The Aboriginal Medical Services Alliance Northern Territory: engaging with the intervention to improve primary health care

John D Boffa, Andrew I Bell, Tanya E Davies, John Paterson and David E Cooper

The Aboriginal Medical Services Alliance sees the Australian Government's recent intervention to protect Indigenous people, the Northern Territory Emergency Response, as an opportunity to improve primary health care. Despite its serious reservations about other aspects of the intervention, the Alliance considers that sustained improvements in primary health care can be achieved via genuine engagement of government with Aboriginal communities

The view portrayed to mainstream Australia in the introduction of the intervention was that an emergency response was essential because nothing in the Northern Territory was working. However, Aboriginal community-controlled health services (ACCHSs) in the NT have been collaborating for some time with the federal Office for Aboriginal and Torres Strait Islander Health and the NT Department of Health and Community Services, to reform and expand the delivery of primary health care services.

A challenge and opportunity for these existing services has been, and continues to be, to harness the intervention's child health checks to ongoing efforts to develop comprehensive primary health care services for Aboriginal communities in the NT.

In recent years, before the intervention, there was progress in dealing with key identified inadequacies in primary health care and related health services. Remedies included:

- initiatives related to needs-based planning, with delivery of more equitable and increased primary health care funding;
- training, recruitment and retention of the health workforce and planning for comprehensive, regional primary health care services;
- development of state-of-the-art information technology systems for patient information and access to records; and
- development of high-quality-care initiatives based on key performance indicators.

These changes have been recognised as leading to the current improvements in the life expectancy of Aboriginal people and the reduction in the rates of some chronic diseases.[1,2]

The Northern Territory Emergency Response and its effects

The emergency intervention came from left field. The health component, like the intervention as a whole, got off to a bad start. Individual health checks on children were not recommended in the *Ampe akelyernemane meke mekarle: "little children are sacred"* report,[3] but the Australian Government initially talked about compulsory forensic examinations of all children to ascertain a level of sexual abuse. This would have been a form of assault if carried out, and it is likely that no doctor would have agreed to participate in such a process. Thankfully, this never occurred. As with other parts of the intervention, it appears not to have been properly thought through.

Within a week, the Minister for Health had publicly given guarantees that the checks would be voluntary and would be carried out by a procedure already being used throughout Australia — Medicare item 708, Aboriginal and Torres Strait Islander child health check.[4] Developed in collaboration with ACCHSs, the health checks, if properly done, contribute to children's health in a broad and holistic manner. Nearly 1000 of these checks had been completed in the NT before the intervention. If providers had suspicions of sexual abuse or neglect they would refer the children to the appropriate person or authority, as was already their mandatory duty, but it was recognised that the health checks were not designed to detect child abuse.

Unfortunately, the initial suggestion of compulsory sexual examinations generated widespread fear and misinformation about the health checks. It has taken much work to explain to Aboriginal communities that these were the same checks that were already being done by ACCHSs. The only reason they had not already been provided to all Aboriginal children was a lack of resources.

Another concern that was raised in some quarters was the cost of doing the health checks. It could be argued that the $83 million could be better spent on other priorities. While this may be true, there was little room to discuss doing anything else with the money. The Australian Government had already decided that the checks would be done and had allocated the necessary funding.

Undertakings by Aboriginal medical services

The Aboriginal Medical Services Alliance Northern Territory (AMSANT) decided that it was important to engage with the process of children's health checks for two reasons.

First, without the full cooperation of and engagement with existing ACCHSs, the health checks would not be done as well, would not reach as many children, and would not be properly coordinated with the systems and ongoing responsibilities of ACCHSs. ACCHSs across the NT had begun providing the checks, so this part of the intervention was seen as an opportunity to do them much more quickly and with a commitment to ensuring that the necessary follow-up was available. An average of 67% of children across the NT have been brought by their families to have a health check by the visiting teams in the more than 40 prescribed communities that have been visited so far.

The second reason for AMSANT to engage with the health checks was to enable it to continue to work with the Department of Health and Ageing to secure the longer-term needs of the primary health care system. This has led the Department to commit an additional $100 million over 2 years for improving comprehensive primary health care in the NT. The total current expenditure on Aboriginal primary health care in the NT is about $80 million a year. Therefore, an additional $50 million a year is a substantial commitment. An improved primary health care system can sustainably and routinely deliver better health care for children.

Since the intervention began, AMSANT and its members have lobbied effectively for an improved and more participatory process. As a result, the Australian Government has worked constructively

with AMSANT in planning the details of the follow-up programs. In contrast to the previous approach of offering health checks in the absence of adequate services to provide subsequent treatment, we have the opportunity here to significantly expand primary care and specialist follow-up.

The key barrier to the successful implementation of the Australian Government's initiative is the workforce shortage. In particular, further teams of nurses, general practitioners, ear health workers and others are needed to ensure apprpriate follow-up. It would be unacceptable for deficiencies in the workforce to prevent the children who have been checked from being followed up. The intervention has provided an opportunity for health professionals from mainstream Australia to work in the NT, and we hope they will return to work again with our dedicated teams in the bush. Continued support from various peak health professional associations and the Australian Government is required for this recruitment process now and into the future.

