Capacity Development in Aboriginal and Torres Strait Islander Health Service Delivery - Case Studies

Cindy Shannon and Helen Longbottom, School of Population Health, University of Queensland
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In 2003, a series of papers was commissioned to provide information, analysis and advice to Government as part of a Review of the Australian Government’s Aboriginal and Torres Strait Islander Primary Health Care Program. The Review examined issues relating to funding for comprehensive primary health care for Aboriginal and Torres Strait Islander people and the impact of activity in this area. The commissioned material complemented information obtained from previous reviews and evaluations as well as that obtained from program data.

An Interdepartmental Committee (IDC) oversaw the Review process. Members of the IDC were from the Australian Government Departments of the Treasury; Prime Minister and Cabinet; Finance and Administration; Immigration and Multicultural and Indigenous Affairs; Health and Ageing (Chair); and Aboriginal and Torres Strait Islander Services.

This is Volume 4 of the published Review papers.

The papers in this series are:

Volume 1. National Strategies for Improving Indigenous Health and Health Care by Judith Dwyer, Kate Silburn and Gai Wilson, La Trobe University.

Volume 2. Investment Analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory by Carol Beaver, Centre for Chronic Disease, University of Queensland and Yuejen Zhao, Health Gains Planning Unit, Department of Health and Community Services, Northern Territory.

Volume 3. Costings Models for Aboriginal and Torres Strait Islander Health Services by Econtech Pty Ltd.

Volume 4. Capacity Development in Aboriginal and Torres Strait Islander Health Service Delivery – Case Studies by Cindy Shannon and Helen Longbottom, School of Population Health, University of Queensland.


Volume 6. Maternal and Child Health Care Services: Actions in the Primary Health Care Setting to Improve the Health of Aboriginal and Torres Strait Islander Women of Childbearing Age, Infants and Young Children by Sandra Eades, Menzies School of Health Research.

Volume 7. Substance Misuse and Primary Health Care among Indigenous Australians by Dennis Gray, National Drug Research Institute, Curtin University of Technology; Sherry Saggers, Centre for Social Research, Edith Cowan University; David Atkinson, Rural Clinical School, University of Western Australia and Phillipa Strempel, National Drug Research Institute, Curtin University of Technology.

The opinions expressed in these papers are those of the authors and are not necessarily those of the Australian Government.

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## Abbreviations

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<tr>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>ACCHS</td>
<td>Aboriginal Community Controlled Health Service</td>
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<tr>
<td>AGPAL</td>
<td>Australian General Practice Accreditation Limited</td>
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<tr>
<td>AHMRC</td>
<td>Aboriginal Health and Medical Research Council</td>
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<td>AHO</td>
<td>Aboriginal Health Organisation</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AMS</td>
<td>Aboriginal Medical Service</td>
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<tr>
<td>APY Lands</td>
<td>Ngangu Pitjantjatjara Lands</td>
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<tr>
<td>ATSIC</td>
<td>Aboriginal and Torres Strait Islander Commission</td>
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<tr>
<td>B.E.S.T</td>
<td>Breastfeeding Education Support Team</td>
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<td>BMI</td>
<td>body mass index</td>
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<tr>
<td>CAEPR</td>
<td>Centre for Aboriginal Economic Policy Research</td>
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<td>CDC</td>
<td>Communicable Disease Control Centre</td>
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<tr>
<td>CDEP</td>
<td>Community Development Employment Program</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CGC</td>
<td>Commonwealth Grants Commission</td>
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<tr>
<td>CoA</td>
<td>Commonwealth of Australia</td>
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<tr>
<td>EPC</td>
<td>Enhanced Primary Care</td>
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<tr>
<td>FBT</td>
<td>fringe benefits tax</td>
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<td>FTE</td>
<td>full time equivalent</td>
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<tr>
<td>GCT</td>
<td>glucose challenge test</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
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<tr>
<td>HACC</td>
<td>Home and Community Care</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>IAHS</td>
<td>Illawarra Area Health Service</td>
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<td>IT</td>
<td>information technology</td>
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<td>LGA</td>
<td>local government area</td>
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<td>MBS</td>
<td>Medical Benefits Scheme</td>
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<td>MCH</td>
<td>maternal and child health</td>
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<td>MPS</td>
<td>multi-purpose service</td>
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<tr>
<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<tr>
<td>NATSIHC</td>
<td>National Aboriginal and Torres Strait Islander Health Council</td>
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<tr>
<td>NAHS</td>
<td>National Aboriginal Health Strategy</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NHC</td>
<td>Ngarampa Health Council</td>
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<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<td>NIASHS</td>
<td>National Indigenous Australians' Sexual Health Strategy</td>
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<tr>
<td>NSFATSISH</td>
<td>National Strategic Framework for Aboriginal and Torres Strait Islander Health</td>
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<tr>
<td>OATSIH</td>
<td>Office for Aboriginal and Torres Strait Islander Health</td>
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<td>PAL</td>
<td>physical activity levels</td>
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<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PCR</td>
<td>polymerase chain reaction</td>
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<td>PHC</td>
<td>primary health care</td>
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<td>PHCAP</td>
<td>Primary Health Care Access Program</td>
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<td>PIP</td>
<td>Practice Incentive Program</td>
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<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
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<tr>
<td>RACP</td>
<td>Royal Australasian College of Physicians</td>
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<tr>
<td>SAR</td>
<td>service activity reports</td>
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<tr>
<td>SCATSISH</td>
<td>Standing Committee on Aboriginal and Torres Strait Islander Health</td>
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<tr>
<td>SCMSAC</td>
<td>South Coast Medical Service Aboriginal Corporation</td>
</tr>
<tr>
<td>SDGP</td>
<td>Shoalhaven Division of General Practice</td>
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<tr>
<td>SEIFA</td>
<td>socioeconomic indexes for areas</td>
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<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>TAHIS</td>
<td>Townsville Aboriginal and Islander Health Service</td>
</tr>
<tr>
<td>TAFE</td>
<td>Technical and Further Education</td>
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<tr>
<td>TOR</td>
<td>terms of reference</td>
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<tr>
<td>UPK</td>
<td>Uwankara Palyanyku Kanyintjaka</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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1 Section one

The primary health care case studies documented in this report provided a component to the Review publication: *National Strategies for Improving Indigenous Health and Health Care* (Dwyer et al. 2004), which is an assessment of the Aboriginal and Torres Strait Islander Primary Health Care Program and in particular current expenditure and its impacts.

1.1 Introduction

Over the past 20 years, there has been little evidence of any significant improvement in the overall health of Australia’s Aboriginal and Torres Strait Islander people. The underlying causes of poor health in the Indigenous population have been well documented. In summary, they include dispossession, poor socioeconomic status, and low levels of education, lifestyle factors, prejudice and discrimination, substandard environmental conditions, inadequate and inappropriate service provision, and a lack of involvement of Indigenous people in policy and decision-making processes.

It is only in the last decade or so that there has been any real understanding of the need for a framework to promote Aboriginal and Torres Strait Islander health, and the Australian Government, and state and territory governments have formulated strategic policies that recognise self-management and self-determination for Aboriginal and Torres Strait Islander people. This has been expressed in various ways including:

- the development of community-controlled health services;
- Indigenous-specific health policies and programs;
- increasing participation of Indigenous people within the health professions;
- the development of more sensitive and collaborative approaches to health research; and
- the acknowledgment of the importance of primary health care as a mode of health improvement in keeping with a self-determination political framework.

1.2 The emergence of community-controlled models of service provision

At the time of Federation, health care was identified as an area of constitutional responsibility of state governments. The exceptions were quarantine issues that were the responsibility of the Commonwealth. After the 1967 referendum, the Commonwealth became increasingly more involved in Aboriginal and Torres Strait Islander health, with the establishment of its new Office of Aboriginal Affairs to make specific grants to the states/territories for ‘Aboriginal advancement’. Health was one of four functional areas that were covered by these arrangements. It has been suggested that this was a conservative response at the time (Anderson & Sanders 1996), and that it did not respond to the new politics that were emerging among Indigenous Australians, which specifically called for rights and autonomy. This resulted in the formation of Aboriginal community-controlled organisations, and the establishment of the first Aboriginal Medical Service (AMS) at Redfern in Sydney in 1971.

One of the major reasons community-controlled services developed was the perception that mainstream services were not responding to community needs.

The report of the House of Representatives Inquiry into Indigenous Health, the *Health is Life Report* (CoA 2000), found that...
‘... the effectiveness of community-controlled services is dependent on the level of available resources, and that despite numerous reports recommending increased levels of community involvement, the community-controlled services have struggled to achieve funding support and to develop effective working relationships with mainstream services.’ (p.38)

Role of the health system

The substantial improvements that have been achieved in the health of all Australians over the past few decades have not benefited all sectors of the population equally. While there has been a reduction in premature mortality from most major causes, the disparities in social, mental and physical health between the most advantaged and the most disadvantaged population groups, such as Aboriginals and Torres Strait Islanders, are as great as ever. Tackling socioeconomic inequalities is said to represent a major public health challenge. This had led to calls for a move from a focus on ‘downstream’ level factors, to ‘upstream’ level ones. The former refers to illness and disease, while the latter involves more macro-level approaches that have the greatest potential to influence the fundamental social and economic determinants of health, such as education, employment, housing, and transport.

It is important to understand the limitations on the role of the health system in responding to such inequalities, the determinants of which are multi-causal and interrelated. The role of the health system is to treat and prevent illness, which is done through timely high quality diagnosis, treatment, rehabilitation and palliative care in line with level of illness; and facilitating health improvements through early intervention and illness prevention mechanisms that promote both individual and population health and wellbeing.

It is also important to recognise that the health system is more than health services, and that the way in which the health system organises its two key functions, stewardship and service delivery is responsible for variations in performance. These are described as:

- **stewardship**—the government’s contribution to planning (including workforce planning), financing, investment, evaluation and monitoring; and

- **service delivery**—the delivery of accessible, high quality and responsive health care ranging across the continuum from primary, secondary and tertiary care.

In terms of service delivery, the focus of the case studies has been on primary health care, and where relevant, examples of improved access to secondary and tertiary care have been explored.

1.3 Health system issues

1.3.1 Funding for Aboriginal and Torres Strait Islander Health

The National Aboriginal Health Strategy (NAHS), released in 1989, was built on extensive community consultation to produce a landmark document that set the agenda for Aboriginal and Torres Strait Islander health. The 1994 evaluation of the NAHS concluded that it had never really been effectively implemented and that significant changes to institutional arrangements for Indigenous health were inevitable (ATSIC 1994).

With strong advocacy from the community-controlled sector, responsibility for Indigenous health service funding was transferred to the then Commonwealth Department of Health and Aged Care in 1995 and the Office for Aboriginal and Torres Strait Islander Health Services (OATSIH) was established. The National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) is a complementary document that builds on the 1989 NAHS and addresses approaches to primary health care and population health within contemporary policy environments and planning structures.
Following this transfer of responsibility, the Commonwealth health portfolio has adopted a leadership role in Indigenous health. This has been built on:

- achieving comprehensive and effective health care for Aboriginal and Torres Strait Islander people through development of infrastructure and resources;
- addressing key health issues and risk factors impacting on health;
- improving the evidence base through strategic research, effective data systems and evaluation and promoting the use of effective policy; and
- improving communication with service providers and the general population.

The focus on review of arrangements for funding has been influenced by recent reports, including the Australian Institute of Health and Welfare (AIHW), *Expenditure on Health Services for Aboriginal and Torres Strait Islander People (1998–99)* (AIHW 2001), the Commonwealth Grants Commission (CGC) *Report on Indigenous Funding 2001* (CGC 2001), and the *Health is Life Report* (CoA 2000). Funding and planning arrangements between the state and territory governments, and the Australian Government have often been reviewed and various new initiatives had been implemented. Examples are listed.

- The Australian Health Care Agreements were bilateral Agreements between the Australian Government and each state and territory government to provide and jointly fund health services in public hospitals, within the terms of the Agreement.
- The Aboriginal and Torres Strait Islander Health Framework Agreements set up joint processes for planning for improved access to health services, full and formal Aboriginal and Torres Strait Islander participation in decision making and priority determination and the collection of better data. The Agreements are between the Australian Government, individual state and territory governments, state affiliates of the National Aboriginal Community Controlled Health Organisation (NACCHO), and the Aboriginal and Torres Strait Islander Commission (ATSIC).
- The Public Health Outcome Funding Agreements were bilateral funding agreements between the Australian Government and each state and territory to provide funding for public health programs.
- A re-basing exercise that was undertaken in 1998 to move services to an ongoing base-funding model, to be indexed and granted annually subject to ongoing satisfactory performance. However, this exercise did not allow services to expand their health service delivery in line with the needs of the local population.
- The Aboriginal Coordinated Care Trials, which aimed to achieve a more coordinated approach to delivery of health care services to people with a range of complex and chronic health care needs.
- Initiatives to improve access to the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS), including:
  - improving the level of Indigenous enrolment in Medicare;
  - legislative arrangements to allow doctor performed services in an Aboriginal community-controlled health service (ACCHS) to claim under Medicare;
  - new health assessment and care planning items on Medicare; and
  - new legislative arrangements to improve access to PBS medicines in remote areas.
- The Primary Health Care Access Program (PHCAP), which is being implemented as a key part of improving access to mainstream services and programs and the development of Indigenous specific services and strategies to complement mainstream services based on regional plans.
- The allocation of funds to implement specific policy and program initiatives that have a primary health care component:
- The National Indigenous Australians’ Sexual Health Strategy that was launched in 1997 and is current until June 2004 provides a comprehensive approach to preventing the spread of HIV and sexually transmitted infections in Indigenous communities (Department of Health and Family Services 1997).

- The National Aboriginal and Torres Strait Islander Eye Health Program that was developed in 1998 as a result of the review of eye health services.

- The release of the *Bringing Them Home* report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (HREOC 1997).

- The Aboriginal and Torres Strait Islander Aged Care Strategy, which has resulted in the extension and diversification of aged care responses.

- The National Aboriginal and Islander Hearing Strategy which funds a range of hearing health components including child hearing sites, equipment and training, capital infrastructure and strategic research.

### 1.3.2 Other health system issues

In addition to under-funding, the NSFATSIH identified a number of reasons for the poor performance of the health system in responding to needs of Aboriginal and Torres Strait Islander populations. In summary, these included:

- the location of some services makes access difficult;
- poor linkages between private, government and specialist sectors and poor linkages between health services and other related programs;
- poor performance of the health system in meeting the needs of people with complex and multiple conditions;
- inappropriateness of some health promotion programs;
- a workforce that is generally poorly trained to respond to Indigenous issues and unwilling to work in remote locations; and
- the lack of training or professional development opportunities for Indigenous people working in the health sector.

In addition to the funding initiatives identified, a number of projects have been implemented to improve the quality of health system monitoring and reporting in relation to Aboriginal and Torres Strait Islander health. In summary, these include the following initiatives.

- The *National Aboriginal and Torres Strait Islander Health Information Plan* (ABS & AIHW 1998) that includes reporting against a set of National Performance Indicators, annual reporting against the Framework Agreements, and the delivery of a Service Activity Reporting Framework for ACCHSs.

- The establishment of a joint venture between the Australian Bureau of Statistics (ABS) and AIHW that has resulted in the production of *The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples* (ABS & AIHW 1999, 2001, 2003).

- Collaborations between the Health portfolio and ABS to improve the quality and accuracy of Indigenous data collections.

- Efforts by the National Health and Medical Research Council (NHMRC) to improve access to and outcomes from research in Aboriginal and Torres Strait Islander health, including the development of the NHMRC Roadmap for Indigenous Research (RAWG 2002).
1.3.3 Structural influences

The establishment of the National Aboriginal and Torres Strait Islander Health Council (NATSIHC), OATSIH and the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) have strengthened coordination of health policy and program development, complemented by a consolidation of the role of the community-controlled sector through NACCHO and its state/territory affiliates.

1.4 Health service delivery

1.4.1 Community-controlled health services

Service activity reporting data for 2000–01 suggests that there were 129 Aboriginal community-controlled health services funded by the Australian Government to provide Indigenous-specific primary health care services. A number of these organisations also provide substance misuse services and mental health services. These services are unevenly distributed across the states and territories, and there are huge variations amongst the services, in terms of staff size and operating budget. This reflects the largely historical and generally unplanned nature of the decisions to fund each of the individual services. In summary, they:

- diagnose and treat illness and disease and make referrals as appropriate;
- conduct population health programs;
- provide emotional and social wellbeing services, such as counselling; and
- provide advocacy and community support roles.

Numerous reports have highlighted the significant role played by the Aboriginal Community Controlled Health Services (Department of Health and Aged Care 2001). In summary, this includes:

- they provide an established mechanism for increasing Indigenous control over management of primary health care services;
- they represent a major source of education, training, achievement and pride and have developed a pool of knowledge and expertise about Indigenous health issues;
- they are an integral part of the health system, participating as partners with governments in policy, planning and through the Framework Agreements; and
- they can ensure that a range of primary health care services are available in one place.

1.4.2 Comprehensive primary health care

International experience has shown that a comprehensive approach to primary health care can contribute to significant improvements in health in developing countries and among indigenous populations in developed countries comparable to Australia. The comprehensive approach to primary health care is based upon the definition given in the World Health Organization (WHO) Alma Ata Declaration (WHO 1978):

‘...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s overall health system, of which it is the central function and main focus, and the overall social and economic development in the community with the national health system bringing care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process...’
For the purposes of Aboriginal and Torres Strait Islander health policy and programs, comprehensive primary health care has included:

- clinical care—including emergency care, treatment of acute illness and management of chronic conditions;
- population health programs—examples include antenatal services, immunisation, screening programs for early detection of disease, and specific health promotion programs (e.g. physical activity);
- facilitation of access to secondary and tertiary care—including the improvement of linkages across a range of services that would otherwise be inaccessible to many Aboriginal and Torres Strait Islander people, such as specialist medical care; and
- client/community assistance and advocacy—includes an advocacy role where health risk factors and health determinants fall outside the direct ambit of the health system.

1.5 Key concepts related to primary health care and community control

1.5.1 Role of governance

The Queensland Government Green Paper on community governance: *Making Choices about Indigenous Community Governance* (Qld Government 2003) refers to governance as being, in broad terms, about power, relationships and accountability and suggests that ‘good governance’ can be defined as a model that leads to social and economic results desired by citizens. It also suggests that it is important to distinguish between ‘governance’ and ‘government’, the latter referring to a particular institution, whereas the former is about the process of making decisions.

In a recent release by the Centre for Aboriginal Economic Policy Research (CAEPR), it is argued that

‘...a fundamental issue confronting Indigenous Australian groups and communities is how to develop to capacity to engage strategically with the general Australian society, in particular with its political and economic dimensions’ (Martin 2003, p. iv).

This refers to the processes through which Indigenous individuals, groups and communities are able to interact with, contribute to and draw from (and reject), the formal and informal institutions of the dominant society in a considered and informed manner that provides them with real choices as to where to go, and how to get there – it refers to a process rather than an outcome. Further, the CAEPR Research Plan for 2002 (CAEPR 2002) suggests that questions in relation to Indigenous affairs governance are of considerable importance in relation to welfare reform and progress in Indigenous economic and community development and socioeconomic status. A question of particular relevance to the case study analyses is: ‘How are Indigenous organisations at various geographic levels representative of, and accountable to, their constituencies?’

The Green Paper on community governance also highlights a key problem in looking at Indigenous community governance as being the problematic concept of ‘community’. It points out that what are now considered ‘Aboriginal communities’ are relatively recent and artificial creations in Aboriginal history, a legacy of the protectionist policies that brought widely dispersed groups of Aboriginal people together onto reserves and missions.

It further suggests that the word ‘community’ suggests a common interest or shared identity, as well as a sense of social and political unity among a group of people located together. As Rowse (1996) notes, various anthropological studies would suggest that Indigenous people might be more likely to affiliate themselves with their kinship or tribal group than the community in which they live, which raises the question of whether a ‘community government’ is the best means of progressing interests.
1.5.2 Responding to need

In its 2000 Report on Indigenous Funding (CGC 2000), the Commonwealth Grants Commission estimated Indigenous need for primary health care. It noted the following conceptual and practical difficulties in relation to reliable data on need:

- some measures may not assist with resource allocation decisions (e.g. hospital separation data reflect met need and not the extent to which there are unmet needs and gaps in service delivery);
- it is difficult to identify funds used to meet Indigenous needs in some cases, especially within mainstream programs;
- needs may not be met because of systemic or other structural problems; and
- broad measures mask variations at the local level.

One of the main aims of the Australian health care system is to achieve equity for all Australians. The common definition of equity—‘equal access to health care for equal need’—raises questions as to how need and access are defined and how they are measured (McDermott & Beaver 1996). This was also the approach taken by the CGC, with need defined by reference to ‘capacity to benefit’ and concluded that ‘on the evidence available to us, the poorer health status of Indigenous Australians, and their greater reliance on the public system, would justify at least a doubling of the average per capita government expenditure on non-Indigenous Australians’ (CGC 2001, p. 127).

The National Achievements in Aboriginal and Torres Strait Islander Health project was commissioned by SCATSIIH in 2001 to develop a framework for measuring success and to provide documented evidence in this regard. The project resulted in ten in-depth case analyses. The approach taken in this project in relation to need was:

- whether funding was sufficient to meet the needs and objectives of the program, project or intervention—adequacy of resources;
- recognition that projects are often ‘set up to fail’ when they don’t have/receive adequate funding; and
- whether programs, projects or interventions represented value for money.

1.5.3 Issues in relation to access to services

A number of initiatives have been implemented to improve access to primary health care services by Aboriginal and Torres Strait Islander people. The case studies will explore the impact of these at the local level and the extent to which barriers to access have been overcome. Some of the common barriers to access identified in the NSFATSIH (National Aboriginal and Torres Strait Islander Health Council 2003) include:

- cultural and social factors—particularly historical mistrust in the system, discrimination, communication issues and cultural misunderstandings;
- locational factors—particularly in rural and remote communities, but little is known about urban Indigenous access issues;
- poor linkages—particularly important given the high rate of chronic disease in Indigenous communities and the need for individuals to work their way through the system;
- lack of a population health focus—particularly important given multiple chronic morbidities in Aboriginal and Torres Strait Islander communities;
- workforce issues—including inadequate training for a range of health professionals (including cross-cultural context, dealing with complex multiple morbidities and issues specific to Indigenous health), along with high staff turnover; and
- financial barriers—including income-related barriers as well as structural barriers such as fee-for-service-type activities.
1.5.4 Measuring outcomes

The types of indicators of indigenous health commonly used in Australia, Canada and New Zealand range from central indicators (such as age-standardised rate ratios for Aboriginal and Torres Strait Islander people) to secondary indicators (such as change in the prevalence and incidence of chronic diseases, like diabetes in Aboriginal and Torres Strait Islander communities). It has been suggested that it would be useful to develop additional indicators that more closely reflect Aboriginal and Torres Strait Islander community models and values. Existing indicators are said to represent outcomes rather than opportunities for early intervention, such as early childhood development and youth resilience (Bauert et al. 2003).

