clinics were set up at the summit's Garma festival.

These initiatives to develop a community-led agenda for Aboriginal health were complemented with a campaign to improve administrative arrangements for Aboriginal primary health care. Setting up a transparent and accountable planning structure was a key objective.

The signing of the Framework Agreement between AMSANT and the NT and Australian governments in April 1998 saw the planning structure come into being—the Northern Territory Aboriginal Health Forum.

For the first time the Aboriginal community controlled health sector was at the table as an equal with government.

AMSANT is the permanent chair of the Health Forum and works with our Forum partners to ensure funding and planning improve Aboriginal primary health care services and coordination of the health system.

AMSANT successfully campaigned for the Commonwealth Government to “cash out” Medicare funds for Aboriginal people living in remote regions, generating extra funds for primary health care and creating a mechanism for developing regional health services.

This led to the Aboriginal Coordinated Care Trials in the NT and the Primary Health Care Access Program announced in the budget of 1999. AMSANT and Forum secured increased and more equitable program funding for Aboriginal primary health care and two successful regional health services were subsequently established: Katherine West Health Board in 1999 and the Sunrise Health Service in 2005.

These services demonstrated that regionalised community control can produce better services and improved health outcomes. Rolling out this model across the Territory remains a major objective of the joint planning process under Forum.

In 2009 an agreement was signed by the Forum partners, committing Government to transition all Aboriginal primary health care services in the NT to Aboriginal community control.

This was a landmark achievement.

The significance of having the NT Aboriginal Health Forum as an effective, high-level health planning body with the Aboriginal sector at the table cannot be understated. It has meant that our advocacy is able to reach into the decision-making process.

It’s also important to acknowledge that the kind of access we have is something that is denied other areas of Aboriginal affairs policy and has been to the detriment of getting positive policy outcomes for our communities.

The effectiveness of primary health care has increased markedly over the last twenty years driven by the leadership of the Forum. The NTAHF provides strategic leadership across the sector and has driven a host of improvements which have contributed to the gains that have been made in health.

To get to this point has not been a straight line. What might have been the outcome if we didn’t have those demonstrations on the streets of Alice Springs over forty years ago? It has not been easy. It has taken hard work and tireless advocacy for the evidence-based development of comprehensive primary health care.

Our services and clinicians have been at the forefront, pushing the development of better health systems, including sophisticated electronic patient records systems, the development of a set of indicators to measure and report on progress, and the development and use of common compulsory clinical protocols.

We have led developments in areas such as eHealth and continuous quality improvement, or CQI systems. Adopting these new technologies has driven improvements in the efficiency, accountability and quality of health services.

We can demonstrate that there has been good improvement over the last twenty years.

For example, there have been substantial drops in infant and child mortality largely due to reductions in infectious diseases with success factors including high rates of immunisation and new immunisations, better primary health care and more timely and better hospital care.

But as we all in this room are only too aware, there is still a very long way to go before we can achieve health equity for Aboriginal people.

Closing the Gap reports year after year continue to show sluggish, patchy progress.

In fact we are at risk of stalling or going backwards without the right policies and services.

Just one example. A significant factor in the slowing of health improvement is high rates of chronic disease, with evidence that the tide of chronic disease is still growing. The NT has one of the highest rates of renal failure in the world with around 450 people on dialysis with rates still climbing. Unless our health system is geared up to respond to this, the problem will continue to grow.

Good advocacy is needed now more than ever. And that means advocacy for government to continue investment in primary health care, ongoing system reform, including further development of regional health services, and investment in quality improvement measures, better coordination between acute care and primary health care, and importantly, more focus on prevention.

There are areas of concerns for the PHC sector. One key one is the Aboriginal workforce. Aboriginal people are included in all levels of our workforce from receptionists to CEOs and board members of our organisations. However Aboriginal Health Practitioners (registered health professionals who are a critical part of the workforce providing clinical care and acting as culture brokers) are in decline in the NT for a variety of complex factors.