The future

The health checks and an improved primary health care system are now clear potential benefits of the intervention. Also, the additional police and other improved services have been needed and are welcome.

Some other aspects of the intervention are less likely to be positive and others are likely to be harmful. In particular, its initial implementation was profoundly disempowering to many Aboriginal people in an environment where disempowerment and loss of identity lie at the root of community dysfunction. The medical profession knows that lack of control of life circumstances can contribute significantly to worse health outcomes. This could be a very damaging effect of the intervention, particularly in the light of the already large gap in life expectancy between Aboriginal and Torres Strait Islander peoples and other Australians (17 to 20 years' difference).

It is also vitally important that the racially discriminatory aspects of the intervention, such as the welfare changes and the forced prohibition of alcohol, be repealed, as there is a clear and well established relationship between the protection of fundamental human rights and population health.[5,6]

Welfare reform may have merit, but any reform needs to be applied to all welfare recipients across Australia or targeted at particular people who are identified as not acting appropriately with their children. The discriminatory quarantining of income of Indigenous people is also not in the spirit of the Australian Government's stated aim of encouraging individual responsibility. Similarly, alcohol reform is desperately needed, but the measures the intervention has imposed — forced prohibition in certain places and the need to record takeaway alcohol purchases of more than $100 — have no evidence to support them, are unevenly applied and do little to reduce the supply of alcohol.

The need to reform the Community Development Employment Projects, in which an estimated 7500 Aboriginal people in the NT are employed in community-controlled projects funded by block unemployment benefit grants, is widely accepted. To scrap them altogether will rob many of meaningful work, self-esteem and confidence, and diminish the capacity of Aboriginal organisations and communities. This may add to, rather than diminish, social dysfunction.

The medical profession has been aware for a very long time of the importance of education to improving the health of populations. The need to fund adequate preschool, primary school and secondary school places for Aboriginal children across the NT is paramount, but this has largely been ignored up to now. The small amount of new funding allocated by the NT Government to education is just a fraction of what is needed to ensure that all Aboriginal children can access all tiers of education.

Additional housing is also urgently needed. Chronic overcrowding contributes to poor health outcomes and places children at risk of sexual abuse. The additional $780 million for housing currently offered is a welcome new investment, but will probably not be enough.

AMSANT's experience with the intervention's child health checks is instructive for other aspects of the intervention. It has required refocusing an initial highly inappropriate measure (compulsory checks for sexual abuse) so that an existing appropriate service (the health checks under Medicare) can be advanced and so that an improved, sustainable primary health care system will ensure the capacity and resources for proper follow-up. A similar rethinking, focused on child protection, is required for other aspects of the intervention. Crucially, this can only occur through a process that achieves genuine engagement of Aboriginal communities as well as the support and cooperation of both the federal and NT governments. This, after all, was the central thrust of the "Little children are sacred" report. For the sake of the children, we must continue to pressure governments to adopt its recommendations.

Competing interests

None identified.

Author details

John D Boffa, MB BS, MPH, Public Health Medical Officer[1]
Andrew I Bell, FAFPHM, FACRRM, DRANZCOG, Medical Director[2]
Tanya E Davies, FACRRM, FRACGP, DRANZCOG, Public Health Medical Officer[3]
John Paterson, Executive Officer[3]
David E Cooper, PhD, Policy Officer[3]
1 Central Australian Aboriginal Congress, Alice Springs, NT.
2 Katherine West Health Board, Katherine, NT.
3 Aboriginal Medical Services Alliance Northern Territory, Darwin, NT.
Correspondence: john.boffa@caac.org.au

References

1 Thomas DP, Condon JR, Anderson IP, et al. Long-term trends in Indigenous deaths from chronic diseases in the Northern Territory: a foot on the brake, a foot on the accelerator. *Med J Aust* 2006; 185: 145-149.
2 Wilson T, Condon J, Barnes T. Northern Territory Indigenous life expectancy improvements, 1967–2004. *Aust N Z J Public Health* 2007; 31: 184-188.
3 Wild R, Anderson P. Ampe akelyernemane meke mekarle: "little children are sacred". Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse. Darwin: NT Government, 2007. http://www.nt.gov.au/dcm/inquirysaac (accessed Nov 2007).
4 Medicare Benefits Schedule. Item 708: Aboriginal and Torres Strait Islander child health check. Canberra: Australian Government Department of Health and Ageing, 2007. http://www9.health.gov.au/mbs/search.cfm?q=708&sopt=I (accessed Nov 2007).
5 François-Xavier Bagnoud Center for Health and Human Rights [website]. Boston: Harvard University, 2007. http://www.hsph.harvard.edu/fxb-center/ (accessed Nov 2007).
6 Centre for Public Health and Human Rights, Bloomberg School of Public Health [website]. Baltimore: Johns Hopkins University, 2007. http://ww.jhsph.edu/humanrights/index.html (accessed Nov 2007).

(Received 8 Nov 2007, accepted 8 Nov 2007) ❑