There is increasing recognition that it is no longer acceptable to use measures such as morbidity and mortality rates alone to assess outcomes in Aboriginal and Torres Strait Islander health, and that there are a range of measures, particularly intermediate ones, that more accurately reflect successful approaches to Indigenous health and likely longer-term health improvements.

This was acknowledged in the report of the National Achievements in Aboriginal and Torres Strait Islander Health project (Shannon et al. 2002), which found that all achievements in Indigenous health may be defined as producing positive change in some variable which contributed to Indigenous wellbeing or community empowerment. These could be considered under the following four categories:

- an improvement to health outcomes (e.g. an improved infant mortality rate);
- improvements to process indicators with a proven link to better health outcomes (e.g. improved antenatal care leading to better obstetric outcomes);
- improvements in the health system or components thereof (e.g. health policy, data collection or the shape of service delivery—also known to lead to improved health outcomes); and
- improvements in other areas, such as education, employment or housing, which are also known to lead to improved health and wellbeing.

1.5.5 Role of capacity building

The House of Representatives Standing Committee on Family and Community Affairs, in its Health is Life Report (CoA 2000), found that ‘Indigenous communities easily attract criticism for financial mismanagement, but that they have considerable difficulty in accessing the administrative support they need to address these problems’ (p. 45). They concluded:

‘The important thing about community control is that the community has the capacity to do it. It is no good just suddenly hurling a whole bunch of money into a community and saying ‘you have community control now’, when the people in the community do not necessarily have the capacity to do that…’ (p. 44).

Clearly, in order to achieve desired outcomes in Indigenous health, one of the key issues for consideration is the capacity of services to deliver successful programs. In terms of what is meant by the term capacity, there exist a range of definitions in the literature.

However, despite the increasing emphasis upon building community capacity in an Aboriginal and Torres Strait Islander Health context and in a spirit of self-management for Indigenous people, there is no universal agreement on how this is defined or the strategies needed to achieve capacity. Recent attempts in this regard include the following.

- According to the NSFATSIH, building capacity to service Aboriginal and Torres Strait Islander communities requires ‘an increased financial investment, increasing the Aboriginal and Torres Strait Islander workforce, devolving resources and decision making to communities, and reforming health systems’ (National Aboriginal and Torres Strait Islander Health Council 2003, p. 48).
• Martin (2003) suggests that it is not only Indigenous capacity that needs to be built, but that capacity of
government and its agencies is often a major limiting factor in addressing disadvantage. He concludes
that building the capacity to strategically engage with dominant political and economic interests in
Australia is fundamental to achieving self-determination, and is dependent upon effective governance
mechanisms.

• The National Evaluation Report of the Aboriginal and Torres Strait Islander Coordinated Care Trials (KPMG
2001) used a number of indicators to report on community capacity. These included organisational
structure and processes, decision-making roles and responsibilities of organisational entities, decision
implementation, organisational activities, program infrastructure, and enhanced professional capacity to
work towards better health.

• In its submission to the House of Representatives Standing Committee on Aboriginal and Torres Strait
Islander Affairs – Inquiry into Capacity Building in Indigenous Communities, Central Australian Aboriginal
Congress Inc. (CAAC 2002) drew upon Sander’s work and looked at the following components of
capacity:
  - acceptance of responsibility to carry out tasks;
  - having the authority to carry out tasks;
  - having access to and control over resources necessary to perform the tasks; and
  - having the knowledge and skills to perform the tasks.

Despite the lack of a universally accepted definition of capacity building, there appear to be a number of
consistent dimensions and these will be explored in the case analyses. The Community Capacity, Health
Inequalities and Sustainable Communities Network in Australia identify the common themes as:
• participation and leadership;
• skills (such as planning, coordination, advocacy, management, problem solving, and conflict
resolution);
• social and inter-organisational networks;
• sense of community (belonging, influence, emotional connection);
• resources (access to resources, financial capital, social capital and technology, and the ability to use them
prudently);
• understanding of community history;
• community power (amalgamation of sense of community, leadership, shared concern);
• community values (how consensus of values is achieved); and
• critical reflection.

In terms of analysing capacity within a policy framework, the work of Barrett and Fudge (1981) is relevant.
They suggest that effective policy implementation depends on four factors:
• knowing what you want to do (clearly defined objectives);
• availability of the required resources;
• ability to marshal and control those resources to achieve the desired end; and
• if others are carrying out the task, communicating what is wanted and controlling their performance.
1.6 Local context

The NSFATSIH notes that Aboriginal and Torres Strait Islander communities are diverse. Cultural differences, historical developments, policy contexts and differences between rural, remote and urban locations have resulted in different patterns of service delivery. Identifying health service needs in particular communities requires:

- an examination of what is working and not working; and
- identification of the gaps in services compared to local needs, strengths and opportunities.

Health services must devolve decision-making capacity to the local level and in turn, the services must be inclusive, providing services in response to the needs and wishes of individuals and families in the community. The case studies seek to explore the various concepts and issues identified in this chapter as they apply to the individual services involved in this study. This requires an in-depth analysis of the various inputs and processes used within services in different locations, and linking of these with outputs and outcomes achieved over time. It will also allow for some conclusions to be drawn about the extent to which needs are being met through current governance, service delivery and planning processes, and the identification of barriers in this regard.
2 Section two

2.1 Methodological considerations

The case studies used information available at the national and local level. An ‘inputs-processes-outputs-intermediate outcomes-outcomes’ model was used to measure the impact of a health service. Central to the model is acknowledgment of the fact that outcomes are influenced by a myriad of social-economic and biological pathways and that it is difficult to measure the contribution of a specific factor such as a health program (DHA 2003). Additionally, the measurement of health outcomes must encompass factors such as changes in physical, social and emotional functioning, quality of life, levels of empowerment as well as the more traditional measure of life expectancy. The model allows for some understanding of the relationships between inputs and outcomes, and acknowledges the lag time between investments in the health care system, capacity building within the system, and health outputs and outcomes.

The model describes both intermediate outcomes and outcomes. An intermediate outcome is one that has a direct relationship to the work of a service (an output) and can use evidence from the literature to support its relationship to a health outcome. For example, a service may run a cervical screening program that results in increased rates of screening (an intermediate outcome). There is evidence from literature that increased rates of screening improve health outcomes for cervical cancer (outcome). In many instances it is possible to document changes in intermediate outcomes but it is too early to document changes in actual outcomes.

The model differentiates between system and service level factors. System level factors are defined as factors associated with the policy, economic and social context in which a service operates. National health policy and funding policy are examples of system level factors. Service level factors are those that relate specifically to the service. Examples include governance, funding, infrastructure and planning.

The purpose of the model is to have a consistent approach to evaluation and analysis and thus allow for the identification of common themes and factors that have contributed to the development of effective primary health care delivery systems that meet the needs of individual communities.

2.2 Data

While the case study investigation framework specifies an ideal set of data and an analytical method, its application at each individual site is dependent on the availability of information. The most recent data from each service was included in each of the case studies. Lack of readily available retrospective data limited the length of the time periods in some instances. Both quantitative and qualitative data were used.

2.2.1 Quantitative data

Quantitative data comes from a number of sources including:

- routine population statistics from Australian Bureau of Statistics (ABS);
- background health data from Australian Institute of Health and Welfare (AIHW) morbidity and mortality reports and from published surveys and reports;
- funding information from the financial reports of the services and government reports;
- workforce data came from the reports of the services and from service activity reports (SAR);
- background health, health services, social and economic information from regional plans developed as part of the Framework Agreements process;
• administrative data from each service; and
• outputs and intermediate outcomes from the services.

2.2.2 Qualitative data

Site visits were undertaken to each of the services and structured and unstructured interviews were conducted with a broad range of people involved in the services. These people included members of boards, chief executive officers, doctors, nurses, health workers, allied health staff, administrative staff and clients. In some instances, people from allied or associated services were interviewed where this was possible. This interview provided factual information about the services and their histories. They also provided descriptive and anecdotal information on the services and factors relating to their development and capacity. A broad range of people were interviewed in order to obtain as complete a picture as possible of each service.

Standard information was sought at each site visit including information on:
• governance;
• community capacity and community empowerment;
• service planning;
• accessibility;
• coordination with other local health care services and other regional infrastructure;
• responsiveness of service to community needs; and
• the quality of service provision.

The reflective questions that were used in the structured interviews were:
• What do you see as the major role of the service within the community?
• What do you see as being the major achievements of the service since its establishment?
• Why do you think these outcomes were achieved?
• What are the most significant changes you have seen within the service over the period of your relationship with it?
• What do you think are the major health needs within this community?
• Comment on how well the service is presently able to meet these needs, including any barriers to meeting them.

In some services external evaluation reports of the services were available and these were used as additional sources of information.

2.2.3 Consumer/client feedback

Data from existing surveys and accreditation reports were used as sources of information on consumer/client feedback. This information was available in two of the services. It was not possible and in one instance, not appropriate, to conduct separate focus groups or surveys.

2.3 Key indicators

Key indicators that were used in the case study investigation framework and their data sources are listed below (Table 1).
Table 1: Proposed key indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Possible data type/source</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: The context</td>
<td></td>
</tr>
<tr>
<td>Geographic</td>
<td>Descriptive information on geographic region and the community, including proximity to major centres etc.</td>
</tr>
<tr>
<td>Social</td>
<td>Population (total and Indigenous) - ABS. Community infrastructure (e.g. existing health infrastructure, schools, housing) - state/territory and local government.</td>
</tr>
<tr>
<td>Economic</td>
<td>Per capita income - ABS. Unemployment rates/ Social Services Benefits - ABS.</td>
</tr>
<tr>
<td>B: Inputs</td>
<td></td>
</tr>
<tr>
<td>Investment/funding</td>
<td>OATSIH data, MBS, PBS, data from service and state/territory government funding information.</td>
</tr>
<tr>
<td>Governance/management/ community capacity</td>
<td>System of governance of the service – descriptive from site visit and reports. Administrative systems in place at service – SAR and descriptive information from site visit.</td>
</tr>
<tr>
<td>Physical infrastructure</td>
<td>SAR - and descriptive information from site visit. Photographs where appropriate, subject to agreement by the individual service.</td>
</tr>
<tr>
<td>Staffing</td>
<td>Staffing levels, staff mix and staff training, also continuing education opportunities for staff – SAR, annual reports from services and descriptive information from site visits. Indigenous/non-Indigenous staff ratios and systems in place for recruitment, retention and career development of Indigenous staff.</td>
</tr>
<tr>
<td>Community</td>
<td>Largely from site visits.</td>
</tr>
<tr>
<td>C: Processes</td>
<td></td>
</tr>
<tr>
<td>Planning</td>
<td>Processes for planning at the local level and coordination with local, regional and national initiatives – information from reports (national and regional) and information from site visits.</td>
</tr>
<tr>
<td>Links between ACCHS and other local health Services</td>
<td>Information from sites visits and SAR and other reports (e.g. a strategic plan for a region).</td>
</tr>
<tr>
<td>Links between ACCHS and secondary and tertiary health facilities</td>
<td>SAR and descriptive information from site visit.</td>
</tr>
<tr>
<td>Quality measures</td>
<td>Use of recall and reminder systems – SAR and descriptive information from site visit. Patient satisfaction surveys or focus groups – information from site visit. Accreditation.</td>
</tr>
<tr>
<td>D: Outputs</td>
<td></td>
</tr>
<tr>
<td>Service provision (clinical services and specific programs and protocols)</td>
<td>Types of services provided by ACCHS (clinical, preventive, outreach, etc.) – SAR and descriptive information from site visit (e.g. information from preventive programs and screening programs).</td>
</tr>
<tr>
<td>Quality and responsiveness of the health service</td>
<td>SAR and information from site visits; have services been accredited? Systems in place for monitoring and evaluation.</td>
</tr>
<tr>
<td>Service outputs</td>
<td>Process information on types and mix of services; client numbers; this information will be collected for ACCHS and also for other local services if this is applicable – SAR, information from site visit, data from other local services; Information from secondary and tertiary referral services – state/territory government, in-patient statistics.</td>
</tr>
</tbody>
</table>
2.4 Analysis

Each service was analysed as an individual case study. The information from each case study was mapped, changes over time described, and factors that improve capacity and barriers to capacity development were identified. The indicators were reported on over the time scale that was appropriate for the specific service so that critical periods in the service’s development and longitudinal trends could be identified. There were limited data available for early periods in the life of some services and this influenced the time scale used for the case study in these instances.

In each of the services, a specific program or programs was selected and explored in depth, such as the Mums and Babies Program in Townsville. This allowed for better identification of factors that contribute to capacity and barriers to its development. The exception to this was Case Study 4, a rural Aboriginal Health Clinic, where no specific programs were in place.

An analysis of information from the four case studies was done and common themes identified and explored. This analysis was then used to address the terms of reference for the study.

2.5 Addressing the Terms of Reference (TOR)

It was anticipated that the data collection and analysis undertaken in the case studies would allow the consultants to address all the relevant terms of reference for the study. Below is a schema of how we anticipated specific terms of reference would be addressed.

2.5.1 TOR 1

Assess the level of current spending and its impact in various locations including urban, rural and remote areas. This will include an assessment of the capacity of the health system, mainstream and Indigenous health services and communities to respond to Aboriginal and Torres Strait Islander health needs.
The first task here was to define capacity. While the literature suggests that there is ongoing debate about which dimensions are integral to the notion of community capacity, in the health field, community capacity building is seen as the foundation for processes aimed at maintaining and promoting wellbeing. According to Bush et al. (2002), it is:

‘...the ability to utilise and develop existing resources within a district’ ... [and] ...it advocates the use of locally based skills, combined with the resources of a range of organisations and government to ensure the provision of services and programs that are broadly based and appropriately matched to the district.

Our hypothesis was that the inputs and processes identified in Table 1 are contributors to capacity building, and by linking the reported outputs and outcomes to these, we would be able to draw conclusions about the extent to which this has involved elements of capacity building, including the reasons for such success and the likely impact of further investment in terms of capacity building.

For example, from the data we were able to document the health infrastructure, workforce and skills level and health programs and other factors that contribute to capacity in the area of the chosen ACCHS such as governance and community empowerment. We were also able to document health indicators (both intermediate outcomes and outcomes) and their change over time. An analysis of these indicators and comparison of results between the individual case studies, allowed us to draw some conclusion about capacity and the factors that contribute to it.

The level and nature of service provision compared with relative health need

The definition and description of relative need is central to addressing this term of reference. Standard measures (e.g. those used in AIHW reports) and indicators from Table 1, Sections A, E and F were used. Information on the level and nature of service provision came from indicators in Table 1, Section B, C and D (e.g. we could describe the level and mix of services, and links between ACCHSs and secondary and tertiary services). The site visits also sought to provide feedback on the health needs within the community and the extent to which these are being met. Where gaps in terms of assessing or meeting need are identified, we explored potential strategies for addressing them. We were able to map developments over time and to make comment between the different locations chosen for the case studies.

The accessibility and quality of current services

The definition of accessibility and quality are important. We explored the known barriers to access (such as Medicare access, remoteness, cultural issues, workforce, financial, family and other social constraints) as well as those specific to the local context. Indicators in Table 1, Sections C and D were used. For example, we looked at the type of service and programs and how they meet the community needs; community access to services; community feedback on the service; the processes that the service has in place to monitor effectiveness of programs (e.g. system to monitor immunisation rate); use of recall and reminder systems. This provided the basis for developing a working definition of quality, as perceived by the key stakeholders and evident in the analysis of available data. The key elements of quality and contributors to successful approaches over time were identified.

An assessment of the health improvements that have been achieved to date.

Indicators from Table 1, Sections E, F and G were used allowing us to track changes over time. For example, we were able to see changes in indicators such as immunisation rates, health screening, or appropriate
management of chronic conditions (use of Angiotenzin-converting Enzyme (ACE) inhibitors in people with diabetes). The indicators chosen were dependent on availability of data and on the programs that are in place in individual services.

Any barriers to the achievement of better health outcomes for Indigenous Australians

Barriers to achievement were identified in a number of ways. At the individual service level some barriers and gaps were identified by the longitudinal analysis of the indicator data. For example, it become apparent that there was a link between optimal immunisation or screening rates, and staffing levels and skills and/or information systems. Other barriers at the service level were identified at the site visits. These may be indicators related to inputs (e.g. governance, infrastructure, planning). At the system level, barriers were identified by analysis between the different case studies. Findings in relation to need, access and quality issues were important.

2.5.2 TOR 2

Provide advice on the strategy and relevant timeframes required to achieve appropriate levels of comprehensive and effective health care for Aboriginal and Torres Strait Islander people.

We have addressed this in the last paragraph of Section 6 (Analysis). Specifically we identified:

- milestones in the development of services;
- factors that influence the capacity of a service to impact on health; and
- the timeframe that it may take a service to reach a threshold level of capacity for health indicators to improve.

2.5.3 TOR 3

Determine the likely short, medium and longer-term health impacts that could be expected to result from increased investment in this area.

The case studies documented health impacts over time for specific services. We were able to identify factors that influence the capacity of a service and to comment on how capacity may initially lag behind impact but once a threshold level is reached the impact may have an exponential increase.
Section three – Townsville Aboriginal and Islander Health Service (TAIHS)

Townsville Aboriginal and Islander Health Service (TAIHS) is a well established service that has served the Townsville community since the early 1980s. For many years its core business was providing basic clinical services to the Aboriginal, Torres Strait Islander and Islander communities in the Townsville area. In recent years the service has undergone rapid growth and now provides comprehensive primary health care and additional community programs.

This case study will:

- focus on the recent history of TAIHS;
- examine the factors that have contributed to the growth and development of the service; and
- attempt to identify whether these factors have contributed to a change in health outcomes.

3.1 History and description of the area and people

Townsville is situated at latitude of 19 degrees south, 1380 km north of Brisbane and 350 km south of Cairns. The TAIHS provides services to individuals who are located within Townsville and surrounding areas. Its boundaries extend to Magnetic Island but do not include Palm Island.

According to the Townsville Indigenous Health Profile, the total population of Townsville was 131,249 in 1996, of which 5,946 were Indigenous. Aboriginal and Torres Strait Islander people accounted for 4.5% of the population compared to the Queensland average of 2.9%. Townsville also has a significant proportion of Torres Strait Islanders, with 24.8% of the Indigenous population identifying as such, and a further 6.4% identifying as both Aboriginal and Torres Strait Islander. (CoA 1998; ABS 1996)

3.2 Service

The TAIHS provides a comprehensive range of primary health care services for Aboriginal and Torres Strait Islander people within the Townsville region and surrounding districts. Services include outreach services to the Aitkenvale Reserve and Ki-Meta Night Shelter. Medical, dental and social health programs are provided.

The medical program includes:

- general practitioner (GP) services;
- child and maternal health services including immunisation, antenatal and postnatal care, and fortnightly specialist clinics by a visiting paediatrician;
- nutrition and diabetes clinics, and health promotion and education; and
- monthly hearing assessments that are conducted by an audiologist from Australian Hearing Services.

The dental program includes:

- dental health education and promotion;
- restorative and preventative dental services; and
- mobile outreach services to a number of communities within the Townsville ATSIC region.
The social health program includes:

- mental health services including access to a psychiatrist;
- counselling services;
- a bereavement program; and
- provision of accommodation for the homeless.

Transport is provided for clients attending appointments with hospital specialists and at the clinic’s dental and dental prosthesis service.

### 3.3 An environment for change

The latter part of the 1990s saw a number of significant changes in the development and growth of TAIHS. These changes took place within a broader context of national changes to the responsibility for policy and funding for Indigenous health and policy and funding changes to primary health care delivery for mainstream services. For the purposes of this case study, therefore, available data for the period 1997–98 has been compared with the most recent data, and a description of the factors that have contributed to changes over this period provided.

### 3.4 Governance

An elected Indigenous Board of Directors, delegated with the authority to undertake the executive management of the organisation, manages TAIHS. At each year’s annual general meeting, a minimum of five new directors are elected to the ten-member Board. TAIHS has experienced significant changes in terms of its administrative and governance processes since 1997. The current chief executive officer (CEO) of the organisation commenced in 1997 and there has been a period of continuity and sustained leadership within TAIHS. Changes over this period are listed.

- A major restructure of the organisation was initiated in 1997–98. In this process, Board members were allocated to portfolios, and the administration and service delivery functions of the organisation were structurally separated. A new position of health programs coordinator was created, and a new section (medical health/primary health care) created. This latter change acknowledged the importance of community and preventive health programs as well as the established clinical programs. In this process, detailed job descriptions were developed for all positions within the organisation. TAIHS has developed a policies and procedures manual that guides the Board in executing its responsibilities. It also serves as a useful resource for staff in relation to a number of important issues, such as human resource matters, code of conduct, policy in relation to vehicles, equipment and use of premises. The existence of such procedures and policies is thought to prevent any capacity for management to be undermined. This process could have initially been viewed as a disempowerment of management, but has been accepted and seen to alleviate any possibility for dysfunctional power.

- Regular Board meetings are now held. This change was made because of the extent of the work that the Board needs to get through and the demanding and tiring nature of late night meetings.

- Regular meetings between senior managers and the Board are held. Senior staff and program coordinators have the opportunity to meet every three months. The organisation recognised that there needed to be a change in Board culture, and that the Board must also be more accountable.

- Board/staff workshops are held twice a year and these are extremely valuable in terms of interaction within the organisation, as well as providing an opportunity for input into planning processes and setting strategic directions for TAIHS. These workshops are facilitated and have a structured program.
When planning decisions are made the program coordinators make detailed submissions to the Board (e.g. for a new program or if they are going to put in a submission for a grant). This is done through the senior management team, although the Board makes the final decision. Either the Board or senior management may initiate new initiatives. However, they are always supported by a detailed submission that must justify the proposal.

### 3.5 Funding

#### 3.5.1 OATSIH funding

OATSIH provides core recurrent funding for TAIHS, but the organisation has also been able to attract funds from a number of other sources, and its capacity in this regard appears to be increasing. OATSIH funding has grown from $1.5 m in 1997–98 to $2.6 m in 2002–03. The major reason for the increase does not relate to their base funding, but rather to the implementation of new specific initiatives in eye health, mental health, immunisation and child and maternal health. Despite increasing demands on the service, core recurrent funding has remained relatively stable (Table 2).