We cannot have an effective and culturally secure clinical workforce without Aboriginal Health Practitioners being at the centre of it.

We also know that critical areas of comprehensive primary health care such as Social and Emotional Well Being services and early childhood programs are resourced only in a few Aboriginal primary health care services, largely the urban services. If these services are not provided within primary health care, they are either not provided at all or are provided as visiting services, often poorly integrated with the local health service. They are quite often provided by mainstream NGOs that do not have close connections with the communities.

But the other side of the health advocacy equation is in relation to the non-health service factors—the social determinants of health. The health system can only do so much. We also know that other factors, such as education, employment and housing need to improve significantly if we are to close the gap. Equally important are psycho-social factors, particularly empowerment.

To quote the eminent Sir Michael Marmot, Chair of the WHO Commission on the Social Determinants of Health: “Empowerment is key … we saw empowerment as having a material dimension—if you haven’t the money to feed your children you can’t be empowered; having a psycho-social dimension—having control over your life and not having lots of bad things happen to you; and a political dimension—having voice”.

If you think about this quote it’s not hard to see that our Aboriginal communities in the Northern Territory score a trifecta of disempowerment.

Underlying this are the ongoing impacts of racism that we know exists and that is a factor in poor mental health and physical health outcomes. What we call institutional racism is also present and affects the treatment Aboriginal people receive in health services and hospitals.

This brings into the equation questions of equity and access and social justice.

Another important factor is that too much government policy in the social determinants area is not evidence based, but driven by ideology and political considerations.

The Northern Territory Emergency Response of June 2007—commonly known as the Intervention—is such an example of a top-down policy without evidence that has delivered very little improvement despite huge investment.

As an example, a comprehensive evaluation of income management found no evidence that it achieves its stated objectives, yet the Australian government has spent hundreds of millions of dollars imposing it on Aboriginal communities in the NT and has allocated a further $137 million in the current budget to keep it going.

There is a saying about the definition of madness that seems appropriate here.

The Northern Territory Government’s Alcohol Mandatory Treatment is another example of an expensive, non-evidence-based policy. We know, and evidence clearly shows, what works in addressing alcohol misuse and harm in our communities, and AMSANT, along with many others, has consistently argued for a comprehensive, evidence-based strategy around alcohol and other drugs.

An example of AMSANT’s involvement in cross sectoral activity to engage in direct advocacy in relation to the social determinants is the Aboriginal Peak Organisations NT alliance, or APONT. We joined together with the two land councils, the NLC and CLC, and the two Aboriginal legal services, NAAJA and CAALAS, to work collaboratively on issues of joint concern.

Our work has included convening Aboriginal forums on issues such as alcohol and other drugs, housing, employment and governance.

APONT has also spearheaded a further initiative to help turn around the disempowerment of Aboriginal communities and organisations by engaging with non-Aboriginal NGOs in developing a set of Partnership Principles to guide the

activities of NGOs towards supporting the building of capacity of Aboriginal organisations in service delivery.

It is about putting Aboriginal people back in the driver's seat and about our belief that Aboriginal organisations should be at the forefront of service delivery for our communities.

We have had 18 major NGOs endorse the Principles so far, and have a joint steering committee driving the implementation of them, including encouraging government to adopt the principles in relation to tendering out services to Aboriginal communities.

Just imagine if the Principles had been used in relation to the recent Indigenous Advancement Strategy tendering process? We would have had a very different outcome.

We firmly believe that allowing Aboriginal communities to control their own services is key to 'closing the gap' in Indigenous disadvantage.

I hope this has provided a window into the broader issues underlying Aboriginal health in the Northern Territory and the challenges we face.

Advocacy has been, and will continue to be, a vital part of ensuring that we continue to make progress towards real health equity.

It's important that we understand how advocacy can help us work more effectively to achieve our goals.

I might stop there and would be happy to take any questions.

Thank you.