**Table 2: Summary of OATSIH Funding to TAIHS 1997–98 and 2002–03**

<table>
<thead>
<tr>
<th>OATSIH funding for financial year</th>
<th>1997–98 ($k)</th>
<th>2002–03 ($k)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical services</td>
<td>582 877</td>
<td>975 611</td>
</tr>
<tr>
<td>Staff training and support</td>
<td>37 667</td>
<td>42 761</td>
</tr>
<tr>
<td>Eye health</td>
<td></td>
<td>108 248</td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
<td>85 789</td>
</tr>
<tr>
<td>Bringing Them Home</td>
<td>145 850</td>
<td>175 800</td>
</tr>
<tr>
<td>Immunisation</td>
<td></td>
<td>9 821</td>
</tr>
<tr>
<td>Sexual health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finance and administration</td>
<td>547 600</td>
<td>741 169</td>
</tr>
<tr>
<td>Dental</td>
<td>178 579</td>
<td>300 014</td>
</tr>
<tr>
<td>Maternal and child health</td>
<td></td>
<td>145 000</td>
</tr>
<tr>
<td><strong>Total expenditure per year</strong></td>
<td><strong>1 492 573</strong></td>
<td><strong>2 584 213</strong></td>
</tr>
</tbody>
</table>

Clearly, a number of specific initiatives are responsible for the major increases in OATSIH funding over this period. System level influences in this regard include the following:

- The National Aboriginal and Torres Strait Islander Eye Health Program commenced in 1998, as a result of the review of Eye Health Services that was undertaken by Professor Hugh Taylor in 1997 (Taylor 1997). The program is a regional model of eye health service delivery, focusing on increasing eye health services (particularly specialist support) in Aboriginal and Torres Strait Islander primary health care settings, by providing the necessary infrastructure and resources. Through increasing access to specialist eye health services within the context of comprehensive primary health care, the program aims to address the range of eye health conditions experienced by Aboriginal and Torres Strait Islander people, such as cataract, diabetic retinopathy, trachoma and refractive error. Major components of the program include the establishment of Eye Health Coordinator positions nationally within Indigenous primary health care settings and provision of ophthalmic equipment and training for coordinators and
workers in identified Aboriginal Community Controlled Health Services. Prior to this, eye health services were provided through the state-wide Aboriginal and Torres Strait Islander Trachoma and Eye Health Program. Funding for the Program in 2002–03 was $108,248.

- The release of the *Bringing Them Home report* in 1997 (HREOC 1997) based upon the 1995 national inquiry into the forcible removal of Indigenous children from their families has resulted in funding initiatives, particularly for the employment of grief and loss counsellors.

- The implementation of the National Indigenous Australians’ Sexual Health Strategy (NIASHS) in 1996–97 (Department of Health and Family Services 1997) has also influenced practice and service delivery. For example, screening for sexually transmitted infection (STI) is a routine component of antenatal care and data in relation to this is provided in the analysis of the Mums and Babies Program. While TAIHS has not specifically been funded through the NIASHS thus far, arrangements have been made in 2003–04 for the transfer of two Queensland Health-based sexual health worker positions to TAIHS.

- Fringe benefits tax (FBT) supplementary funding has been made available to not-for-profit Aboriginal and Torres Strait Islander health organisations to make adjustments for the introduction of the FBT Cap. TAIHS received $82,884 for this purpose in 2002–03.

### 3.5.2 Other sources of funding

**Table 3: Other income TAIHS**

<table>
<thead>
<tr>
<th>Source</th>
<th>1997–98 ($)</th>
<th>2002–03 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>176,101*</td>
<td>629,511*</td>
</tr>
<tr>
<td>Department of Family Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supported accommodation</td>
<td>185,484</td>
<td>519,814</td>
</tr>
<tr>
<td>Adult overnight shelter</td>
<td></td>
<td>258,767</td>
</tr>
<tr>
<td>Youth overnight shelter</td>
<td></td>
<td>576,577</td>
</tr>
<tr>
<td>Child protection / Alternative Care Unit</td>
<td></td>
<td>68,885*</td>
</tr>
<tr>
<td>Intensive Family Support Action Research Project</td>
<td></td>
<td>117,810*</td>
</tr>
<tr>
<td>Department of Community Services Emergency relief</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>11,408*</td>
<td>15,340*</td>
</tr>
<tr>
<td>NDIP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes clinic</td>
<td></td>
<td>17,790*</td>
</tr>
<tr>
<td>DEETYA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff training and support</td>
<td>22,000*</td>
<td></td>
</tr>
<tr>
<td>RACGP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General clinic – training</td>
<td></td>
<td>118,953*</td>
</tr>
<tr>
<td>Rio Tinto</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal and child health</td>
<td></td>
<td>122,400*</td>
</tr>
<tr>
<td>Ian Potter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal and Child Health</td>
<td></td>
<td>70,000*</td>
</tr>
<tr>
<td>NCNP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Child Nutrition Project</td>
<td></td>
<td>48,500*</td>
</tr>
<tr>
<td>Breastfeeding Support project</td>
<td></td>
<td>35,500*</td>
</tr>
<tr>
<td>NIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illicit Drugs diversion</td>
<td></td>
<td>97,350*</td>
</tr>
<tr>
<td>Total</td>
<td><strong>394,993</strong></td>
<td><strong>2,697,197</strong></td>
</tr>
</tbody>
</table>

*refers to non recurrent income/project grants
TAIHS has been able to demonstrate capacity to attract funds from a number of sources in recent years, as well as to develop strategies that seek to maximise the benefits from reforms to MBS, PBS and other recent funding initiatives. Examples include the following:

- A review of Medicare funding and ensuring that it is properly costed has resulted in an increase from $176 000 in 1997–98 to almost $630 000 in 2002–03. An analysis of the recent income suggests that $52 was earned from Medicare per doctor hour, Medicare income per clinic day was $2522, and the average rebate per patient was $28. This increase has been achieved through a commitment by medical and administrative staff to implement processes that ensured patients were being billed, and at the correct level, as well as that claims were being processed.

- The Rio Tinto and Ian Potter Foundations have both contributed funding to the Mums and Babies Program. The former has increasingly focused its health grants on prevention, through research and community education. One of its areas of assistance is to support innovative programs designed to improve the delivery of services to people handicapped by health conditions. The Rio Tinto Aboriginal foundation was established in December 1996 with the aim of enhancing the status and capabilities of Australian Aboriginal and Torres Strait Islander peoples, by supporting initiatives that improve education, health, and cultural preservation. The trustees of the Rio Tinto Aboriginal Foundation follow a set of guidelines when considering proposals for funding. Appropriate projects are seen as those that are initiated by a community or community organisation, address specific Indigenous needs, can contribute direct and sustainable benefits and have defined outcomes that are measurable.

- The Practice Incentive Program (PIP) and the Enhanced Primary Care (EPC) Medicare items allowed TAIHS to access funding for immunisations, diabetes care and care plans for people with complex needs. To access these programs the service needs to be accredited by Australian General Practice Accreditation Limited (AGPAL).

- Funding from the National Child Nutrition Grant has supported the activities of the Mums and Babies Program. This grant program, funded by the Australian Government, is associated with the community grants program and is aimed at improving the nutrition of pregnant women and children throughout Australia. TAIHS has been funded to employ two workers, one on its breastfeeding support project and the other on the schools-based child nutrition project.

- TAIHS has recently been successful with its application for funding from the Cardiovascular Research Grants in General Practice. The project aims to improve nutrition, level of physical activity and decrease the burden of chronic disease by the introduction of a comprehensive lifestyle intervention program, in the Townsville Indigenous community. It has been funded for three years.

TAIHS has recently demonstrated success in obtaining funds from a number of sources. Developing and writing submissions such as these is extremely time-consuming and requires dedicated effort. The organisation has been strategic in its devotion of resources to this area and is now in a position to become even more competitive with research and project grant applications.

Funding problems were also identified. These included the following.

- TAIHS is reliant on ‘soft’ money. A number of positions within the service, considered critical to success of programs, are funded for fixed periods or from one-off grants, and this creates problems in terms of sustainability of outcomes and continuity of care. It could be argued, for example, that nutritionists should have core funding because of their central role in preventive health regarding chronic diseases. It should be noted that in 2002–03, total funding for TAIHS was $5 533 248 and the total recurrent funding base was $3 341 455, which represents a significant reliance upon non-recurrent funding.
Problems occur when accessing mainstream funds as some of the criteria are not appropriate for Indigenous health. For example, with PIP funding for diabetes the criteria for funding is calculated as the number of people who complete the annual cycle of care as a percentage of the number of HBA1c (a test to monitor diabetes control) tests ordered. It may be difficult for the service to meet the 20% required for funding as the number of tests ordered in an Indigenous population may be much higher than the number of tests ordered in the non-Indigenous population.

3.6 Workforce

Table 4 shows the staff profile for TAIHS in the 1997–98 and 2002–03 periods.

- Total staff numbers have grown from 32.5 FTE in 1997–98 to 81 in 2002–03. The ratio of Indigenous to non-Indigenous staff remains high at 2.25. As expected, a large number of the non-Indigenous staff are employed in the medical section (including clinic staff for the Mums and Babies Program), and this is consistent with the shortage of Indigenous health professionals nationally.

- A significant proportion of the staff are female (77%). This is also consistent with national trends. There is now a realisation that more male health workers need to be employed in Indigenous health services. In fact, only three of the Indigenous male employees are located within the health service.

- While growth in total staff numbers can be attributed in part to expansions within the health service, it must also be acknowledged that in recent years, the service has assumed control of a number of other services, including Supported Accommodation, Child Protection and Alternative Care, Intensive Family Support, and the Youth Shelter. Health staff numbers have grown from 21.5 FTE in 1997–98 to 46 FTE in 2002–03 (Table 4).

Table 4: TAIHS workforce composition and numbers

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical services</td>
<td>13.5</td>
<td>18</td>
</tr>
<tr>
<td>Maternal/child health</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Breastfeeding support team</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Clinic support services</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Dental services</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Social health services</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Finance and administrative services</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Supported accommodation services</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Child protection and alternative care Services</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Intensive family support services</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Youth shelter</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Total staff numbers</td>
<td>32.5</td>
<td>81</td>
</tr>
</tbody>
</table>

In a period of growth such as that experienced by TAIHS, human resource management practices and structural change has been extremely important. Examples of processes and change implemented within the service, along with some of the ongoing issues in this regard are summarised below.
The service encourages professional development and its incorporation into service activities, where possible. For example, while completing a Masters in Public Health, the senior medical officer looked at perinatal outcomes in the Townsville area and was able to use the key findings from this work to inform discussions in relation to the formation of the Mums and Babies Program. Some medical staff employed within the service are currently on the Royal Australasian College of Physicians Public Health Training Program, and this also provides an opportunity to incorporate research and project specific work into service planning and program delivery.

An Indigenous employee with over 20 years experience with the service has progressed from being a health worker to a senior registered nurse. This provides an example of capacity being built within the Indigenous workforce, but also highlights the need for a long-term plan and commitment in this regard.

Because the service has grown so rapidly, the administrative and management functions of the organisation are now very complex and require high skill levels in a range of areas, such as financial management, human resource management, information technology and health planning. The organisational structure shows that a number of middle management positions now exist with specific responsibility for managing particular aspects of the organisation.

The organisation has been strategic in the decision to fund a research and development officer, along with an information technology position. The former is seen as critical to the ongoing capacity of the organisation to identify and compete for other sources of funds, as well as to collate and disseminate information. The latter is critical in terms of staff and infrastructure support.

There are a number of visiting specialists who are able to bill Medicare and then retain the fees. TAIHS has experienced difficulty accessing an endocrinologist, but it is understood that they now have organised a visiting specialist in this regard.

With the establishment of the Medical School at James Cook University, an opportunity now exists for TAIHS to be actively involved in medical education and for greater attention to be paid to Indigenous issues in the curriculum. Similar opportunities and collaborations are in place for the Nursing School.

The organisation has been without the services of a dentist for four months. Despite having a well-equipped surgery and offering competitive conditions, TAIHS has been unsuccessful in its attempts to recruit locally and is now seeking an appointment from overseas. This is consistent with trends nationally, and the associated shortage of public dentists. Until an appointment is made, TAIHS continues to refer to the public service in Townsville, which, according to staff reports, has a three-year waiting list for a tooth filling.

Allied health workers are considered a critical component of care, but the reliance on ‘soft money’ for positions such as nutritionists, creates a potential barrier to workforce development in this regard.

While it is acknowledged that the Aboriginal and Torres Strait Islander health workers play a critical role in the service, concerns were expressed in relation to their ongoing professional development needs and emerging issues in the workplace. Despite efforts in Queensland and nationally to articulate and formally recognise the role of health workers, there remains an inconsistent approach to their employment and training. This is also complicated by the emergence of specialist workers who are expected to play such a role, but little is understood in terms of required skill level and opportunities for professional development. TAIHS has previously received Rural Health Support Education and Training Program funding to provide opportunities for health worker training in collaboration with James Cook University. This has been at the Certificate level, and the need now for higher-level and more specialised training has been identified. The lack of a population health focus in programs to date was also noted.
3.7 Physical infrastructure

In 2000, TAIHS moved into its newly constructed premises at Garbutt. This ended many years of planning and negotiation on the part of the service. The 1997–98 Annual Report of the Service (TAIHS 1998) reveals the planning processes that were already well in place for the new premises. The restructure that occurred around that time also gave a small number of Board members responsibilities for the building development portfolio.

The result is an extremely impressive facility that is clearly the pride of the local community. The service is well-designed, with:
- a large waiting/reception area;
- a well-equipped dental surgery;
- six medical consultation rooms;
- a large work area with stations for health workers and registered nurses;
- specialist work areas for positions such as dietician, nutrition workers;
- a number of administrative offices;
- a meeting room;
- a lunch/kitchen area;
- a separate and well-equipped room for the eye health program; and
- a separate facility for the Mums and Babies Program.

3.8 Processes

3.8.1 Linkages

The following links were identified as being important to TAIHS.

- Staff membership on various committees, such as the Queensland Aboriginal and Islander Health Forum, NACCHO, the Asthma foundation, and SIDS and Kids Queensland. This is seen as an advantage to the service in terms of both its capacity to influence change as well as to draw upon the resources of such organisations.

- The CEO and senior medical officer of TAIHS have both recently been appointed to the Townsville District Health Council. This is also seen as an opportunity for change and to increase collaboration with Queensland Health in relation to Indigenous health issues.

- Historically, the links with the local hospital have not been good, particularly in relation to discharge planning. Through processes such as shared antenatal care and individual working relationships becoming established, this situation has improved quite dramatically.

- Queensland Health now brings its child health staff to TAIHS—the child health nurse for four mornings per week, and the midwife for one day per week. This is clearly an example of improved access and collaboration.

- The relationship with the local Division of General Practice is unclear and it is uncertain how much could be achieved through greater collaboration. Examples of specific initiatives do exist (e.g. they have provided conference support, and allowed for TAIHS activities to contribute towards Continuing Medical Education points). An opportunity exists to identify opportunities in this regard, with doctors employed by TAIHS now on the governing committee of the local Division of General Practice.
3.8.2 Quality issues

TAIHS is accredited with Australian General Practice Accreditation Ltd (AGPAL), a leading provider of accreditation for Australia’s General Practices. This process involves a three-year cycle where practices:

- perform self-assessment against the Royal Australian College of General Practitioners (RACGP) Standards for General Practice (RACGP 2003, ed.);
- undergo a survey visit facilitated by peers;
- commence a continuous quality improvement cycle towards best practice; and
- receive documentary validation and recognition as an accredited general practice on achievement of AGPAL Accreditation.

While the staff acknowledge that this was a labour-intensive and time-consuming process, it is a valued achievement and allows the service to access the EPC items and PIP.

Other quality measures evident within the service include:

- client surveys (e.g. two patient surveys have been undertaken in the Mums and Babies Program and feedback incorporated into service delivery);
- continuing education for staff (e.g. TAIHS has supported opportunities for staff to gain formal qualifications; embraced research that is useful to TAIHS and complies with ethical requirements; contributes to the training of health professionals at James Cook University; and provides a placement opportunity for public health trainees);
- collection, use and review of data used on a regular basis to review programs; identify areas of need; and to support a case for a new initiative (e.g. the processes that have led to the development of the Mums and Babies Program and the Walkabout Together Program);
- development and implementation of the TAIHS Policies and Procedures Manual; and
- development of standardised forms for data collection and service delivery, including for foot assessment for people with diabetes, the antenatal shared care plan, hypertension review sheet, multidisciplinary care plan for hypertension/diabetes/obesity, and nicotine dependence assessment form.

3.8.3 Information technology

TAIHS has given priority to the development and maintenance of appropriate information systems. It uses the Medical Director program, which allows:

- comprehensive integrated patient information system;
- computerised patient recall system;
- scheduled health interventions such as immunisation;
- data analysis and reporting (local data on health status and services for effective planning);
- electronic Medicare claims;
- GP script writing facility;
- electronic pathology reports (imported directly into patient records); and
- activity and staff workload scheduling.
3.9 Clinics

TAIHS provides a comprehensive range of primary health care services for Aboriginal and Torres Strait Islander peoples within Townsville and surrounding districts. It provides programs in the area of medical, dental and social health, and serves an estimated population of 5946. TAIHS also provides outreach services:

- the mobile van visits Happy Valley regularly;
- services are planned for the Shalom School in Townsville; and
- medical staff visit Stuart prison 3–4 times per week. According to staff at TAIHS, 70–80% of inmates in the prison are Indigenous. Visiting the prison places a very high burden on TAIHS. Incentive payments are provided for doctors to undertake this task, and it costs TAIHS around $200 per hour for doctors to carry out clinics at the prison. Records for prisoners are not computerised and the service provided tends to revolve around the prison and its needs rather than individual patient needs.

The Medical Program provides GP services, nutrition and diabetes clinics, health promotion and education sessions, and specialist clinics in areas such as eye health, adult health and endocrinology. Table 5 below demonstrates the growth in client numbers and evidence of increased access over time in a number of major program areas.

<table>
<thead>
<tr>
<th>Work unit</th>
<th>Client contacts 1997–98</th>
<th>Client contacts 2002–03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Services Unit</td>
<td>12 006</td>
<td>19 564</td>
</tr>
<tr>
<td>Eye Health Program</td>
<td>4 782</td>
<td>1 970</td>
</tr>
<tr>
<td>Dental Services Unit</td>
<td>1 831</td>
<td>1 985</td>
</tr>
<tr>
<td>Social Health Unit</td>
<td>1 193</td>
<td>1 985</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15 030</strong></td>
<td><strong>28 301</strong></td>
</tr>
</tbody>
</table>

3.10 Non-health impacts

In the delivery of its health services, TAIHS is involved in initiatives that may have impacts in other sectors. While they may still be viewed mainly as health-related projects, the capacity to engage with other sectors and community development approaches should be acknowledged.

- Funding was recently received from the National Child Nutrition Grants for the Indigenous schoolchildren nutrition and exercise project. This is an action research project aimed at improving Indigenous school children’s nutrition and exercise attitudes, knowledge and behaviours with a view to testing impact of improved eating, drinking and exercise on their health and educational outcomes.
- TAIHS has recently made arrangements to provide services at the Shalom School, particularly in the area of sexual health.
- TAIHS now has responsibility for a number of other services such as Child Protection and Alternative Care, Youth Shelter, and Supported Accommodation. Evidence of demand on the adult shelter as an example, is provided.
### Table 6: Adult shelter: client turnover, 2002–03

<table>
<thead>
<tr>
<th>Month</th>
<th>Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2002</td>
<td>37</td>
</tr>
<tr>
<td>August 2002</td>
<td>32</td>
</tr>
<tr>
<td>September 2002</td>
<td>31</td>
</tr>
<tr>
<td>October 2002</td>
<td>37</td>
</tr>
<tr>
<td>November 2002</td>
<td>36</td>
</tr>
<tr>
<td>December 2002</td>
<td>34</td>
</tr>
<tr>
<td>January 2003</td>
<td>38</td>
</tr>
<tr>
<td>February 2003</td>
<td>22</td>
</tr>
<tr>
<td>March 2003</td>
<td>11</td>
</tr>
<tr>
<td>April 2003</td>
<td>17</td>
</tr>
<tr>
<td>May 2003</td>
<td>22</td>
</tr>
<tr>
<td>June 2003</td>
<td>61</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>378</strong></td>
</tr>
</tbody>
</table>

### 3.11 Case Study One – TAIHS Mums and Babies Program

The TAIHS Mums and Babies Program commenced in February 2000, with funding from the Rio Tinto Foundation and the Ian Potter Foundation for a two-year pilot program. Initially TAIHS was able to dedicate a team of workers, including 2 health workers, 1 childcare worker, 1 driver, and 2 female doctors to work on the pilot program. Clinics are held every morning for young families and pregnant women. The overall aim of the program was to improve the quality of antenatal health service delivery to the Indigenous community in Townsville.

**Project inputs**

**Funding**

During the period 1997–98 and 2002–03, TAIHS received the following funding for the Mums and Babies Program.

### Table 7: Funding for Mums and Babies Program

<table>
<thead>
<tr>
<th>Source</th>
<th>Purpose</th>
<th>Amount ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OATSIH</td>
<td>Operating funds</td>
<td>145 000</td>
</tr>
<tr>
<td>Rio Tinto Foundation</td>
<td>Salaries and operating costs to establish program</td>
<td>300 000</td>
</tr>
<tr>
<td>Ian Potter Foundation</td>
<td>Salaries and operating costs to establish program</td>
<td>210 000</td>
</tr>
<tr>
<td>Queensland Health – Golden Casket Grants</td>
<td>Playground equipment</td>
<td>19 500</td>
</tr>
<tr>
<td>Queensland Government – Gambling Community Benefit Fund</td>
<td>Play equipment</td>
<td>14 500</td>
</tr>
<tr>
<td>Dept of Health and Ageing – National Child Nutrition Program</td>
<td>Breastfeeding peer support project</td>
<td>97 152</td>
</tr>
</tbody>
</table>

Note: In addition, the annual recurrent budget for the program provides for Medicare income of $216 000 (600 patients per month @ $30 per visit).
**Workforce**

The following staff positions are associated with the Mums and Babies Program:

- 1 program coordinator;
- 1 health worker;
- 2 medical officers; and
- 1 receptionist.

**Building**

The Mums and Babies Program has its own building adjacent to the main premises of TAIHS. Having its own ‘space’ is considered an important contributor to success, and a move supported by the TAIHS management. To accommodate the program, an existing shelter used for car parking was modified and equipped for this purpose. The waiting room is considered a place where people now meet and children can play quite freely, without perhaps disrupting sick people waiting to see a doctor. This has led to the formation of a playgroup and other organised activities for women and parents.

**The service**

The program has improved service delivery through the following actions.

- Pregnant women and their partners are offered shared care with the Townsville Hospital, which includes comprehensive antenatal care according to the protocols developed by the hospital, including infection screening, dating ultrasound if appropriate, 18–20 morphology scan and 50 gm GCT (glucose challenge test) at 26–28 weeks. These protocols are based on best practice guidelines set out by the Australasian College of Obstetricians and Gynaecologists. High-risk women are referred to the specialist clinic at the hospital. A customised antenatal shared care record has been developed.

- All pregnant women attending the program are seen by an Aboriginal Health Worker and/or a midwife, as well as the doctor.

- The clinic is providing services for infants and children, including immunisations and regular monitoring of growth, development, sight and hearing. Where necessary, referrals are made to the Townsville Hospital or to Community Health Services for specialist or paediatric care.

Features of this service include:

- an integrated team approach;
- no need to make appointments;
- family orientation;
- development of protocols for shared care;
- good information systems that include a pregnancy register and monthly recall system;
- provision of transport where necessary; and
- incorporation of education and health promotion activities.
Program outputs

From data collected for the period 1 January 2000 – 30 September 2002, it is possible to provide evidence of impressive service outputs. This includes all pregnancies, with the exception of 37 pregnancies for which the data is incomplete. The following outputs should be noted.

- In the 18 months prior to the commencement of the program, records at the Townsville Hospital show that 86 women attended TAIHS for antenatal care, while in the 33 months after the clinic commenced, 268 women attended the clinic for antenatal care. During 2002, approximately 110 women regularly attended the clinic at any one time for antenatal care.
- Of the 268 women attending the clinic, 93% had at least one ultrasound, 45% had a dating scan and 57% had an 18-week morphology scan.
- The clinic was seeing some 40 clients per month when it first started in January 2000, and this had risen to over 500 clients per month in January 2001. Total client contacts in 2002–03 were 6,343, representing 1339 individual patients.
- While there is no hard data on improvements in immunisation rates, the program provides a service for children and immunisations are delivered through the Mums and Babies Program.
- Through the implementation of B.E.S.T. (Breastfeeding Education Support Team), three members of the TAIHS team have been trained as peer counsellors by an experienced lactation nutritionist from the Tropical Public Health Unit of Queensland Health.
- Two patient surveys have been conducted: the first in late 2000 with 34 respondents, and the second in early 2003 with 100 respondents.

Intermediate outcomes

In the relatively short period of time that the program has been in operation, it is able to demonstrate some outcomes that are positive and, if sustained, likely to lead to significant health gains for the Indigenous population in the longer term. These include:

- 50% of women now attending the clinic for antenatal care are presenting in the first trimester;
- a doubling of antenatal visits that women are making per pregnancy with the number of women having fewer than four antenatal care visits falling from 65% pre-program to 25% at present;
- an increase from 15% to 20% of the proportion of girls who are younger than 20 years of age attending for care;
- small increases in pregnancy-induced hypertension (5%) and gestational diabetes (6%) was recorded—this may be linked to better service delivery and information;
- identification and treatment of large numbers of women with infection of STIs—overall 10% of women tested positive for Chlamydia, and in the less than 20-year age group (n=65), prevalence of Chlamydia was 27% and gonorrhoea 15%; and
- enrolment of 110 women in the B.E.S.T. program with 84 giving birth. Further follow-up is now needed in relation to breastfeeding practices.

Longer-term impacts

Indigenous women have babies, on average, at younger ages than non-Indigenous women. Babies of Indigenous mothers are twice as likely to be of low birth weight (<2500 g) as babies born to non-Indigenous
mothers (ABS & AIHW 2003, p. 125). Over the period 1998–2000, the national perinatal mortality rate for babies born to Indigenous women was twice as high as that for babies born to non-Indigenous women. If TAIHS is able to sustain its current outputs, then the literature would support the following longer-term outcomes:

- fewer pre-term births;
- fewer babies born of low birth weights;
- fewer perinatal deaths; and
- better obstetric outcomes.

Townsville Aboriginal and Islander Health Service is now also collecting data that could link socioeconomic indicators to strategies for improved maternal and child health (MCH) outcomes. For example, they are collecting information in relation to smoking rates and alcohol consumption during pregnancy, and are hoping to add education, employment and other relevant indicators to undertake more detailed analysis in this regard and to develop strategies to complement existing service delivery.

**Other information obtained during interviews**

The service is seen to play a significant role within the community. Indigenous staff felt that they could relate to the needs of the client and also had personal experience within the mainstream system. They are therefore, aware of the issues that Indigenous women face when accessing mainstream services. They value the link with the hospital and the processes that are now in place for shared care. In summary, other issues identified as contributors to success included:

- the operating environment—the fact that the program has its own space and offers a friendly environment for families;
- identification by the women with clinic attendance for antenatal care and not because they are ‘sick’; and
- continuity of care and cultural sensitivity.

### 3.12 Case Study Two – TAIHS Chronic Disease Program

TAIHS currently has 560 patients on the hypertension register. Health workers, doctors, nutritionists and podiatrists hold diabetes/hypertension clinics weekly. A recent random chart audit of 100 patients with diabetes attending TAIHS, showed that:

- 50% were obese;
- patients have a mean body mass index (BMI) of 31.8 +/- 0.9;
- patients have a mean HBA1C of 8.8 +/- 0.3; and
- only 20% had seen a nutritionist in the past 12 months (unpublished data).

In addition, a small pilot study conducted at TAIHS using the Yale physical activity survey tool with the assistance of trained Aboriginal and Torres Strait Islander health workers found 20% of patients met current guidelines for sufficient physical activity.

Over the past 12 months the staff in the medical section worked hard to both audit present standards of practice for patients with diabetes and hypertension and to improve the coordination of care for these
patients. As part of this drive the TAIHS medical team has standardised care plans for hypertension and diabetes and is seeking to develop a comprehensive approach to lifestyle modification with a view to reducing risk factors for chronic disease within the local Indigenous community.

TAIHS was recently successful in its application for funding from the Cardiovascular Grants in General Practice. The Walkabout Together project is a lifestyle intervention program concentrating on nutrition and physical activity. The program aims to improve health outcomes by increasing physical activity levels (PAL) and improving nutrition. The PAL component is based on the use of a pedometer. The nutrition component is based on the Queensland Healthy Weight Program. Participants will be recruited as part of lifestyle/preventive health strategy incorporated in best practice clinical care at TAIHS. If the project is successful, TAIHS will incorporate the lifestyle intervention in standard clinical care of appropriate patients, and will develop a practical framework for the adaptation and implementation of lifestyle modification programs for chronic diseases in Aboriginal and Torres Strait Islander health services across Australia.
Section four – South Coast Medical Service Aboriginal Corporation (SCMSAC)

4.1 Introduction

The South Coast Medical Service Aboriginal Corporation (SCMSAC) is a long established service that has serviced the Indigenous people of the southern coast of New South Wales since the early 1980s. Its primary role for many years was to improve access to mainstream services. More recently this role has changed and the services have expanded to a more holistic primary health care service provision model.

The SCMSAC was chosen for the case study in order to examine the factors that have contributed to this changing direction and capacity, and to understand which investments and processes are necessary for this growth in capacity to continue. For this purpose, the case study focuses on the time period between 1999 and 2003.

4.2 Description of area and people

The SCMSAC is based in the town of Nowra, NSW. It services the residents of the local government area of Shoalhaven (4,567.3549 sq km). The Shoalhaven district is located on the NSW south coast, 76 km south of Wollongong, and 155 km south of Sydney. According to SEIFA Index of Relative Socio-Economic Disadvantage (ABS 1998), Shoalhaven represents the most socioeconomically disadvantaged area of the Illawarra region. The distribution of Aboriginal and Torres Strait Islanders in this district is largely determined by historical settlement patterns. Many communities exist on and around the old ‘missions’. Approximately 3.3% of Shoalhaven residents are Indigenous (1204), which is above average for the State.

Information from the ABS shows that the Aboriginal and Torres Strait Islanders in this area have a younger age profile than the non-Indigenous population. The Wreck Bay Aboriginal Community located on the coast near Nowra at the Wreck Bay Village, is serviced by the SCMSAC, which reports that the population of this Indigenous community is 171. Indigenous history in this region has been traced back more than 20,000 years. Sites located within this region are of great spiritual significance to Aboriginal people. The people of the community were granted land rights over 403 hectares of land in 1986. A further grant of the Australian Government’s Jervis Bay National Park was made to the Wreck Bay Aboriginal Community in December 1995.

4.3 Health profile

The Illawarra Area Health Services (IAHS) six-year plan for 2000–2006 comments that ‘Aboriginal people are by far the most disadvantaged group in terms of health status in the Illawarra region.’ (Illawarra Area Health Services Plan (IAHS 2000)). Indigenous access to mainstream services, particularly the primary health care services in the Shoalhaven area is very low. The 1997 Illawarra Aboriginal Health Advancement Survey (which includes the Shoalhaven local government area) is the most recent detailed health survey, and provides some valuable information of the health profile of the people living in the Shoalhaven. The main health issues for toddlers’ and children’s health are low immunisation rates, low breastfeeding rates, otitis media and hearing loss, and asthma (possible under-diagnosis and under-treatment). The main issues for teenagers’/adults’ health are ischaemic heart disease and related risk factors, in particular smoking, poor nutrition and overweight/obesity; diabetes; high risk levels of alcohol consumption; asthma; kidney problems; and low cervical smear screening rates. The survey found that unemployment, alcohol control and rehabilitation, housing, leisure activities, and education were the five highest concerns for the community.
Mainstream services include GP services and hospitals. The Shoalhaven Hospital in Nowra is the district facility for the Shoalhaven area. The average number of beds available is 129. The hospital provides emergency, surgical, elective orthopaedic and plastic surgery, medical care, intensive care, obstetric, gynaecology, paediatric, neonatal care, renal services and rehabilitation services. For more specialised care, patients need to travel to Sydney.

The *Illawarra Area Health Plan for 2000–2006* (IAHS 2000) identifies improving the health status of Indigenous people in the area as a key strategic objective. As detailed in the plan, the IAHS will work towards this objective by targeting three main areas—healthier people, fairer access and quality health care (IAHS 2000).

Other Aboriginal community-controlled health services in the Shoalhaven area include:
- Waminda Aboriginal Women’s Health Centre;
- Oolong Aboriginal Corporation Drug and Alcohol Rehabilitation Service; and
- Rose Mumbler Retirement Village.

### 4.4 System issues

A number of system issues have impacted significantly on the service.

- Change over of funding from ATSIC to OATSIH in 1996 has provided recurrent funding and national policy.
- Ability to access funds for special projects/processes (e.g. the quality reviews, information technology [IT], building funding [a commitment from ATSIC]).
- Access to Medicare funding for ACCHSs.
- The introduction of EPC Medicare items to enable GPs to improve health and quality of life for groups in the community including Aboriginal and Torres Strait Islander people.
- The PIP is being used to encourage general practice to become accredited and access the EPC items.
- The introduction of specific purpose funding such as for counselling services following the release of the *Bringing Them Home* report and sexual health services as part of the *National Indigenous Australians’ Sexual Health Strategy*.
- Framework Agreements and the development of a regional plan for the area has further encouraged the close cooperation between the SCMSAC and the area health service.
- State government funding and priorities—NSW Health has an *Aboriginal Health Strategic Plan* (NSW Health 1999) that incorporates national objectives and health policy, and the Framework Agreement to improve the health status of Indigenous people. As part of this process the area health service strategic plan was developed.
- Planning processes within the area health service follow on from the Framework Agreements and the *NSW Health Strategic Plan* and lead to the development of the *Illawarra Area Health Plan for 2000-2006*.
- Establishment of Divisions of General Practice and development of their capacity to look at population health issues and service provision.

The first time period for the case study is 1998–99. Services provided were:

- preventative care programs: health education, immunisation, health protection supplies/distribution and antenatal classes and education;
• screening programs: hearing and diabetic screening/testing/counselling; and

• health-related community support services: for example, transport, group activities, cultural promotion activities; welfare services.

During this period no clinical health services were provided by the SCMSAC.

The national and State policy changes enabled SCMSAC to change its revenue base and service provision.

4.5 Major milestones in the SCMSAC history

• The SCMSAC commenced operation in 1982 in Nowra.

• It was incorporated in January 1983 and then applied for funding from various local, state and federal departments (they were assisted with this process by the Redfern AMS).

• In 1986 the Department of Aboriginal Affairs agreed to fund a doctor (gap after bulk billing), an administrator, two health workers and all operating costs.

• In 1988 the NSW Department of Health funded the positions of a public health worker, a drug and alcohol worker, and in 1989 they funded a health care assistant.

• In 1990 funding provided by the NSW Department of Health ceased due to service provision concerns. ATSIC also ceased funding for a full time GP.

• In July 1991, ATSIC ceased funding for possible duplication and non-compliance to funding regulations.

• Funding was restored in September 1991.

• In 1999, through a partnership with the Division of General Practice and OATSIH, a successful model for improving access to health care was implemented.

• In 2000 the SCMSAC moved into its newly constructed premises in Nowra.

4.6 Governance

SCMSAC is an Aboriginal community-controlled health organisation. Membership is open to all adult Aboriginal persons normally and permanently resident in the area between Helensburg and the Victorian border (the South Coast of NSW). While the SCMSAC has grown quite substantially in the past four years, its structure has remained relatively flat. Its recent organisational charts show growth in each of the functional areas of the service, but this has not been matched by a growth in middle-management positions. The organisation has now reached a size where it is very difficult for a single management position to assume responsibility for all staff and services. It is noted that a deputy CEO position has now been created, but is yet to be filled. Current management for the service consists of a Chief Executive Officer, and an administration manager.

4.7 Funding

The SCMSAC receives core recurrent funding from OATSIH, and has also been successful in attracting funds from a number of other sources. Funding received by the service in 1999–2000 and 2002–03 is summarised in the Table 8 below.
Total funding for the organisation has increased from $406 000 to $1 871 893 between 1999–2000 and 2002–03, representing a more than three-fold increase.

Total OATSIH recurrent funding has grown from $236 000 to $895 567 over this period. Some of this growth (around $120 000) can be attributed to the decision to fund the SCMSAC for general practice clinics, following the successful pilot with the Division of General Practice (see detailed case study).

Additionally, the organisation is in receipt of funding ($633 414) for drug- and alcohol-related projects from a number of sources. In summary these include the following.

- A new project in receipt of recurrent funding from OATSIH in 2002–03 was the Aboriginal Holistic Healing Service ($257 416). The vision of this organisation is to provide quality substance misuse prevention and treatment programs, grounded in the Aboriginal holistic view of health, which involves healing the physical, social, emotional and spiritual aspects of life. Funding for this service provides for the employment of a service manager, two substance use workers/educators, and an administrative assistant. As at June 2003, all these positions were filled.

- It should be noted that, in addition to this service, OATSIH provides funding for the substance misuse program ($171 115), for the employment of a coordinator, youth worker and substance use worker.

- A related position, that of a mental health worker, is funded by NSW Health ($55 000). This position was vacant as at June 2003.

- Funding from NSW Health for a public health officer, and drug and alcohol worker ($124 141) in 2002–03. The latter position was vacant at June 2003.

- The *Bringing Them Home* report is based on the 1995 national inquiry into the forcible removal of Indigenous children from their families and communities since the early days of European occupation of Australia. One of the important benefits of the Inquiry that was conducted by the Human Rights and Equal Opportunities Commission was the validation of the stories of generations of Indigenous people who experienced tremendous trauma associated with violation of human rights. While the report was released several years ago, SCMSAC first received funding from this source in 2002–03: $87 639 recurrent funding for counselling support and a capital grant of $41 000 (for purchase of vehicle).

- As shown in Table 8, Australian Government initiatives to improve Medicare access for Aboriginal and Torres Strait Islander people, provided an estimated income of $125 000 in 2002–03. Because the employment of doctors within the organisation is only relatively recent, it is not possible to comment

### Table 8: SCMSAC funding

<table>
<thead>
<tr>
<th>Funding source</th>
<th>1999–2000 ($236 000)</th>
<th>2002–03 ($895 567)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Government Grant: recurrent</td>
<td>236 000</td>
<td>895 567</td>
</tr>
<tr>
<td>Australian Government Grant: one off</td>
<td></td>
<td>41 000</td>
</tr>
<tr>
<td>NSW Health Grants: recurrent</td>
<td>138 000</td>
<td>211 686</td>
</tr>
<tr>
<td>IAHS Grants: recurrent</td>
<td></td>
<td>198 135</td>
</tr>
<tr>
<td>Dept. of Community Services</td>
<td></td>
<td>195 696</td>
</tr>
<tr>
<td>Estimated Medicare income</td>
<td></td>
<td>125 000</td>
</tr>
<tr>
<td>Rental income</td>
<td>32 000</td>
<td>46 000</td>
</tr>
<tr>
<td>GST</td>
<td></td>
<td>158 810</td>
</tr>
</tbody>
</table>
on trends in this regard. However, this is potentially an area in which further capacity can be built, particularly as systems are put in place for ensuring patients are being billed at the correct rate and claims processed.

- SCMSAC took over responsibility for management of the Out-of-Home Care Program in 2002–03. The NSW Department of Community Services provides recurrent funding.

- The Service has recently been approved for access to PIP funding following its accreditation by AGPAL. Staff are currently setting up a system of colour coding on patient information charts to assign care plans to clients with conditions related to mental health, asthma and diabetes. It will also provide a plan for monitoring immunisation status. It was acknowledged that the Enhanced Primary Health Care (EPC) funding provides an opportunity for the SCMSAC to access additional funding and provide more comprehensive clinical services. At present, the proper systems are not in place and the service is considered too time-consuming and demanding on the doctors’ time. Additionally, the SCMSAC does not employ a nurse and has one health worker who supports all the clinical services and the preventive programs around diabetes, asthma, and eye and ear health.

- The SCMSAC receives funding from the Waminda Aboriginal Women’s Corporation for rental on space within the SCMSAC premises.

### 4.8 Workforce

The table below shows the composition of the workforce as at Jan 1999 and at June 2003.

<table>
<thead>
<tr>
<th>Position</th>
<th>1999 No. of workers</th>
<th>2003 No. of workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator/CEO</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Deputy CEO</td>
<td></td>
<td>1 (vacant)</td>
</tr>
<tr>
<td>Public Health Officer</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Health Worker</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Family Support Worker</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Driver</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Substance use coordinator</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Counsellor</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Substance use/mental health worker</td>
<td>5 (1 vacant)</td>
<td></td>
</tr>
<tr>
<td>Admin officer</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Admin/reception</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Senior medical officer</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Part-time medical officers</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Dentist</td>
<td></td>
<td>1 (vacant)</td>
</tr>
<tr>
<td>Dental assistant</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Manager – holistic healing service</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Out of home care coordinator</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Case worker</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>
The SCMSAC has grown from having funding for six positions in 1999 to its current establishment of 24 funded positions. In addition, two part-time medical officers are employed. As at 30 June 2003, at least three positions were vacant and a further three were occupied by staff acting in the positions.

The major growth areas for the SCMSAC result from its success in accessing funding for the delivery of drug- and alcohol-related programs, and from the establishment of the medical clinic. However, a substantial proportion of the funding for this latter service could be offset against Medicare income. The establishment of the clinic has not resulted in a parallel increase in other clinical positions, such as health worker or nursing staff. Most of the support for the clinic and related preventive services is provided by the health worker in the Public Health Office position. This is a large work load for one person given that the clinic has been growing in numbers. Additionally, more nursing or health worker staff may enable the clinic to establish systems to access the PIP items.

In addition to the above points, the following issues were raised during the site visit.

The rapid growth of the SCMSAC has resulted in much bigger administrative workload. The CEO continues to assume almost all responsibility in this regard, and there is clearly a need for a designated financial management/book-keeper position. It is noted that a deputy CEO position has recently been created, but that the SCMSAC has experienced difficulty in filling it.

Another administrative area in which organisational growth has had a significant impact is that of human resource management. It was acknowledged that this is an area in which the SCMSAC currently lacks some capacity (e.g. in relation to performance appraisal and staff planning and development). This is reflected in the current difficulties being experienced in relation to staff recruitment and retention. High turnover of staff limits opportunities for sustaining change and development within the SCMSAC.

The SCMSAC is also experiencing difficulty in recruiting a dentist. This is consistent with trends nationally in public dentistry (Healthy Horizons Outlook 2003-2007, A Joint Development of the Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee and the National Rural Health Alliance, 2002). This represents a barrier to service delivery in this regard.

The SCMSAC places priority on transport for patients and has indicated an increasing demand for this service. As a result, NSW Health has agreed to a shift in funding from the employment of a sexual health worker to that of a driver.

The SCMSAC does not have funding for the employment of a nurse. This is regarded as a critical need within the clinic setting. At present, clinic staff need to be selective about which patients they see and are now referring patients to the hospital, for treatment that may essentially be able to be provided by a nurse, such as wound care, antenatal care and immunisation.

The skills level of the health workers employed within the service appears to be highly variable. While it is recognised that competency levels have been set by the Aboriginal Health and Medical Research Council, the SCMSAC is not always able to employ staff that possess the required competencies. This limits the capacity of the service to deliver programs, particularly in specialised areas. Training providers in the region include the Wollongong TAFE and Cumberland Campus Course at the University of Western Sydney.

There does not appear to be a program for the professional development of the staff. This is particularly important when there is concern about competency levels and where there has been a growth in the responsibilities of the staff in terms of service provision and mix of service.
4.9 Physical infrastructure

4.9.1 Building

The SCMSAC has a new building close to the city centre in Nowra. Funding for the building, named after one of the founders of the organisation (Jane Ardler) and officially opened in 2000, was provided through an OATSIH capital grant. However, it was reportedly approved by ATSIC prior to the transfer of responsibility for funding to the then Commonwealth Department of Health and Aged Care. It appears to be regarded as a community centre, rather than a health clinic. Features of the two-storey building include:

- a large waiting room;
- reception area;
- two consultation rooms;
- consultation room for eye health and hearing programs;
- storage area for health records (patient charts);
- office for CEO, and open office that would accommodate 4–5 staff;
- area occupied by Waminda (approximately one-third of the ground level); and
- dental surgery and meeting areas on the upper floor.

The SCMSAC has made an investment into vehicles and information technology (though exact expenditure figures are not available). It is anticipated that the technology will assist in administration and monitoring of outputs and intermediate outcomes—although this is not happening at this stage.

4.10 Processes

A Governing Committee, which meets monthly, of seven elected members of the corporation manages the SCMSAC. These members hold office for a period of two years and the organisation pays a sitting fee to its Directors. The SCMSAC reportedly has had a relatively stable Board membership over recent years. The corporation has around 130 members some 25 to 30 of whom attend the annual general meetings. The CEO of the SCMSAC is responsible for the day-to-day management of the organisation.

SCMSAC has developed a Policy and Procedures Manual. This was considered critical in terms of addressing some of the issues that are not specifically addressed in the Rules of the Corporation. Examples include the need for rules on how to conduct meetings, and some expansion on the rules in relation to codes of conduct. This was considered especially important for Directors of the organisation. This process also provided an opportunity to review the role of committee members, and the staff recruitment policy, and provided a transparent process for dealing with staff misconduct.

During consultations, because of the relatively flat structure of the organisation and the growing administrative workload of the CEO, the following issues were raised that are likely to impact on future capacity of the SCMSAC.

- The lack of current processes in the area of human resource management limits the capacity of the SCMSAC to recruit suitable applicants, provide opportunities for staff development and interaction, and to undertake career planning through staff appraisal systems.
- The strategic plan of the SCMSAC has lapsed, and this was identified as an important priority to be addressed.
• The implementation of the Ferret System (for computerised recording of services) has resulted in the need for more advanced training of staff. It was acknowledged that better use could be made of existing data, but capacity is limited due to the need for more intensive work with the system that has been implemented. Episodes of care are recorded but there is currently no data available on immunisation, screening rates or reasons for presentation. Planning processes could be enhanced through concentrated effort with the health information systems (either paper-based or computerised).

• Related to the above point, there is need for dedicated resources to implement a Patient Information Recall System.

• At present all medical records are paper based and given the small number of staff involved in the clinics, it is considered to work well. However, this may need to be revisited if the SCMSAC continues to expand and provide outreach clinics.

• The need for designated financial management support and the implementation of systems to support monitoring and reporting requirements for the various sources of funding to the SCMSAC is also critical.

4.10.1 Quality issues

The SCMSAC is accredited with the Quality Improvement Council in NSW. A review in 1999 for service development, found that it met only 27% of the applicable standards from the Australian Health and Community Services Standards. The recent review found that SCMSAC met 93% of the standards, achieved through:

• updating of policies and procedures;
• partnerships established with other organisations;
• division of labour;
• increase in client numbers; and
• learning lessons from the initial review process.

The SCMSAC has also been accredited by AGPAL in May 2003. This accreditation means the service has met every standard set down by the RACGP. The accreditation also means that the service can access PIP under Medicare.

As part of the accreditation a patient feedback survey was undertaken. Overall the patients felt that the service provided by doctors and staff was excellent. A suggestion was made that there could be more preventive services for sexual health for young people.

An additional review was conducted by an external consultant, Ferrier Hodgson, in 2002. This review made a number of recommendations about strategic planning, structure, staff training, and reporting systems. These issues have all been identified in the current case study.

4.10.2 Linkages

The SCMSAC is able to demonstrate some very strong links in the Shoalhaven region, and these are seen to contribute significantly to development of capacity. While some of these relationships have been driven by SCMSAC, external collaborators have initiated others. Two examples are provided in more detail in the case examples (the partnership with the Division of General Practice and the relationship with the Waminda Aboriginal Women’s Corporation). Additional relationships include the following organisations.
• Illawarra Area Health Service. The Partnership Agreement between SCMSAC and the IAHS is viewed as a significant achievement. Specific initiatives achieved through this relationship include the employment of a hospital liaison at the Shoalhaven Memorial Hospital and the provision of a child health nurse for 1 day per fortnight. Also, the 1997 Illawarra Aboriginal Health Advancement Survey (which includes the Shoalhaven local government area) provided some valuable information on the health profile of the people living in the Shoalhaven and has been a useful resource for planning processes.

• The Shoalhaven Memorial Hospital. Referrals are made to the hospital by both SCMSAC and Waminda, the former for routine type health problems that are unable to be addressed in the absence of a registered nurse and additional clinic staff, and the latter in relation to antenatal care and problems associated with screening outcomes particularly in relation to pap smears and sexual health.

4.11 Service provision

SCMSAC currently provides a range of services including:

• clinical health care, general practice, general/public health, dental health, social and emotional wellbeing;
• preventative care programs;
• screening programs;
• pharmaceutical services;
• health-related and community support services (e.g. family support);
• substance use programs;
• sexual health services; and
• out-of-home care.

Data provided by SCMSAC suggests that service demand in certain areas has grown quite substantially over a short period. Because it is only in recent years that the organisation has employed clinic staff and offered general practice services, data for the past two years is compared.

Table 10: SCMSAC clinic contacts

<table>
<thead>
<tr>
<th>Clinic work</th>
<th>2001–02</th>
<th>2002–03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>3,066</td>
<td>5,462</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>446</td>
<td>837</td>
</tr>
<tr>
<td>Total</td>
<td>3,512</td>
<td>6,299</td>
</tr>
</tbody>
</table>

Table 11: SCMSAC fieldwork contacts

<table>
<thead>
<tr>
<th>Fieldwork</th>
<th>2001–02</th>
<th>2002–03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>155</td>
<td>323</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>343</td>
</tr>
</tbody>
</table>
Of note here is the rapid increase in the number of staff employed in this area, particularly in drug and alcohol, and mental health-related positions. In January 2000, the organisation had two field positions, and by June 2003, this had increased to 11 positions.

### Table 12: SCMSAC transport services

<table>
<thead>
<tr>
<th>Transport</th>
<th>2000–01</th>
<th>2002–03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Females</td>
<td>1 031</td>
<td>1 660</td>
</tr>
<tr>
<td>Males</td>
<td>532</td>
<td>1 028</td>
</tr>
<tr>
<td>Total episodes</td>
<td>1 563</td>
<td>2 688</td>
</tr>
<tr>
<td>Transport to ACCHS</td>
<td>680</td>
<td>2 056</td>
</tr>
<tr>
<td>Transport to local GP</td>
<td>683</td>
<td>522</td>
</tr>
<tr>
<td>Transport to outside areas</td>
<td>200</td>
<td>110</td>
</tr>
</tbody>
</table>

The growth in demand in this area requires some consideration. SCMSAC policy in relation to transport is not clear, but this data suggests that a local service is provided to transport patients to both the ACCHS and local general practitioners, as well as to other areas (reportedly mainly Sydney) for treatment. Concerns were expressed in relation to the Patient Transfer Assistance Scheme, which does not assist Nowra community residents because they live within a 200 km radius of Sydney. The growing demand in this area has resulted in an agreement with NSW Health to transfer funding for a sexual health worker position to that of a driver, in addition to an existing full-time driver position.

### 4.12 Case Study – The General Practitioner Aboriginal Clinics Project

In 1999, the Shoalhaven Division of General Practice (SDGP) undertook a health needs assessment in the area and identified a number of concerns relating to local Indigenous health including:

- demographic disadvantage;
- access to health care (particularly in relation to cultural barriers);
- the need for health education and support for GPs and other health professionals; and
- specific areas of health concern, such as women’s health, sexual health, drug and alcohol issues and mental health issues.

A partnership was then formed between the SDGP, SCMSAC and OATSIH in an effort to address some of these concerns and in particular to improve access to health care services. The long-term aim of the project was to demonstrate the need for service in the community and for a full-time salaried GP position at SCMSAC. A memorandum of understanding between the three parties to the partnership was signed in July 1999.

#### Inputs

**Funding.** OATSIH provided funding towards the clinical sessions that were provided by local GPs. According to data provided by SCMSAC, Commonwealth funding in 1999–2000 was $236 000.

**Workforce.** Eight local GPs were involved in the trial.
Services. Two four-hourly sessions were conducted each week for the trial period, on a bulk-billing basis.

Physical infrastructure. The clinics were conducted at SCMSAC premises, to facilitate acceptance of the project in the local community.

Governance. A Clinic Management Committee, comprising representatives from the three partners was established to jointly manage the project.

Outcomes
The project was successful in achieving the following outcomes.

- In the period July 1999–March 2000, 59 clinic sessions were held, 191 new patients were recorded with 423 visits.
- There is evidence to suggest that this led to improved access to general practice services—data collected over a one-month period suggests that 40% of patients did not have a regular GP outside the clinic, 30% did have a regular GP outside the clinic, and 30% were unrecorded.
- Patient feedback suggests satisfaction with the services offered.
- Data collected by SCMSAC suggested that there remained a high level of unmet need, with a substantial number of enquiries for after hours care.

Impacts

- At the local service level the project has resulted in recurrent funding from OATSIH to employ a full-time doctor.
- At the system level, the project has provided a model for collaboration between ACCHSs and mainstream organisations that could be replicated elsewhere.
Section five – Nganampa Health Council

5.1 Introduction

The Nganampa Health Council (NHC) is an Anangu community-controlled health organisation providing comprehensive primary health care services to all people living on the Anangu Pitjantjatjara Lands (APY Lands) in the far north-west corner of South Australia. Nganampa Health Council was first established in 1983 and took over the role of service provision from the South Australian Government in 1985.

Nganampa is also involved in other activities and delivers a range of public health services. Some of the innovative work undertaken by the service in the area of environmental health and housing has not only led to improvements in the APY Lands, it has also been incorporated into national standards. Other activities include:

- collaborative research programs in areas including child and sexual health;
- targeted programs such as an aged care and disability program; and
- a health worker training and support program.

Nganampa has developed a reputation for best practice clinical services and for the sustained and steady development of a comprehensive health care service in one of the most remote areas of this country. Its progress and achievements are well documented in annual reports and published literature. It is an ideal service for a case study that is attempting to understand how a service can be sustained and continue to develop against a background of disadvantage, remoteness and social change.

This case study will use information and data from papers, reports and data collected during the life of the service, for the periods 1991–92, 1997–98 and 2001–02. It will also provide a detailed analysis of three program areas—sexual health, the Uwankara Palyanku Kanyintjaku (UPK) Public and Environmental Health Strategy, and aged care.

Programs provided by the NHC are located in various communities on the APY Lands and focus on addressing a number of different health issues including:

- public and environmental health;
- STI control and human immunodeficiency virus (HIV) prevention;
- aged and disability care;
- women’s health;
- child health;
- dental health;
- Anangu health worker education; and
- hospital liaison.

5.1.1 Geographic location

The APY Lands are located in the north west of South Australia. This region can be accessed via car approximately five hours drive from Alice Springs and approximately 12 hours drive from Adelaide.

There are seven major communities across the APY Lands and many smaller communities called homelands. All communities are organised and run by an elected Aboriginal community council. The major communities include Iwantja, Mimili, Fregon, Pukatja, Amata, Kalka, Pipalyatjara and Nyapari.
5.1.2 The Anangu people

The Aboriginal people living on the APY Lands are Anangu. The Anangu people have strong language and cultural ties. They speak Pitjantjatjara and Yankunytjatjara as their first language. English is generally only used at school and when communicating with non-Anangu service providers and agencies. The word Anangu is the Pitjantjatjara word that Pitjantjatjara and Yankunytjatjara people use to describe themselves.[1] Many Anangu people live a traditional existence and continue to participate in traditional ceremonies and activities.

The total population on the APY Lands is approximately 2833, based on data from the NHC Orientation Manual 1998 (NHC 1998). A breakdown by community is provided.

Table 13: Distribution of population on the APY Lands

<table>
<thead>
<tr>
<th>Sex</th>
<th>Iwantja</th>
<th>Mimili</th>
<th>Fregon</th>
<th>Pukatja</th>
<th>Amata</th>
<th>Nyapari</th>
<th>Pipalyatjara</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>233</td>
<td>136</td>
<td>222</td>
<td>262</td>
<td>290</td>
<td>49</td>
<td>177</td>
<td>1369</td>
</tr>
<tr>
<td>Female</td>
<td>241</td>
<td>145</td>
<td>192</td>
<td>316</td>
<td>296</td>
<td>46</td>
<td>208</td>
<td>1444</td>
</tr>
<tr>
<td>Total</td>
<td>474</td>
<td>281</td>
<td>414</td>
<td>578</td>
<td>586</td>
<td>95</td>
<td>385</td>
<td>2813</td>
</tr>
</tbody>
</table>

5.1.3 Health

Common types of child health problems reported in this region include respiratory illness, ear disease, gastroenteritis, skin infections, trachoma, meningitis, malnutrition and growth failure, adolescent illness, STIs and petrol sniffing-related illness.

Common types of adult illness reported in this region include cardiovascular disease, diabetes, hyperlipidaemia, obesity, renal disease, hypertension, STIs (including pelvic inflammatory disease and associated infertility), tuberculosis, rheumatic fever and hepatitis B virus-related disease.

5.1.4 Education

- Schools are located in each of the communities on the APY Lands in order to provide education for primary and lower secondary children. The schools are staffed by Anangu education workers and teachers from the South Australian Education Department.
- Many children attend high schools in Alice Springs, Adelaide or Port Augusta. A secondary schooling program called, 'Wiltja' specifically for Pitjantjatjara children is based in Adelaide.
- Vocational education and training facilities offering education to Anangu including literacy and mechanical training are located in some of the communities.

5.1.5 Employment

Employment opportunities on the APY Lands are extremely limited. The CDEP program operates in a number of the communities.

5.2 A changing environment

The NHC serves a community that is in transition. The Anangu people have a traditional culture that sits uncomfortably with the dominant Western European culture. The people have had to make a rapid transition from an isolated and traditional life to one where their lifestyle and culture has been changed and influenced by forces beyond their control. The information provided below illustrates the important dates in the life of the APY Lands.
Table 14: Important dates in the life of the APY Lands (source: Nganampa Orientation Manual 1998)

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early 1920s</td>
<td>Government and mission authorities establish reserves in South Australia, Western Australia and in the Northern Territory.</td>
</tr>
<tr>
<td>1934</td>
<td>On the western outskirts of these reserves Warburton Mission was established.</td>
</tr>
<tr>
<td>1937</td>
<td>Ernabella Mission was established by the Presbyterian church. Lutheran missions were established at Hermannsburg and Areyounga. Food rations were distributed to Aboriginal people. Aboriginal post World War Two government welfare programs were established.</td>
</tr>
<tr>
<td>1946–1960s</td>
<td>Based upon an agreement between the Australian and British government testing of rocket and nuclear weapons began on the reserves.</td>
</tr>
<tr>
<td>1950s and onwards</td>
<td>Aboriginal people began to report the high incidence of illness and mortality.</td>
</tr>
<tr>
<td>1960s</td>
<td>More settlements were established in homelands.</td>
</tr>
<tr>
<td>Mid-1960s</td>
<td>Majority of Anangu were based at missions and settlements. Nursing staff were employed by the South Australian Government and were based at Amata homeland. Regular trips were conducted to Iwantja to provide health services.</td>
</tr>
<tr>
<td>1961</td>
<td>Fregon was established due to pressure on the Ernabella area for firewood and water. The majority of settlers were from Shirley well. Musgrave Park was established by the South Australian Department of Social Welfare and Aboriginal Affairs.</td>
</tr>
<tr>
<td>1967</td>
<td>At Iwantja a 12 sq mile area of land was made available for local Aboriginal people to settle on.</td>
</tr>
<tr>
<td>1968</td>
<td>The name was changed from Musgrave Park to Amata.</td>
</tr>
<tr>
<td>1970s</td>
<td>With the support of Commonwealth and State governments the dispersed resettlement of homelands began.</td>
</tr>
<tr>
<td>1971</td>
<td>South Australian Department of Public Health was assigned the role of provision of health care on the North West Reserve. Health care was of a ‘curative’ focus and involved the employment of one non-Anangu registered nurse and Anangu health workers in Iwantja, Mimili, Fregon, Pukatja and Amata.</td>
</tr>
<tr>
<td>1977</td>
<td>Successful submission to the Federal Minister for Aboriginal Affairs seeking funds for establishment of mobile community-controlled health service namely the ‘Pitjantjatjara Homelands Health Service’ located at Pipalyatjara. This health service was staffed by Anangu health workers, a non-Anangu medical officer and a non-Anangu registered nurse.</td>
</tr>
<tr>
<td>1981</td>
<td>Freehold title to the old South Australian reserve given to Anangu. Aboriginal Health Organisation (AHO), part of the South Australian Health Commission, were responsible for the provision of health care to Anangu.</td>
</tr>
<tr>
<td>1982</td>
<td>AHO commissioned the Pitjantjatjara council to review the existing health care system, east of Amata due to increasing dissatisfaction with the model of service delivery and continued high levels of ill health.</td>
</tr>
<tr>
<td>Dec 1 1983</td>
<td>NHC assumed responsibility for the delivery and maintenance of primary and preventative health care throughout the eastern communities.</td>
</tr>
<tr>
<td>Jan 1986</td>
<td>The western communities of Pipalyatjara and Kalka amalgamated with NHC.</td>
</tr>
</tbody>
</table>

The development of the health organisation and consideration of its capacity must be done within this broader context. This case study will focus specifically on the period from 1991 until the present time.
5.3 Service

NHC has had four formal reviews by funding bodies since its inception. The most recent was in 1998. The organisation’s philosophy and mission statement underpin its work, structure and processes and commitment to excellence in primary health care delivery. NHC believes that documentation of the goals and strategies and ongoing evaluation has been one of the main reasons that it has survived.

Table 15: NHC mission and philosophy

<table>
<thead>
<tr>
<th>Philosophy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nganampa Health Council is an Aboriginal – controlled organisation</td>
</tr>
<tr>
<td>• The board of management is Anangu. They make the key decisions about policy, resource allocation and staffing.</td>
</tr>
<tr>
<td>• The director and all the clinic managers are Anangu. Their jobs include working closely with all Anangu in communities to make sure Nganampa Health Council is providing services that the Anangu want.</td>
</tr>
<tr>
<td>• Where specialist programs are implemented, Anangu are employed in various capacities. (Program coordinators, advisors and malpas).</td>
</tr>
<tr>
<td>• Whilst ensuring that key policy, staffing and resource allocation decisions are made by Anangu, the Board of management recognises and values the important roles played by non-Anangu technical advisors in the delivery of health services.</td>
</tr>
<tr>
<td>• Nganampa Health Council believes that staff are its most important asset.</td>
</tr>
<tr>
<td>• Various forums allow staff an opportunity to be involved in making decisions.</td>
</tr>
<tr>
<td>• We want staff to be involved in decision making.</td>
</tr>
<tr>
<td>• Health programs are developed on the basis of need and must be continually evaluated.</td>
</tr>
<tr>
<td>• Nganampa Health Council aims to be recognised as an efficient and effective provider of health services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mission Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nganampa Health Council will:</td>
</tr>
<tr>
<td>• Improve the health status of Anangu.</td>
</tr>
<tr>
<td>• Deliver a comprehensive primary health care service to residents of the Anangu Pitsjantjatjara Lands.</td>
</tr>
<tr>
<td>• Provide quality clinical health care and health education.</td>
</tr>
<tr>
<td>• Run sustainable health programs.</td>
</tr>
<tr>
<td>• Balance the budget and minimise costs.</td>
</tr>
<tr>
<td>• Evaluate the health care services and programs.</td>
</tr>
<tr>
<td>• Attempt to gain resources to meet the needs of all communities, including homelands.</td>
</tr>
<tr>
<td>• Encourage training and development of its staff.</td>
</tr>
</tbody>
</table>
5.4 Funding

Funding for NHC has grown quite substantially over the period under review. Income from all sources for the periods 1997–98 and 2001–02 is provided in Attachment 1. Specific data about funding sources for 1991–92 period is not available. Total funding for the 1991–92 year was $4,265,222. The key messages from this funding data can be obtained from the graphs below:

- Total funding has increased from a little over $4 m in 1992–93 to nearly $9 m in 2001–02, an increase of more than 100%;
- Recurrent funding for primary health care services has remained relatively stable and the major increases in Australian Government funding can be attributed to specific initiatives including:
  - the implementation of the Indigenous Australians’ Sexual Health Strategy and funding of HIV/STI prevention initiatives (see detailed case study);
  - the review of eye health services that was undertaken in 1997, has resulted in new models of eye health service delivery and funding for NHC in this regard; and
  - the growth of the aged care program, particularly the establishment of the Aged Care Facility in 2000 has resulted in recurrent funding from both the Australian and SA governments for this program area (see detailed case study).
The capacity of the organisation to attract funds from other sources should also be noted.

A large number of specific purpose grants have been obtained from the State and Australian governments for initiatives in areas such as women’s health, child health, substance abuse and staff training. Reliance on ‘soft money’ poses enormous challenges for services such as NHC, but it is also clear that a stable recurrent funding base has been established and sustained and this provides a critical platform on which to build and expand sources of income and program activities. NHC has been strategic in its program development and in responding to new directions in policy and funding.

Access to Medicare funding is difficult because:

- at present there are only 1.5 FTE doctors on the APY Lands;
- approximately 70% of medical consultations are reportedly via telephone;
- NHC is only able to make a bulk claim, based upon doctors’ summaries—this generates around $70,000 per annum, and it is estimated that it should probably be around $350,000, but the philosophy of the service is such that medical issues take precedence; and
- there is debate as to whether the supplementary funding from OATSIH addresses this issue and allows for the development of service growth.

5.5 Governance

The governance structures and processes are aligned with the philosophy of the NHC.

- Decisions are made by the Anangu Health Committee in consultation with the relevant people.
- The Health Committee consists of 20 people comprised of the Director, Anangu Health Mayatjas, an elected representative from health worker stations at Yunyarinyi, Watarru and Murputja, three elected representatives of the Women’s Council, four elected general representatives from the APY Lands, two elected Anangu Health Worker representatives, and Chairman of Anangu Pitjantjatjarra.
The Committee meets every four to six weeks and staff often present reports. The Director of the NHC is Anangu and works under the direction of the Health Committee. Community liaison, government liaison, planning and public relations are important aspects of this role.

The Health Services Manager works for the Health Committee alongside the Director to assist in planning and implementation of objectives. A major part of the role is presenting options and potential consequences in decision making and problem solving. Other responsibilities include public relations, consultation, government liaison, evaluation and delegation.

The part-time Medical Director is responsible for medical and clinical matters and works closely with the Director and Health Services Manager. Public relations, government liaison, evaluation and planning are all important aspects of this role.

Each clinic has an Agangu Health Mayatja who is the clinic manager and who is responsible to the Director of NHC. The person is responsible for public and environmental health, participation on the Health Committee, and clinic organisation.

Clinic staff must liaise with the Mayatja on matters that affect the management of the clinic.

A finance manager, program accountant and book-keepers are based in Alice Springs and are responsible to the Health Committee for accounting and reporting.

The Finance Manager provides financial planning advice to the Health Committee, Director and Health Services Manager, and has administrative responsibility for the management of the Alice Springs office.

Thus the NHC is Anangu-controlled and has representation from both community and the health sectors. The Director of the Council and the clinic managers are also Anangu and have responsibility for the day-to-day management of the service. They are supported in their roles by technical advisers (e.g. clinical, financial) and processes are in place for input from NHC staff. One of the challenges that the NHC faces is that English is not the language of the Anangu people and the western organisational structures and processes are not their traditional ways. From the site visits and from documentation it is apparent that a number of key non-Anangu staff had a very long association with the NHC and that this appeared to have promoted stability and development in the organisation.

5.6 Clinics

There are six major clinics across the APY Lands and three health worker stations in smaller communities. The main clinics are: Iwantja, Mimili, Fregon, Amata, Pukatja, Pipalyatjara. The health worker stations are at Yunyarinyi (Kenmore Park), Nyapari and Watarru.

The NHC delivers a comprehensive primary health care service with the aim of improving the health status of Anangu people. This includes acute clinical care, prevention programs (e.g. immunisation, sexual health screening and chronic disease management), and programs such as the UPK.

The clinical service goals as set in 1987 were:

- a population register to provide the basis for activity and outcome reporting and program planning;
- 100% immunisation coverage;
- antenatal screening through out the antenatal period—including early presentation, regular clinic visits, ultrasounds, consultation with Alice Springs obstetric registrars and tours of the obstetric ward;
- growth monitoring of children under five years;
- STI screening and HIV control—men and women between the ages of 12 and 40 years are offered screening for STIs annually and follow-up treatment; and
- maintenance of a chronic disease register.
The clinics are staffed by an Anangu Mayatja who is the director of the clinic, nurses, health workers. Each clinic has a part-time Anangu cleaner/caretaker. There is currently one medical officer on the APY Lands, based at Pukatja. The part-time Medical Director is based in Sydney and there is also another doctor who is currently not based on the APY Lands but who is available for phone consultations and visits regularly.

The health workers have an important clinical role and they provide an important cultural and language link between clients and non-Anangu staff. This can sometimes be a very difficult role for them to broker.

**Figure 3 and Figure 4: Evacuations and referrals**

![Graph showing evacuations and referrals over time](image-url)
NHC is able to show a significant decrease in the number of evacuations of young children (0–14 year age group). This has fallen from 30% of total evacuations in 1991–92 to around 18% in 2001–02.

One of the philosophies of the NHC is that 'health programs are developed on the basis of need and must be continually evaluated'. The service views this as a critical factor in the ability to maintain existing services to the highest possible standards, to meet clinical and preventive health goals, and to identify new or emerging health issues. A good health management information system is central. The clinics all use paper-based clinical charts and have developed a paper-based system for daily collection of health statistics. They have developed a daily contact sheet that enables them to collate information on age, sex, diagnosis, trauma, outcome and associated risk factors. This sheet uses symbols so that it is easy for all staff to use at the time when the patient is cared for. A number of associated issues need to be considered including:

- the NHC understanding that health information and regular evaluation are critical to the management of current health issues and the development of programs to improve health status;
- the decision by NHC to develop a paper-based system as they do not have the resources to install and maintain computerised information systems;
- the commitment of clinic staff to collecting and collating this system—considerable dedication in very busy clinics, particularly important as NHC has put most of its resources into clinical staff and most clinics do not have any administrative staff to assist with this task; and
- the use of the data at a local level and at the NHC level to evaluate their work (e.g., a clinic could use the system to identify infants and children who are not immunised and to then follow up with the parents).

Other significant clinical achievements that could also be regarded as quality systems include:

- adoption of standard treatment protocols for use in each clinic to ensure standardisation of investigations and treatments;
- establishment of population registers that include all Anangu clients, details of daily clinical contacts and a series of specialised medical databases; that are used to plan and implement strategic health interventions; to provide activity reports to staff, communities and funding bodies; and seek to track mobility factors on the APY Lands;
- a Chronic Disease Register established to improve the management of clients with a chronic illness. In 1998, 451 Anangu were listed on this register, which represented 16% of the total population at the time. In 2002, 48% of the population over the age of 15 had a chronic illness.
5.7 Workforce

A table detailing the composition of the workforce during the periods under review is at Attachment 2. The changes over time are shown in Figure 5.

**Figure 5: Composition of NHC workforce**

![Bar chart showing composition of NHC workforce](attachment:chart.png)

This data suggests that the major changes in the workforce have been as a result of specific program initiatives, and the administrative and clinical staff numbers have remained relatively stable over time. This is consistent with the analysis of the funding data, which suggests that the increases are largely program-specific.

The NHC philosophy highlights the value that the organisation places upon its staff. ‘Nganampa Health Council believes staff are its most important asset.’ This was reinforced during discussions with a number of staff, and it was clearly evident that staff felt valued, supported and able to discuss difficult issues when they arise. Strategies adopted by the NHC to ensure high staff morale and to seek to retain staff include the following.

- A recruitment strategy for all new and managerial positions that involves bringing short-listed applicants to visit communities on the APY Lands and understanding the environment in which they would be working.
- An intense orientation process that includes a one-week program in Alice Springs that includes a significant focus on cultural issues, the local service delivery context and practical issues such as two-day 4-wheel drive training course and becoming acquainted with the staff at the Alice Springs office of NHC and the Alice Springs Hospital.
- A four-month probation period for new staff.
- Feedback from staff who have completed this program suggests that it is extremely worthwhile and provides a realistic orientation towards living and working in a remote Aboriginal community.
• Terms and conditions for staff that reflect an understanding of the demands placed upon staff and the personal and professional isolation that can be felt working in remote communities. For example, staff have a one-week break every 12 weeks, in which they are required to leave the APY Lands. Also there is an open phone policy, which encourages staff to talk with one another, seek advice and debrief in relation to difficult issues.

• A high value is placed on the role of the Anangu health workers, and they are regarded as a critical component of the primary health care system. The Anangu health worker training program has been operating since the late 1980s and offers accredited training up to Certificate 4 level.

• Clinic staff meet regularly (3–4 times per year) to review clinical goals and strategies.

Figure 6: NHC Indigenous/non-Indigenous composition of the workforce

A key outcome of these strategies has been the capacity of the organisation to retain staff. However, a number of issues in relation to workforce were raised during consultations.

• Recruitment, retention and development of Anangu Health Workers. While the value placed upon these workers is extremely high, in some communities turnover is very high and skill level varies quite considerably. Concerns were expressed about the education system on the APY Lands and the implications that the failures in this regard have in relation to providing opportunities for employment and career progression. Literacy levels are of concern and non-Anangu staff recognise that there are cultural barriers as well as educational ones to recruitment and retention that are possibly more extreme in communities such as those on the APY Lands. Gender issues, for example are particularly important. Also, given the importance placed upon the role of the Anangu Health Workers, their rate of pay is very low and there is a lack of incentive for them to progress. The pressures placed upon health workers are enormous and those who are retained for longer periods reportedly tend to come from outside the community in which they are working.

• The Health Worker Education Program continues to achieve successes, however it has been difficult to secure recurrent ongoing funding. This issue was highlighted in the external review of 1998.
Lack of secretarial support in the clinics is a critical issue.

Staff housing is only provided to non-Anangu staff, yet some Anangu health workers experience housing difficulties that can impact on the workplace.

5.8 Research

NHC has a strong history of collaborative research in areas pertaining directly to their work in improving health status. The research has been in the following areas.

- Respiratory tract disease particularly in children. An important outcome of this research has been recognition that Indigenous children in central Australia have one of the highest rates of pneumococcal disease in the world. This has led to the introduction and funding of pneumococcal vaccine for these children.

- Sexual health research has led to the development of screening programs and protocols. The National Notifiable Diseases case definition for syphilis was changed as a result of work done at Nganampa. Importantly, there has been a decrease in disease rates in the APY Lands.

- Environmental health. The UPK program has done significant work in the area of housing. This is discussed in detail in the case study at the end of this report. An important outcome of this research has been the inclusion of the work into national house standards.

The NHC has worked in collaboration with tertiary institutions including the Menzies Centre for Health Research and the University of Wollongong.

5.9 Information technology

NHC uses computers for some of its administration and management. However, in the clinics it relies on hand-recorded data collection and on telephone and facsimile for communications. The organisation has made a decision not to use IT for routine clinical work until it has the resources for purchase of the necessary hardware and software, staff training, and maintenance. In 2003 all clinics were linked into an organisation-wide intranet network via satellite technology; on-line computers, training and maintenance have been established at the seven main clinics and aged care facility.

5.10 Processes

NHC has very well defined management and administrative processes. One could argue that these have contributed significantly to its success. Some of the important components of the processes are listed.

- A clear and well-defined organisational structure with roles and responsibilities that are defined.

- An organisational structure that has the necessary mix of staff and skills to support an organisation of its size. For example, the organisation recognises the importance of managerial and administrative expertise (there are financial and human resources managers). However, they have also made a decision that they do not have sufficient resources to have administrative staff in the clinics.

- Good human resource management structures (e.g. an orientation program and orientation manual, adequate leave entitlements and a staff development program).

- The organisation has a clear philosophy and mission statement that supports its work.

- An ongoing program of review and evaluation that is supported by routine collection of health information. This process has a number of components:
- data are reviewed at the clinic level and used to monitor clinical and preventive activities (e.g. immunisation rates);
- data are reviewed at the NHC level and used to monitor programs and to detect new and emerging issues; and
- data are used for submissions for new funding and programs.

- The NHC has had four external evaluations over the years. The last one was commissioned by the NHC in 1998.
- Annual reports are produced every year and provide a comprehensive overview of NHC work including financial statements.
- There is a regular program of meetings whereby planning and review can take place (e.g. clinical meetings are held every three months and it is compulsory for all clinical staff to attend).
- There are clear policies and procedures for the work of NHC and these are reviewed and updated as required.

A feature of NHC that was mentioned by staff in a number of the interviews is that they keep their eye on the main game—that is the provision of clinical and preventive services. When they take on something new they do the careful planning first:
- identifying the need;
- defining the problem;
- consulting;
- developing possible strategies; and
- if feasible, implementing a plan.

There is evidence of this approach time and again in their work and this will be discussed in more detail in the smaller case studies.

The other feature of Nganampa is the retention of a number of key staff over many years. These people have a commitment to the NHC and to the Anangu people and to the philosophies of the organisation.

5.11 Case Study – Nganampa Health Council Aged Care Program

NHC has an Aged and Disability Care program that has grown quite substantially over the past decade, details of which are explored in this case study.

Background to aged care for Indigenous Australians

The range of services available to older Australians is extensive and could be argued to incorporate not only residential and community care but also primary and hospital care as main components of a formal system of care. The Australian Government funds numerous programs designed to meet the care needs of older people. In many instances, it is also recognised that younger people make use of the services commonly associated with older people. Factors such as higher rates of chronic diseases at younger ages in the Indigenous population mean that there is a greater proportion of Aboriginal and Torres Strait Islander people becoming ill and needing care at an earlier age.

The Aboriginal and Torres Strait Islander Aged Care Strategy was developed in 1994 and seeks to address issues of access to services, including those related to rural and remote locations. In regard to the latter,
where the community is too small to support standard systems of aged care, multi-purpose services (MPS) operate, bringing together a range of local and aged care providers under one management structure. This is the case on the APY Lands, with the MPS known as the NHC Aged Care Program. The steering committee for this program comprises representatives from the NHC, the Pitjantjatjara Council (AP Council) and the Women’s Council. A consultant was engaged in 1995–96 to undertake an assessment of the aged care needs on the APY Lands, and this included interviews with 133 older people.

In aged care services the age profile of Indigenous people is lower than that of non-Indigenous people. When age-specific rates are used, Indigenous people make higher use of both Community Aged Care Packages and residential care than the non-Indigenous population (AIHW & ABS 2003).

Disability services are funded as part of a State-Australian Government agreement, designed to provide services for those who need ongoing support with everyday life activities including accommodation support, community support, community access and respite care programs. It should be noted that the level of disability services is not necessarily an adequate reflection of the level of disability in a community, nor the need for assistance.

In relation to disability services, Aboriginal and Torres Strait Islander people are more frequent users of community support and respite services, but less frequent users of employment and community access services. Indigenous users of disability services are on average, younger than non-Indigenous users (AIHW & ABS 2003).

NPC Aged and Disability Care Program

In 1991–92 the NHC did not have a program specifically for aged care.

In 1997–98 the Aged and Disability Care Program operated in four communities (Fregon, Pukatja, Amata and Iwantja) and employed a person for 24 hours per week in each of these communities. Of significance at this time were:

- gaps in service delivery were identified for the communities of Kalka and Pipalyatjara;
- older people requiring care and treatment needing to go to Alice Springs, Port Augusta or Docker River;
- the site for the construction of the aged care facility Pukatja had been chosen and approved;
- an Aged Care Steering Committee had been established and consultations (across the APY Lands) on the design of the new building were ongoing;
- after completing a tendering process for the design of the building, Troppo Architects were chosen for the job;
- a number of training initiatives were implemented to provide in-house training for workers in areas such as food preparation, nutrition, and dementia; and training workshops were also held for community members, particularly family carers;
- service activities included delivery of meals to aged and frail people, washing clothes and blankets, and cleaning older people’s camps; and
- staff support was also provided through the Community Development Employment Projects (CDEP) program.

In October 2000, the Tjilpi Pampa Ngura (aged care facility) at Pukatja was officially opened, after five years of planning and a Australian Government/State funding commitment of $2 757 750. A longstanding staff member described this as the ‘jewel in Nganampa’s crown’.

By 2001–02, the following are of significance.
• It was the first full year of operation for the aged care facility at Pukatja—a total of 179 Anangu from all communities on the APY Lands spent a total of 2298 nights at the facility, for periods varying from a few days up to a month at a time.

• The Home and Community Care (HACC) program was operational in 6 communities with more than 120 people registered for assistance. The extension of the program to the Kalka/Pipalyatjara communities responded to a previously identified gap in service delivery.

• HACC services included daily meal preparation and delivery, washing of clothing and bedding, supply of firewood, and advocacy of people’s needs.

**Funding**

The following table shows extracts from the financial reports of NHC for the 1997–98 and 2001–02 periods that relate to the Aged and Disability Care Program:

**Table 16: NHC Aged and Disability Care recurrent funding**

<table>
<thead>
<tr>
<th>Source – program</th>
<th>1997–98</th>
<th>2001–02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health and Family Services* – recurrent</td>
<td>295 153</td>
<td>665 358</td>
</tr>
<tr>
<td>Department of Health and Family Services – training</td>
<td>28 980</td>
<td></td>
</tr>
<tr>
<td>Aged Care Medley</td>
<td>9 000</td>
<td>3 101</td>
</tr>
<tr>
<td>Aged Care meals – Iwantja</td>
<td>3 274</td>
<td></td>
</tr>
<tr>
<td>HACC funding</td>
<td>52 140</td>
<td>108 491</td>
</tr>
<tr>
<td>Home and Community Care – SA Department of Human Services</td>
<td>37 275</td>
<td>412 025</td>
</tr>
<tr>
<td>Total</td>
<td>425 822</td>
<td>1 188 975</td>
</tr>
</tbody>
</table>

* Now Australian Government Department of Health and Ageing

**Workforce**

**Table 17: NHC Aged Care workforce**

<table>
<thead>
<tr>
<th>Position</th>
<th>1997–98</th>
<th>2001–02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinator</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Anangu Coordinator</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HACC Coordinator</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Aged and Disability Care workers</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Aged Care Facility Manager</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Aged Care Facility Residential Manager</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Project worker</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Cook</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Driver</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>31</td>
</tr>
</tbody>
</table>
5.12 Case Study NHC – STI Control and HIV Prevention Program

The following extract from the 1996–97 annual report of the NHC summarises the issues in relation to sexual health in the period 1991–92 to 1997–98 (NHC 1980).

‘Five years ago program priorities in Central Australia were developed on the assumption that syphilis and donovanosis were the main threats to sexual health. The community knew little about HIV and AIDS, and condom use was minimal. Five years later, the introduction of Azithromycin has significantly improved the management of donovanosis and there has been a sustained decline in the incidence of syphilis. However, Polymerase Chain Reaction (PCR) technology has transformed the accuracy of diagnostic tests, and detected a high prevalence of gonorrhoea and Chlamydia… a common challenge facing remote health services is how to maximise the effectiveness of STI control activities, given the changing pattern of infection whilst conserving scarce resources.’ (p. 11)

In 1991–92, it seems that there was no specific focus on sexual health, but that it fell into the communicable diseases program area. Data available for this period in relation to sexually transmitted infections is:

- in terms of number of cases: syphilis (72), gonorrhoea (21), chlamydia (20), and donovanosis (7); and
- State-based notification procedures continued to present problems for the clinics on the APY Lands (e.g. although the Communicable Disease Control Centre [CDC] and the STI clinic in Adelaide were notified for all diseases then listed in the Public and Environmental Health Act, the CDC in Alice Springs was the regional unit for donovanosis and thus cases of it in the APY Lands became registered in the Northern Territory).

In 1994 the NHC established a comprehensive STI and HIV control program. Prior to this, the Council’s major control activity had been for syphilis detection and treatment through annual community-wide screening. This had achieved a ten-fold reduction in syphilis prevalence (Miller et al. 1998).

In 1997–98, program activities in relation to sexually transmitted infections were enhanced considerably by the implementation of the Indigenous Australians’ Sexual Health Strategy. However, NHC was already implementing activities that formed the basis of the major recommendations in this strategy. A number of new programs, particularly in relation to screening and health promotion and prevention were implemented. In summary, the following outcomes were achieved during this period.

- One thousand and seven people on the APY Lands participated in the annual STI screen.
- Results of this process show a reduction in the prevalence of gonorrhoea (by 46%) and chlamydia (by 20%) in the period 1996–1998. This represents a reduction in prevalence rates of 7.7% and 7.2% respectively. This process and the outcomes it achieved has had a significant impact on the implementation of the strategy in other parts of Australia.
- In August 1998, there was only one remaining chronic case of donovanosis on the APY Lands.

In summary, the activities and local strategies that contributed to the outcomes described above include:

- access for STI care was improved through the provision of men’s and women’s rooms with separate access in all clinics and male and female clinic staff;
- introduction of PCR testing for screening for gonorrhoea and chlamydia;
- annual well men’s and well women’s screening on an opportunistic basis;
improved clinic systems for confidentiality;

- promotion of early presentation with signs and symptoms of STI;

- improvement in the speed and accuracy of diagnosis and interval for treatment;

- improving compliance—introduction of single dose therapy; and

- epidemiological treatment and reporting back to the community.

In 2001–02, the success of the STI Control and HIV Prevention Program continued. The following outcomes were reported.

- The overall participation rate in the STI screen was 65% (slightly lower than the previous year).

- Additional screening services were offered to students from the APY Lands staying at Wiiltja Residential College in Adelaide and those studying at Yirara College in Alice Springs. Port Augusta prison also offered screening for inmates from the APY Lands.

- The overall prevalence rates of chlamydia (5%) and gonorrhoea (6%) were similar to the previous years prevalence of 4.5% and 5.3 % respectively.

- The ongoing activity around syphilis control since 1984 has resulted in a reduction from 20% to between 0.5% and 1% in the incidence of syphilis in the 12–45 year age group. The prevalence of syphilis has remained low, with only 6 cases detected during the 2002 screen.

- The acceptance of new technology (use of self-collected swabs) in women for diagnosing STIs has increased from 20% in 2000 to 90% in 2002.

- Improved transport conditions have also resulted in a more accurate estimate of the true prevalence of disease.

- The continuation of the Safe Ceremonies Strategy to promote safe practices during ‘men’s business’ is an important initiative. The project employs senior Indigenous men on a retainer to oversee the distribution of single use equipment during men’s business. With the cooperation of NT Department of Health and Community Services, the strategy has been extended to communities in the Northern Territory and Ngaanyaatjarra communities of Western Australia.

Funding

The following table shows extracts from the financial reports of NHC for the 1997–98 and 2001–02 periods that relate to the STI Control and HIV Prevention Program.

<table>
<thead>
<tr>
<th>Funding source – Program Area</th>
<th>1997–98</th>
<th>2001–02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health &amp; Family Services* – HIV Prevention ethnographic research project</td>
<td>174 307</td>
<td></td>
</tr>
<tr>
<td>Department of Health &amp; Family Services – HIV Prevention 3</td>
<td>106 104</td>
<td></td>
</tr>
<tr>
<td>Department of Health &amp; Family Services – HIV Prevention 4</td>
<td>15 118</td>
<td></td>
</tr>
<tr>
<td>Department of Health &amp; Family Services – HIV and STI Prevention program</td>
<td>279 336</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>295 529</td>
<td>279 336</td>
</tr>
</tbody>
</table>

* Now Australian Government Department of Health and Ageing
Workforce

Table 19: NHC Workforce for STI Control and HIV Prevention Program

<table>
<thead>
<tr>
<th>Position</th>
<th>1997–98</th>
<th>2001–02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Medical Officer</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Senior Male Anthropologist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Project Worker</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ceremonial Health Workers</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10</td>
<td>8</td>
</tr>
</tbody>
</table>

In summary, NHC has been able to demonstrate a major step forward in STI control in remote communities and it provides strong evidence that improving access to and delivery of STI services (early diagnosis and early treatment) can reduce STI prevalence.

5.13 Case Study – Nganampa Health Council Public and Environmental Health Program

Background

The Uwankara Palyanyku Kanyintjaku (UPK) program is an initiative of the NHC. It results from the completion of a survey in 1987, which identified a shortfall in health hardware on the APY Lands. The aim of UPK as a strategy for wellbeing has always been to secure the physical environment within which Anangu can make healthy life choices, and thus have control of some aspects of their own health.

The strategy detailed in the UPK report has today become known as the Housing for Health model and has been responsible for a national approach in this regard. The Fixing Housing for Better Health program was developed by Healthabitat to address the health issues associated with poor housing conditions (including leaking taps, unsafe power, inadequate hot water and inoperable showers). What started as a small public and environmental health review in central Australia in the mid 1980s (UPK), is now a national program that aims to make urgent safety and ‘health hardware’ repairs to existing housing and immediate surrounding living areas. Fixing Housing for Better Health is a collaboration between Healthabitat, ATSIC and State/Territory Indigenous Housing Agencies and Departments of Health in New South Wales, Queensland, South Australia, Western Australia and the Northern Territory.

Projects focus on assessing and fixing the health hardware in houses and living areas in order to allow families to maintain healthy living practices. These are prioritised so that limited funds are expended on issues of most importance for health. The healthy living practices that are targeted are:

- safety—especially electrical safety;
- washing children and adults;
- washing clothes and blankets and the immediate living space;
- removing waste;
- improving food storage, preparation, cooking;
• reducing crowding;
• reducing impact of pests, animals and vermin;
• dust control;
• temperature control; and
• reducing trauma.

An essential feature of this work is that specific tests of function have been developed for the health hardware and services so that performance can be reproducibly quantified not just observed from a distance.

In 1991–92, NHC was experiencing some of the changes incurred as a result of the formation of ATSIC, the organisation that had assumed responsibility for Indigenous health funding. Initial funding for this program represents an ATSIC State Office (SA) response to the shortfall in health hardware identified in the UPK (1987) survey.

As at June 1992, the following units had been installed.

Health hardware:
• 25 shower/laundry units;
• 40 shower/laundry flush toilet units;
• 40 pit toilet units; and
• 47 other works (such as demolition of old shower units and installation of hot water services).

Solar power:
• 32 homepak units;
• 18 pole-mounted area lights; and
• four units of four or five lights.

In addition to the above, the following important advances were made.
• Action research in collaboration with the Australian Housing Research Council commenced to test the functioning of the hardware installed and ensure appropriate maintenance.
• The need for specialised environmental health workers was identified and training opportunities identified.
• The dog program continued and during the year 1000 treatments were administered.
• UPK made a significant contribution to the design and analysis of the ATSIC National Needs Assessment – Housing and Infrastructure Survey.
• Ratification of the Homelands Policy Document, which included sections on the infrastructure and service needs of the Homelands.

In 1997–98, more than 10 years after the UPK review, the strategy had become the Housing for Health model, aimed at providing safe and affordable health hardware while maximising the health benefits.

In addition to improving people’s capacity to wash themselves, clothes and bedding, remove waste water, and control temperature, the stock of houses on the APY Lands had grown from 90 houses in 1986 to 460 houses in 1998. This work was underpinned by the following three principles.
• Safety—will the work promote a safer physical environment for the population?
• Health—will the work promote people’s access to functioning health hardware?
• Affordability and sustainability—will the work increase people’s capacity to access health hardware on an affordable ongoing basis?

Several new initiatives had been implemented including:
• in collaboration with the University of Wollongong, a trial of septic systems at Pipalyatjara was undertaken;
• Phase two of a water study, to map existing aquifers and to measure the potential for contamination and sustainability of supplies; and
• monitoring of energy, with a view to energy efficiency.

By 2001–02, the UPK program had expanded its activities in a number of areas.
• The Mai Wiru Regional Stores Policy. In 1998, the AP Council decided to develop a stores policy for all Anangu stores on the APY Lands, aimed at fixing prices of healthy food and essential health items and to develop rules to govern all stores operations. NHC (through UPK) and the Women’s Council were successful in obtaining funds from the Department of Family Services to develop this policy.
• Christian Blind Mission International funded a project at Pipalyatjara and Kalka, the aim of which was to reduce the level of dust that is contributing to the incidence of trachoma in these communities.
• The dog program continues to operate and dog numbers are being controlled through a successful euthanasia program.
• The implementation of the Economic Incentives Project that aims to provide a framework for reducing socioeconomic disadvantage. One aspect of this project is the development of Rural Transaction Centres which would be networked across the APY Lands and provide increased employment opportunities for Anangu along with improved access to a range of government and non-government services.

Funding


Table 20: NHC UPK funding

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ATSIC</td>
<td>81 173</td>
<td>31 061</td>
<td></td>
</tr>
<tr>
<td>ATSIC Needs Assessment Survey</td>
<td>22 057</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Australian Health Commission</td>
<td>201 450</td>
<td>170 455</td>
<td></td>
</tr>
<tr>
<td>FACS – AP Stores Policy</td>
<td></td>
<td>94 496</td>
<td></td>
</tr>
<tr>
<td>ATSIC – dog health</td>
<td></td>
<td>44 100</td>
<td></td>
</tr>
<tr>
<td>Christian Blind Mission – Trachoma</td>
<td></td>
<td>63 298</td>
<td></td>
</tr>
<tr>
<td>ATSIC – waste water</td>
<td></td>
<td>3 625</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>103 230</strong></td>
<td><strong>232 511</strong></td>
<td><strong>375 974</strong></td>
</tr>
</tbody>
</table>

Despite the enormous success of this program, it only has a core staff of two people—a public and environmental health officer and a ceremonial health worker.
Section six – Case Study 4: Rural Aboriginal Health Clinic

Timeframes for publication of this document have meant that it has not been possible to obtain consent for the identification of the service name and location of this case study. Names of locations have therefore been removed.

Summary of locations
Town A – Aboriginal community located close to a State border
Town B – small neighbouring town
Town C – small neighbouring town across the border
Town D – large town in local area

Introduction
The fourth case study was carried out at an Aboriginal community, Town A, located close to a State border. The town was first established at its current site in 1938. Two small towns (Towns B and C) are located about 15 km and 20 km away respectively. Town C is across the border in another State.

The people living in Town A come from three different language groups. Many people originally from the community have relocated to Town B. The people are fairly mobile and therefore the exact population of the community is not known. However, it has been estimated that approximately 280 people are living there (University of Queensland 2002).

Most services are located within the centre of Town A and are operated by the local people. Key organisations present include:

- a cooperative;
- the CDEP;
- a Centrelink agent;
- an Aboriginal Lands Council; and
- a store.

A preschool and primary school up to year six is located in the community. Both institutions encourage local dance and language. A TAFE College is located in Town B.

Sport has a large influence in the community and in particular the local football team. Facilities include a floodlit football field. Women are strongly involved in basketball and tennis. A craft industry previously located in the community has now moved to larger premises in Town B.

6.1 Health profile
The region appears to have a statistically significant higher standardised mortality rate than the State for premature deaths (deaths that occur before the average life expectancy for the State: currently 77 years for males and 83 years for females). The largest town in the local government area (LGA), Town D, has a higher rate of premature death than for the region as a whole.

The table below summarises the significant differences in mortality rates for the LGA.
Table 21: Mortality features (source: Regional Mortality Report)

<table>
<thead>
<tr>
<th>LGA</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td>32% higher than State</td>
<td>22% higher than State</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>25% higher than State</td>
<td>15% higher than State (not statistically significant)</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>48% higher than State</td>
<td>22% higher than State (not statistically significant)</td>
</tr>
<tr>
<td>Suicide and self-inflicted injury</td>
<td>No significant difference</td>
<td></td>
</tr>
<tr>
<td>Motor vehicle traffic accidents</td>
<td>90% higher than State</td>
<td>30% higher than State (not statistically significant)</td>
</tr>
</tbody>
</table>

Hospital separation data for the past four years from the district hospital in Town D, suggests that Indigenous people comprise around 25% of admissions, with an average length of stay of around four days. Further breakdown of this data is difficult to obtain.

6.2 Service

Town A is serviced by the Local Area Health Service, which is part of a larger Regional Health Service and located in Town D.

6.2.1 The Regional Health Service

The state-funded Regional Health Service provides a comprehensive range of health services to a population of 175,208 people living in a rural area covering 98,000 square kilometres.

The area has a total of 20 public hospitals, 27 community health centres and 2 private hospitals. The Regional Health Service employs over 3000 people and uses the services of a wide range of visiting specialists, medical and allied health professionals.

A major issue for the Regional Health Service is the population distribution in relation to infrastructure and service provision. There are many small towns and villages with a population of less than 200 people, characterised by ageing populations, socioeconomic disadvantage and, in many places, no access to public transport. The delivery of health services to centres such as this is very expensive due to factors such as economies of scale, distance from specialist services and the cost of ambulance retrievals. The model of care that has been adopted by the Regional Health Service has as its core community hospitals and primary health care that includes general practice, community services, and public health and health promotion. These services are supported by larger district hospitals and the non-metropolitan referral hospital. Telehealth has been introduced within the health services and is apparently running successfully in mental health and radiology.

The Regional Health Service receives a budget from the State Government, which is calculated according to a formula that considers issues such as population base, age, sex, Aboriginality, socioeconomic indices and hospital activity to calculate the share of the State’s health budget. It is difficult to identify the level of funding for the Case Study’s Aboriginal Clinic at Town A, other than staffing costs, and what might perhaps be argued as in-kind support through visiting staff.
6.2.2 Local Area Health Service

The state-funded Local Area Health Service provides an acute service role as a District Hospital in Town D with Level 3 acute services for medicine, paediatrics and obstetrics, and a renal satellite unit. The District Hospital catchment includes a number of neighbouring towns. The Local Area Service also has responsibility for providing services via two Community Health Centres at Town B and another township neighbouring Town A as well as for Town A’s Aboriginal Clinic.

There are 13 GPs in Town D (2 are locums with 6 month contracts and another has a 2 year contract); 10 GPs have visiting rights to the hospital, care for inpatients as Visiting Medical Officers and provide the after hours care for the hospital. The Regional Health Service has the highest number of Aboriginal people of any Regional Health Service in the State. Details are provided in Table 22.

The LGA

Data from the 2001 census suggests that there was a total of 12 185 Indigenous people living in the region, which represents 7% of the regional population. The LGA had 2807 Indigenous people, or 17.8% of the population. Indigenous people comprised 1.9% of the State population in total. Despite a decline in the total population for the LGA, the Indigenous population appears to be increasing. This trend is shown in the table below:

Table 22: Regional time series profile – LGA

<table>
<thead>
<tr>
<th></th>
<th>1986 Census</th>
<th>% Total</th>
<th>1991 Census</th>
<th>% Total</th>
<th>1996 Census</th>
<th>% Total</th>
<th>2001 Census</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>2320</td>
<td>13.7</td>
<td>2375</td>
<td>14.1</td>
<td>2615</td>
<td>16.9</td>
<td>2807</td>
<td>17.8</td>
</tr>
<tr>
<td>Non-Indigenous</td>
<td>14 335</td>
<td>84.4</td>
<td>13 626</td>
<td>80.7</td>
<td>12 401</td>
<td>80.1</td>
<td>12 930</td>
<td>82.2</td>
</tr>
<tr>
<td>Not stated</td>
<td>326</td>
<td>1.9</td>
<td>894</td>
<td>5.3</td>
<td>471</td>
<td>3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16 981</td>
<td>100.0</td>
<td>16 895</td>
<td>100.0</td>
<td>15 487</td>
<td>100.0</td>
<td>15 737</td>
<td>100</td>
</tr>
</tbody>
</table>

Local Area Health services provided for the Indigenous population

- The Aboriginal Hospital Liaison Officer is seen as the link between community members and the hospital services.
- The Aboriginal Health Education Officer coordinates health education and promotion programs and ensures access to health services.
- Aboriginal Health Services provides a manager with responsibility for planning, delivery and evaluation of health promotion, and specific program areas such as diabetes/heart health, drug and alcohol, and maternal and child health.
- The community works closely with Aboriginal Community Controlled Health Services in the district. A community-controlled service operates in Town D, offers a range of services within the town and runs the local pre-school.

6.2.3 Town A’s Aboriginal Health Service

The Aboriginal Clinic is located within Town A and has a full-time staff of two: a registered nurse and an Aboriginal health worker. The clinic operates from 8.30 am to 5 pm daily from Monday to Friday and no
after hours or emergency care are available. Despite being in reasonable proximity to the hospital across the border in Town C, the problems associated with transport raise considerable issues in relation to access to health care.

Services provided at the clinic include the following.

- A doctor operates a clinic twice weekly, for a two- to three-hour session—at present a GP in private practice in Town C visits on a bulk billing basis. Prior to this, an arrangement was in place between the Public Health Unit in another large town and the hospital in Town C for a visiting medical officer.
- A range of workers based in Town D visit on a regular basis, including a women’s health nurse, a community midwife, drug and alcohol workers, a mental health counsellor and a dietician.
- The registered nurse conducts a well-baby clinic and an asthma educator visits on an as required basis.

Despite the availability of these services, there is reportedly some difficulty with the uptake of them. Participation and attendance relies upon the extent to which community members are aware of the services being offered as well as their willingness or desire to access them. Staff and community members expressed concerns in this regard, but these would need further exploration in order to draw any conclusions about the adequacy and appropriateness of existing services. In the absence of data this is difficult.

While the Local Area Health Service, based in Town D, is responsible for the services in Town A, many of the community members reportedly prefer to go to Town C for treatment if needed. It appears that the relationship with the district hospital in Town D could be improved. Data to explore the relative use of health services does not appear to be available. However, the frequent need to access services in Town C raises significant issues.

- In a recent unpublished community consultation report cross-border issues were identified as being an important priority by community members as they affected their ‘health and wellbeing’. Many services are not available in Town A and therefore many residents have to travel to either Town D or Town C to access to these services. Accessing services in Town C is difficult due to the limited transport and also the problems associated with residents using a service that is not in their State of residence. A common problem identified by the consultation report was that residents are not entitled to discounts when accessing services in the neighbouring State if they have a pension card from their State of residence. Issues were specifically raised in relation to access to ambulance services. Other cross-border issues identified in the consultation report include medical transport to the major hospitals in the neighbouring State. If referred, the Isolated Patient Transport Assistance Scheme will transport the person to the hospital. However, the scheme does not cover transport once discharged.
- Limited public transport between Town A and Town C leading to isolation of the community was one of the key problems identified by the people of Town A in the 2002 consultation report. Main issues associated with limited transport between the towns have been: lack of access to health services, as well as access to fresh food as there is only a small store located in the community. There is also social loss. Originally, a public bus service operated between the two towns. However, this service has been terminated. In order to get to Town C from Town A people may get a lift from friends, hitchhike, catch the school bus or a taxi, which is quite expensive.

6.3 Governance

While the Aboriginal Community of Town A incorporated its Aboriginal Community Controlled Health Service in the early 1990s, it is not yet operational as such. Attempts were made to explore this issue further, with little success. Clearly, in a small community such as this there is a need for comprehensive primary health care services. However, it is typical of a community with a history of state-based services that it is not large enough to sustain mainstream and community-controlled health services as separate entities.
Governance is an important issue, and it appears that in the absence of a functional medical service, the Board of the organisation cannot perform an administrative/management role and will thus become relatively inactive. The Regional Health Service has established a Health Advisory Committee for Town A, but it is not clear that this group has had an impact on service planning or delivery. It is understood that an agreement has recently been reached between the Regional Health Service and the Community’s Aboriginal Health Service to revisit earlier plans to operate an ACCHS in the community. Clearly, issues of governance are critical and if this is seriously looked at, then transition arrangements would be critical.

6.4 Workforce

There are two full-time staff employed within the clinic: a registered nurse and an Aboriginal health worker. The current registered nurse has been employed within the community for the past 10 years, a considerable length of time. Health worker retention has been more difficult, and turnover in this regard was identified as a major issue. It was also apparent that the role of and career development opportunities for Aboriginal health workers have not yet been addressed. The current duties performed by the health worker tend to be as a driver and receptionist at the clinic.

6.5 Health information

Computer access was identified as an issue for staff, who are yet to gain email access. Patient details are recorded manually on charts and while there is a desire to use local health information for further analysis and planning purposes, this has not been possible. Immunisation data is recorded in a register, as well as patient charts and the information is sent to Town D for central processing. Local data is not available. Recalls are done manually.

6.6 Achievements of the Town A Aboriginal Clinic

While documented evidence is not available, the following were identified.

- Medicare access—a significant amount of work was undertaken to ensure that all community members were enrolled for Medicare purposes. This was done manually and with assistance from the head office. Staff now believe that all members are enrolled and continue to monitor as patients present. This has been critically important to enable a visiting private practitioner to bulk bill in the community.
- Good compliance with pap smear and immunisation recalls—this is difficult to comment on, given that the data is not available in the community and is held in centralised registers in Town D.
- Improved networking and coordination in some areas of service delivery.

6.7 Barriers and access issues

The following issues were identified.

- Despite proximity to other towns, transport remains a significant barrier to accessing services.
- No dental services are provided in the community, and access to services in the neighbouring State is extremely difficult.
- The Eye Health team no longer visits Town A (following the regionalisation of eye health services) and there is a large unmet need in this regard.
- A number of community members are in receipt of ongoing treatment for mental health problems, but limited and irregular services exist to meet these needs.
There is a heavy reliance on visiting people, and community members are not always aware of the extent of services being offered.

There is a need to focus more effort in the areas of health education and health promotion.

Despite attempts to work closely with the community store, little has changed in relation to food supply and pricing. The store is privately leased.

It is very difficult to find any information concerning funding, health or workforce that can be specifically attributed to the Town A Aboriginal Clinic and the community that it serves. The site visit played an important role in identifying a number of issues, but did not assist in terms of obtaining data for further analysis. Despite Indigenous health being identified as a priority for the Regional Health Service, and Town A being the only discrete Indigenous community within the local government area, it is not clear at the community level at least, that there has been a planned and strategic approach to addressing this issue.
Section seven — Discussion and conclusions

7.1 Introduction

These case studies have examined four community-controlled Aboriginal Health Services in different geographic locations each facing a unique set of circumstances that contribute to the social, cultural and health disadvantage of their communities. Three of the services (Nganampa, Townsville and South Coast) have operated under similar system influences but the inputs and processes have differed, as have the outputs and intermediate outcomes. An examination of these services using the case study methodology allows for an understanding of factors that contribute to the capacity of the service to meet the needs of the community.

Some of the difficulties associated with measuring need in an Aboriginal and Torres Strait Islander health context have already been identified. In terms of the case studies, the following comments are relevant.

- Variations across the sites in relation to access to and quality of data. Examples of program responses to identified need, that were based upon accurate and reliable data include: the establishment of the TAIHS Mums and Babies Program; the development of the Nganampa Aged Care Program (that was informed by a commissioned report into the aged care needs of Anangu people); the expansion of the Nganampa STI and HIV Prevention Program; and the development of the clinical services at SCMSAC through the partnership with the local Division of General Practice.

- It is difficult to obtain information about the use of mainstream services by Indigenous Australians. Hospital separation rates generally provide a breakdown by Indigenous/non-Indigenous status, but it is difficult to draw conclusions about this without further analysis of the data and measures in place to ensure quality and accuracy of reporting. It is also difficult to quantify the level of mainstream funding that is supporting Indigenous people.

- It is also important to identify needs that may not be met because of structural or other systemic issues. For example, the capacity for Case Study 4’s Aboriginal community to participate in planning processes (including identification of need) appears limited, and mental health care was identified as one area of great need not currently being sufficiently addressed or given priority. Visiting services from the Local Area Health Service are reportedly not accessed according to need, and gaps exist in relation to follow up treatment in the community following release from the mental health unit and detention centre across the State border.

- The relationship of need to other sector responses is important (for example NHC has been successful in responding to housing and infrastructure need by adopting a health argument [Housing for Health] and the organisation is now seeking to influence store policy in communities by identifying needs in relation to nutritional status of children).

7.1.1 Capacity at service level

Capacity can be defined as the factors that enable a service to impact or change the health disadvantage of their communities. The system influences, both policy and funding, are identified and analysed in the case studies. It can be argued that the policy and funding changes in recent years have supported capacity building. An important finding of the case studies has been the identification of the factors within the services that have contributed to capacity, and allowed them to maximise the advantages of system level changes. In this regard, capacity also needs to be defined in terms of how it can improve the responsiveness of the health system to meet the needs of Aboriginal and Torres Strait Islander populations.
While it is acknowledged that limited conclusions can be drawn from the analysis of four services, the conclusions drawn can certainly be supported by literature around organisational and community capacity. The service factors that have contributed to capacity related to governance, workforce, management, planning and quality. A service with capacity has the following characteristics.

- A clear mission statement or understanding of its role or purpose (e.g. clearly defined aims and objectives). In part this is facilitated by the existence of a strategic plan for the service, but it is also influenced by the human resource management practices of the organisation. For example, staff and directors of Nganampa are very clear about the boundaries in terms of how a health service can be expected to respond to the local problems. This may be inconsistent with some of the arguments in relation to the need for intersectoral collaboration or embracing the holistic definition of health, but it has meant that goals are not too ambitious and that staff and community can feel that they are achieving success in the face of some very difficult and confronting issues.

- A Board and organisational structure that supports the work of the service. Growth in terms of staff numbers and diversity of programs requires a review of the structural arrangements in place to manage such changes. Both TAIHS and Nganampa have responded by restructuring processes that have resulted in middle management positions that are responsible for program, clinical or administrative areas. SCMSAC still has a very flat structure and operational staff would benefit from a structure that delegated some management responsibilities to the unit/program level. Strategies in place for staff with management responsibilities to meet regularly is also very important.

- A clear delineation of roles and responsibilities within the organisation supported by policy and procedures where this is appropriate is important. This is enhanced by an organisational structure that reflects the various work units and in which responsibility for these is clearly understood. In this regard, compliance with the recruitment policies of the service is also very important. TAIHS and Nganampa demonstrated well-established and successful approaches in this regard. This was highlighted by the emphasis they place upon the role of the Aboriginal and Torres Strait Islander health worker and the commitment to their professional development. In the case of Nganampa, they insist on bringing short-listed external applicants to the APY Lands during the recruitment process to familiarise them with the work context. This can be compared with Case Study 4’s rural Aboriginal Health Clinic, where the role of the health worker within the clinic setting is not understood and reporting relationships are unclear.

- A workforce that has the necessary mix of staff to support the work of the organisation. The tables below compare the employment of doctors, nurses and health workers across the three sites and consider these numbers in relation to the Indigenous population base. Clearly, there are problems with such as comparison, but it does allow for some issues to be discussed. For example, as one would expect, there is a much greater dependence upon doctors and nurses in the remote communities serviced by Nganampa. The model provided by SCMSAC reflects a heavy emphasis on medical services provided by the doctor and the lack of nursing and health worker support is of concern. It also needs to be recognised that Nganampa is the only health service operating on the APY Lands, so one can conclude that it is serving the entire local Indigenous population. However, given the existence of other options, such as private GP services, community health centres and hospital services, it is difficult to interpret these figures in relation to TAIHS and SCMSAC as the use of mainstream services needs to be understood.
Table 23: Doctor: Indigenous population ratios

<table>
<thead>
<tr>
<th>Service</th>
<th>Indigenous population base</th>
<th>No. of FTE doctors</th>
<th>Ratio doctor:Indigenous population</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAIHS</td>
<td>5,946</td>
<td>6</td>
<td>1:991</td>
</tr>
<tr>
<td>SCMSAC</td>
<td>1,204</td>
<td>1</td>
<td>1:1204</td>
</tr>
<tr>
<td>Nganampa</td>
<td>2,833</td>
<td>2</td>
<td>1:1416</td>
</tr>
</tbody>
</table>

Table 24: Nurse: Indigenous population ratios

<table>
<thead>
<tr>
<th>Service</th>
<th>Indigenous population base</th>
<th>No. of FTE nurses</th>
<th>Ratio nurse:Indigenous population</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAIHS</td>
<td>5,946</td>
<td>2</td>
<td>1:2973</td>
</tr>
<tr>
<td>SCMSAC</td>
<td>1,204</td>
<td>-</td>
<td>0:1204</td>
</tr>
<tr>
<td>Nganampa</td>
<td>2,833</td>
<td>24</td>
<td>1:118</td>
</tr>
</tbody>
</table>

Table 25: Health worker: Indigenous population ratios

<table>
<thead>
<tr>
<th>Service</th>
<th>Indigenous population base</th>
<th>No. of FTE health workers</th>
<th>Ratio HW:Indigenous population</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAIHS</td>
<td>5,946</td>
<td>2</td>
<td>1:2973</td>
</tr>
<tr>
<td>SCMSAC</td>
<td>1,204</td>
<td>1</td>
<td>1:1204</td>
</tr>
<tr>
<td>Nganampa</td>
<td>2,833</td>
<td>27</td>
<td>1:104</td>
</tr>
</tbody>
</table>

- Management structures that provide support for human resource management, and financial management and planning.
- Ongoing professional development for staff can include a range of initiatives such as in-service training, conference support, sponsorship for study and accredited training programs. Nganampa has incorporated the health worker training program into its structure and it represents a core function of the service. TAIHS has addressed the issue in its Policies and Procedures Manual and evidence of support in this regard was provided. SCMSAC recognises this as a priority, but does not appear to have a planned approach to staff development. Staff relief is often an important issue, particularly for clinical staff, and it needs to be addressed if a commitment to staff development is to be successful. For example, while visiting the service, training in the use of the Ferret system was being provided, but relief staff were not provided, so the health worker was unable to fully participate in the training.
- Information systems (either paper-based or computerised) that allow the service to review, monitor and evaluate its work and to identify and plan for areas of need are needed. The detailed case studies in relation to aged care, sexual health and environmental health for Nganampa and the TAIHS Mum’s and Babies project demonstrate how information and record keeping has allowed for improved planning, monitoring and evaluation. The lack of comprehensive community records in Case Study 4’s rural Aboriginal Health Clinic clearly creates a barrier in this regard.
• Planning procedures that use data that allow board and staff to monitor the work of the service and allow board, staff and community involvement in the identification, development and implementation of new programs and strategies is an issue. TAIHS has regular meetings between management and the Board, and 2–3 times a year has staff/Board planning meetings. Nganampa has an open meeting policy, so that any Anangu is allowed to attend council meetings, but only Directors are allowed to vote. Staff also expressed the importance of the ‘open door’ policy that exists.

• Realistic timeframes to achieve outputs and outcomes is discussed in detail in addressing TOR 2 and 3.

7.1.2 System level capacity

System-level changes are still frequently dependent upon capacity at the local level. In the services reviewed, there are examples of successful implementation of system level changes through building at the service level, such as the TAIHS Medicare access, or the Nganampa Sexual Health Program. However, there are also examples of system-level changes that have been implemented despite poor capacity at the local level. For example, the Bringing Them Home money has resulted in a growth of drug- and alcohol-related programs for SCMSAC, with the funds used mainly for employing additional staff. However, in the absence of comprehensive human resource management processes and a skilled local Indigenous workforce, perhaps a longer-term planning process is needed.

In summary, the following system level influences on capacity were identified.

• Policy development and implementation. An example is the National Indigenous Australians’ Sexual Health Strategy that was implemented in the late 1990s. The Nganampa sexual health case study provides evidence of impact in relation to this strategy. On the other hand, despite being identified as a local priority, SCMSAC has been able to use additional funds provided through the Strategy to employ an additional driver. This raises issues in relation to accountability for specific program funds, and a potential barrier to successful policy implementation at the local level. Arrangements have also recently been made for the transfer of sexual health positions from Queensland Health to TAIHS, which will increase their capacity in this regard.

• Program review. An example is the National Review of Aboriginal and Torres Strait Islander Eye Health Services which has resulted in increased capacity at the local level for each of the services with the exception of Case Study 4’s rural Aboriginal Health Clinic, which no longer receives services as a result of the review, despite reported need.

• Commissioned reports or enquiries. An example is the impact of the Bringing Them Home report with evident impact in the expansion of mental health and counselling programs for both TAIHS and SCMSAC. Despite this, Case Study 4’s rural Aboriginal Health Clinic identified this as a significant priority yet to be addressed. The AIHW report on Expenditures in Aboriginal and Torres Strait Islander Health (AIHW 2001) has also had a significant impact on the Medicare income for TAIHS.

7.2 Responding to the Terms of Reference

TOR 1

Assess the level of current spending and its impact in various locations including urban, rural and remote areas.

In the table below, a summary of the recurrent PHC funding provided by OATSIH relative to the Indigenous population base and the client contact numbers for 2001-02 is provided:
Table 26: Funding to Indigenous population and client numbers ratios

<table>
<thead>
<tr>
<th>Service</th>
<th>Recurrent PHC funding provided by OATSIH ($)</th>
<th>Indigenous population base (1996)</th>
<th>Total client contacts 2001–02</th>
<th>Ratio OATSIH PHC recurrent funding: Ind pop.</th>
<th>Ratio OATSIH PHC recurrent funding: client contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAIHS</td>
<td>975 611</td>
<td>5 946</td>
<td>28 679</td>
<td>164:1</td>
<td>34:1</td>
</tr>
<tr>
<td>SCMSAC</td>
<td>895 567</td>
<td>1 204</td>
<td>7 479 (2002–03)</td>
<td>743:1</td>
<td>119:1</td>
</tr>
<tr>
<td>Nganampa Health Council</td>
<td>4 418 327</td>
<td>2 833</td>
<td>46 255</td>
<td>1559:1</td>
<td>95:1</td>
</tr>
</tbody>
</table>

- The reliability of this population data is not good, given the problems with census and vital statistics data.
- SCAMSAC and TAIHS are both located in areas where there are choices for access to services (e.g., other private general practice services, public hospital services and community health centres). In these cases, there is little data to identify the extent to which mainstream services are being accessed by the community and it is difficult to assess the extent to which the local Indigenous community is dependent upon, or uses the Aboriginal community-controlled services. Nganampa, on the other hand, is the only service operating on the APY Lands, and as such, services the entire community there. Given this, it is reasonable to conclude that the ratio of PHC recurrent funding to Indigenous population is not excessively high for Nganampa, particularly when also adjusting for remoteness and disadvantage.
- It also appears that SCMSAC receives more OATSIH funding on a per capita basis than the other services involved in this study, and that there may be scope for considerable growth in terms of service demands before it reaches its capacity.
- These figures need to be interpreted with caution, as services are increasingly becoming dependent on funding from other sources to supplement their core funding and use it as leverage for attracting additional funds. There remains a clear gap in terms of information about actual level of funds needed for primary health care in the services, and the arrangements are now sufficiently flexible to allow for some shifting of resources, subject to performance outcomes being achieved. The case studies have demonstrated that funding increases alone will not lead to improved outcomes in Indigenous health and there is a danger in providing increased levels of funding to those services that clearly do not yet have the capacity to deliver outcomes:
  - capacity in terms of financial planning and management;
  - capacity to recruit and retain required mix of staff;
  - capacity to implement health information systems that will inform planning and service delivery; and
  - most importantly leadership capacity.

Given the criticisms that are directed at governments for under-funding in Indigenous health, the significant increases in funding for each of the services reviewed could well result in questions about their performance, in view of the continuing poor outcomes in Indigenous health. However, there is a danger in linking outcomes to level of funding alone, particularly given the lack of consensus in relation to an appropriate formula for allocation of funds in Indigenous health and the problems in identifying the level of need for service delivery. In Figure 7 below, the recurrent primary health care funding relative to total funding for each of the services in 2001–02 (in 2002–03 for SCMSAC), is provided.
In summary, each of these services has recently demonstrated success in obtaining funds from a number of sources. Developing and writing submissions for funding is extremely time-consuming and requires dedicated effort. The organisations have largely been strategic in their devotion of resources to secure additional funds, and TAIHS and Nganampa in particular are now in a position to become even more competitive with research and project grant applications. However, funding problems were also identified. These included:

- reliance on ‘soft’ money—a number of positions within the service, considered critical to success of programs, are funded for fixed periods or one-off grants, and this creates problems in terms of sustainability of outcomes and continuity of care; and
- multiple funding sources—the range of funding sources for these services raises issues in relation to financial management and governance. The requirement for high level financial reporting systems now exists in many community-based organisations and the complexity of accountability requirements for different funding sources has been raised as a problem for these services.

The capacity of the health system, mainstream and Indigenous health services and communities to respond to Aboriginal and Torres Strait Islander health needs

In part, this has been responded to in Section 1 above. However, an underlying and fundamental prerequisite for the success of the characteristics identified is their relevance to the local context. For example, while information systems are a critical component of capacity, the type of system and nature of data collected across services differed according to local needs and access to technology. In the case of Nganampa, careful consideration has been given to the patient information, which reflects capacity to incorporate both Western and traditional approaches to health. It also uses visual aids, that have been designed to assist health workers in diagnosis and treatment.

The components of capacity that have been identified above have been analysed in detail for each of the case studies. In summary, capacity was highly dependent on having the resources, financial and human in particular, available and the processes in place for achieving desired outcomes through the application of
these resources. This raised a number of issues in relation to governance, health information systems and linkages across health and other sectors. However, even if these latter strengths exist, without the necessary financial and human resources available and systems in place for managing and monitoring these, gains are likely to be limited.

(a) The level and nature of service provision compared with relative health need

The critical difference in this regard can be attributed to:

- those services that have implemented programs and activities based around locally generated data, community feedback and careful planning;
- those services that have implemented programs more opportunistically, driven by financial or political motivation—more likely to be a reactive approach to service delivery than a strategic and planned one; or
- a combination of the above two points.

Changes within the health system

A brief summary of how each of the services has responded to need follows.

- TAIHS. Data was generated through a Masters in Public Health thesis that identified poorer local Indigenous perinatal and obstetric outcomes. The process of development of the Mums and Babies Program ensured community input and ownership of the newly established service (see detailed case study). TAIHS has also used recently generated data to inform the implementation of its chronic disease management program. Strategic use of PIP funding has also enhanced service delivery in this regard.
- SCMSAC. Funding has been more opportunistically accessed and thus program delivery does not necessarily reflect a planned and informed approach. However, the Illawarra Health Service has assisted with the generation of local data and this informed the initial partnership with the Division of General Practice.
- NHC. Evidence in relation to all of the points above can be demonstrated. For example, the process of developing the aged care program was very much one of collecting locally generated data and carefully planning an appropriate response, aided by the development of a national strategy. The sexual health and HIV prevention program was already achieving successful outcomes when the national strategy was launched, and it has led to improved access in this area.
- Case Study 4. The delivery of health services within this community appears to be influenced by decisions made within the health system in response to changes at that level. There is little evidence of local-level planning that has informed service delivery and responded to locally identified needs.

(b) The accessibility and quality of current services

The following comments relate to each of the services involved in the project.

- TAIHS. Evidence of improved access include the increasing client numbers, diversification of services offered, management of non-health agencies (such as child protection), relocation of premises to an area that has a significant Indigenous population base, commitment to planning and research, and quality accreditation and improved access to Medicare funding. The organisation seems to be a key meeting place and resource for the local community and there appears to be a great sense of pride in the service facilities and its new initiatives. Outreach, mobile and prison services are also examples of meeting the access needs of more marginalised groups within the community. The apparent responsiveness of the organisation to community identified needs is seen as an important component of access and quality.
• SCMSAC. Access to general practice services has been made available through funding specifically allocated for this purpose. However, despite increasing client numbers, there are concerns about the extent to which a service that does not employ nursing and clinical health worker staff can support this growth and provide comprehensive primary health care. Accreditation standards have been met, and outreach clinics are provided to Wreck Bay and Orient Point. Lack of community input and planning processes are important in terms of accessibility.

• NHC. Nganampa has undoubtedly provided access to health care that would otherwise be almost non-existent for people on the APY Lands. The organisation has confronted the difficulties of providing comprehensive care in a very remote part of Australia. Access has been improved through overcoming locational barriers, respect for cultural protocols, careful and long-term planning processes and implementing quality measures. The organisation was also able to provide high quality palliative care for a patient on the APY Lands under very difficult circumstances, largely through the commitment of staff and good links within the system.

• Case Study 4. Access is limited to those services provided by the Regional Health Service and no after-hours care is provided. Lack of transport, along with historical relationships within the health system, make access to services in nearby towns difficult. Efforts to improve Medicare enrolments in the community are likely to have improved access, given that a private GP is currently delivering services within the community.

(c) An assessment of the health improvements that have been achieved to date.

The framework outlined in the methodology section of the report describes both intermediate outcomes and outcomes. An intermediate outcome is one that has a direct relationship to the work of a service (an output) and can use evidence from the literature to support its relationship to a health outcome. In many instances it is possible to document intermediate outcomes but it is too early to document actual outcomes. This is dependent to a large extent on the quality and availability of data for each of the services. Examples from the case studies include the following.

• The TAIHS Mums and Babies Program is able to demonstrate improved attendance for antenatal care which can be linked to better long-term outcomes such as less prematurity and higher birth weights.

• The Nganampa STI and HIV prevention program is able to demonstrate increasing participation rates in screening programs, early detection and management of STIs and reduction in the rates of donovanosis and syphilis. It is more difficult however, to provide evidence of improvements related to the health education/promotion initiatives of this program, such as behavioural change.

• It would be inappropriate to consider health improvements alone for some of the service initiatives. For example, the major outcome achieved by the NHC Aged Care program is likely to be improved access to services on the APY Lands, but measures such as improved quality of life and reduced community and family stress are extremely important and ones that are more likely to be supported by qualitative data.

• Similarly, while the UPK program has undoubtedly led to health improvements, the impact in other sectors is probably equally important, but difficult to measure (e.g. it would be useful to look at impact on school attendance, participation in community activities, mobility among community members, individual hygiene and related behaviour change).

• A number of other preventive measures implemented within the services could be linked to longer-term health outcomes, such as the implementation of child immunisation programs that are linked to central registers and recall systems. The NHC system is a manual one, very much localised to meet the needs of the community and it is unlikely to be of value in one of the other service settings. Case Study 4’s Aboriginal Health Clinic, while linked to the local government area immunisation register, does not have locally relevant data. Pap smear screening services are also offered and linked to central registers (in the
case of TAIHS). SCMSAC tends to be the referral point for Waminda Aboriginal Corporation if women need follow-up treatment after an abnormal pap smear.

- NHC and TAIHS also offer screening programs for adults in the community and maintain a chronic disease register.

**4. Any barriers to the achievement of better health outcomes for Indigenous Australians**

The following is a list of brief comments in relation to the barriers identified in section 1.5.3.

- Cultural and social factors (particularly in relation to the Case Study 4 community). Historical mistrust in the system, discrimination, communication issues and cultural misunderstandings continue to play an important role in terms of people’s willingness to access services.

- Locational factors. Clearly, there are challenges to overcome in order to deliver comprehensive primary health care in remote communities, a major one being the recruitment and retention of suitable staff. Other barriers include the cost of evacuation and limitations of the Patient Transfer Assistance Scheme. Cross-border issues are also important, in the case of NHC (where many referrals are to Alice Springs Hospital) and Case Study 4’s Aboriginal Health Clinic (many referrals to neighbouring cross border town or capital city). There can be dispute in relation to responsibility for costs incurred as well as reporting differences, such as inclusion of Indigenous status on records.

- Poor linkages. This is particularly important given the high rate of chronic disease in Indigenous communities and the need for individuals to work their way through the system.

- Lack of a population health focus. This is particularly important given multiple chronic morbidities in Aboriginal and Torres Strait Islander communities. This was identified as a priority for TAIHS and a gap in the current skill level and training for staff. NHC has had an emphasis on this for some time and has been able to maintain a population health register. This is a barrier that is yet to be overcome in urban settings.

- Workforce issues. This has been highlighted in the context of locational factors, but is also a significant barrier in its own right. All four services involved in this project raised this issue. The following points were highlighted.
  - The significance of the Aboriginal and Torres Strait Islander health workers cannot be underestimated. However, there remains concern about their skill levels, pressures placed upon them when working in their own communities, turnover of health workers, and lack of a consistent approach to employment and training, and role relationships with other health professionals. The degree of specialisation required is also highly variable.
  - The increasing need for Aboriginal and Torres Strait Islander workers within the services to have skills in management, including financial planning and reporting, human resource management and data systems.
  - The need for greater commitment and exposure to Indigenous health issues across a range of training programs for health professionals, particularly nursing and allied health care workers.
  - The chronic shortage of dentists in rural and remote areas.

- Financial barriers. The older services (TAIHS and Nganampa) have continued to operate on a fairly stable recurrent funding base, despite huge growth in the services and demands placed upon them. The re-basing exercise undertaken by the Commonwealth in 1998 provided for ongoing funding and overcame the need for annual funding cycles, but it also prevented the service from expanding in response to the needs of the local population. It also seems that NHC has been unable to receive the benefits from changes to Medicare that other services have, largely because of the nature of their service delivery and
reliance upon community nursing staff. Numerous reports have highlighted the inadequacy of funding provided thus far for Indigenous health, and the need to address the funding formula in a way that gives recognition to the differentials in health status and issues in relation to access to care, particularly in remote communities.

- Accountability issues. While the focus of this issue has historically been on the financial accountability that Indigenous organisations have for Australian Government monies, there is increasing focus on the usefulness of accountability measures as well as the accountabilities that governments and other service providers have for improving Indigenous health outcomes. In this context, the case study review process found that there needs to be a revision of the current process for monitoring services, so that early identification of problems can occur and strategies implemented to monitor change, as well as provision of appropriate recognition and support for successful and expanding programs. Service activity reporting is seen as an accountability mechanism, but it serves little purpose in terms of the planning and monitoring.

TOR 2

*Provide advice on the strategy and relevant timeframes required to achieve appropriate levels of comprehensive and effective health care for Aboriginal and Torres Strait Islander people.*

It appears that current reporting mechanisms do not provide data that adequately describe the service and its capacity to provide comprehensive primary health care as well as managing these increasingly complex organisations.

For example, financial accountability requirements, which have historically been the focus of reporting, do not allow for assessment of capacity of the organisation to attract, manage and account for finances. Rather, current practices tend to uncover problems after they have been incurred and it is too late to change some of the consequences for both the organisation and the individual. It is particularly important that consideration be given to this issue in relation to future requirements of the Board of Management, organisational structures and workforce composition.

Given the rapid growth of some services and the desired expansion for others, and in keeping with Aboriginal community control, it is critical that local capacity issues be considered in the early stages of planning and decision-making. Greater emphasis needs to be placed on the skills required of service top- and middle-level managers and decision-making powers (or processes for informing) of the Boards of Directors.

An important component of the response to this term of reference will include timeframes and workforce targets for the implementation of the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.

TOR 3

*Determine the likely short, medium and longer-term health impacts that could be expected to result from increased investment in this area.*

In the *short term* this could include changes to health indicators and process indicators such as:

- immunisation rates;
- screening rates for early diagnosis and treatment of disease, such as STI screening, pap smear screening, screening for ear disease in children;
- participation in service delivery such as trends in antenatal care, participation in adult health checks; and
• uptake of other preventive programs such as physical activity levels, healthy eating programs.

Being able to demonstrate the impacts of such measures would, however, be subject to good quality data and evidence of capacity to sustain outcomes beyond the short term. Improvements in data collections, such as Indigenous identifiers in vital statistics, local level demographic and health status data, service data and recall systems data can play a significant role in developing a base for monitoring progress.

It should also be noted that there may be consequential outcomes that are not immediately apparent and that are more difficult to measure (e.g. improved self-esteem as a result of weight loss, or improvements in mental health outcomes where it exists as a co-morbidity to chronic disease). Improved quality of life is also likely to be a short-term impact.

In the short term, it is unrealistic to expect that some of the barriers to access and service delivery can be overcome and sustained, particularly where existing capacity is extremely low. For example, workforce planning and development is essential in the short term, but the likely impact is medium- to long-term, given the lead time required to train staff and develop experience for leadership positions. It is also unrealistic to expect that the health sector should take responsibility for prevention of the underlying causes of ill-health in Aboriginal and Torres Strait Islander communities, and that while a whole-of-government approach is critical, it is also important that realistic goals are set within the health system.

Greater investment also needs to be made for the evaluation of existing programs and understanding successful programs. Policy implementation should ensure that indicators that recognise an incremental approach to policy goals and emphasise the need for monitoring and evaluation are built into the system.

In the medium term, with more reliable and accurate data, it should be possible to demonstrate evidence of sustained efforts in Indigenous health and building of capacity within the service and health system more generally (against some index of capacity). In addition, it may be then possible to establish achievable benchmarks and clear indicators for meeting them. Reviews of policy and programs will be critical and should inform future planning and development. Ongoing efforts to consolidate linkages that are beginning to be formed will be critical in terms of providing comprehensive primary health care, and in particular in managing chronic disease in Indigenous communities. Such linkages are often dependent on personal relationships and this process should link closely with staff recruitment, retention and development strategies.

In the longer term, it is clear that the goal is for equitable outcomes in terms of Indigenous health, and this will be made possible through:

• long-term commitments of additional funds;
• addressing the fundamental underlying causes of ill-health in Indigenous communities and being able to demonstrate sustained achievements against social, environmental and economic indicators; and
• incremental and sustained development of capacity in community-controlled health services, particularly in terms of governance, workforce (composition and skill levels), health information and reporting.

7.3 Conclusion

The case studies of Nganampa and Townsville have shown that with the current level of investment and system influences, these services have been able to develop into effective primary health care services. Their development has taken a long time and sustained effort over many years. They have demonstrated that they have good systems in place to manage their resources on a daily basis and have strategic approaches to manage longer-term issues. Both services have intermediate outcomes that should, in time, lead to
improvements in health outcomes. However, the social and economic disadvantage of their communities continues and this is not within the control of the health service. Any health gains that a service makes can be easily undermined unless these broader problems are addressed.

It is of concern that both these services rely for a significant portion of their funding on ‘soft money’, so from year to year there is uncertainty about whether they will be able to maintain their current programs and continue to develop new programs to meet community need. This also makes it difficult to retain skilled and genuinely committed staff. A strong case could be made that greater investments in these services would allow for more stability and continuing development of effective preventive programs and improved health outcomes. This is particularly important given the ongoing social disadvantage of their communities and the disparities in health status between Indigenous and non-Indigenous communities.

The South Coast case study has shown that increases in investment do not necessarily result in an effective service. The analysis highlighted a number of issues about governance, organisational structure and processes that appear to be hampering its development. Conversely, both Nganampa and Townsville are very effective services. Although limited conclusions can be drawn from small numbers, it highlights the issues around the understanding of capacity—how a service can be helped to develop capacity and what indicators or systems can be put in place to monitor a service so that they can be provided with additional support when it is necessary.

While Case Study 4’s rural Aboriginal Health Clinic does not currently have capacity in terms of a community-controlled health service, the case analysis highlights the need for the development of models for community control in small and isolated communities that may not be able to sustain a dedicated full-time primary health care service.

In conclusion, it is recommended that consideration be given to the development of a capacity index for Aboriginal community-controlled health services, along with a system of regular monitoring and strategies. This will ensure that mechanisms are in place for services that are experiencing difficulties in meeting the criteria as well as for recognising successful outcomes and possible transferability of processes to other services. A strategic and planned approach to the development and support of organisational capacity should be considered.

Finally, a point made in the Cape York Justice Study Report (Fitzgerald 2001) is clearly relevant:

‘The overwhelming scale of the problem almost invites the dispirited reaction that nothing can be done to change anything unless we can somehow change everything. This is a counsel of despair, or at best magical thinking. Strategies to relieve the suffering and improve the lot of people in these circumstances may be arduous and slow, but they are not without precedent, and we can learn much from instances of success locally and in other places…’
8 References


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## Attachments

### 9.1 Attachment 1. Nganampa Health Council funding

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### 9.2 Attachment 2. Nganampa Health Council workforce

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<td>Dental</td>
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<tr>
<td>Oral Health Advisor</td>
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<tr>
<td>Women's Health</td>
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<tr>
<td>Program Coordinator</td>
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<td>Anangu Health Worker</td>
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<tr>
<td>Specific Projects</td>
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<tr>
<td><strong>Total</strong></td>
<td>114</td>
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Note: This number relates to FTE positions. Additionally, there were 5.5 FTE locum nurses brought in to cover permanent staff while absent on leave.