

**GOOD NEWS FOR ONCE: FISCAL RELATIONSHIPS
BETWEEN GOVERNMENTS AND ABORIGINAL PEOPLE**

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Understanding and implementing good governance for Indigenous communities and
regions conference.**

Good day ladies and gentlemen.

Today I'm going to tell a story about a mob of Aborigines, a big pile of money, and health. Whenever we put those three topics together, we usually get bad news. But I want to describe a **good** news story for a change. It's the story of how an Aboriginal Health Board way out in the back of beyond set a precedent in fiscal relations between governments and Aboriginal people.

Marion Scrymgour, one of our newly-elected Aboriginal MPs in the NT was Director of that Health Board – the Katherine West Health Board – from 1997 to 2001. With Marion's permission I want to relate some of the lessons we all learnt from that unique experience.

But first some background information, to put these developments into some sort of perspective.

In terms of government funding of Indigenous health, over the years numerous reports and studies have found three key problems.

Firstly, the **overly-complex** and **uncoordinated** nature of government funding. Any one remote community usually has to deal with numerous overlapping government departments and multiple funding schemes. This funding 'maze' makes it almost impossible for a community to **rationally plan** its health services.

Secondly, the lack of an Aboriginal **community perspective** when making decisions about implementing health programs. Decisions about health programs made in the remote community of Canberra are often, to put it nicely, impracticable at the local level – for all sorts of reasons.

And thirdly, the fact that government funding **simply wasn't enough** to cope with the high level of illness and the extra costs caused by remoteness. One reason behind this is that Aboriginal people have a very different pattern of use of health services than do non-Indigenous people.

SLIDE ONE - DATA ON HEALTH SERVICES IN 1995/96 FOR INDIGENOUS AND NON-INDIGENOUS PEOPLE.

This different pattern was first shown in the mid-1990s: for every dollar spent by government on the Medical Benefits Scheme and the Pharmaceutical Scheme for non-Indigenous people, only 24 cents was spent on Indigenous people. Instead of accessing GPs through Medicare, Indigenous people tend to use public hospitals (funded by the States/Territories) and community services to a greater degree.

Now, this situation has improved since the mid 1990s, but the general point remains that the Commonwealth is still getting away lightly in terms of its expenditure on Medicare for Aboriginal people. While Medicare may promote the goal of equity within mainstream or non-Aboriginal populations, the data shows that the Scheme does **not** bring about equity in health care for Aboriginal people.

So, by the mid 1990s these three problems had been defined. Government health service funding for Aboriginal communities was characterised as being unco-ordinated, as isolated from Aboriginal input, and as being insufficient to meet the need.

The Katherine West Health Board 'experiment' aimed to tackle these three problems. It started in 1997.

SLIDE TWO - MAP OF THE KW REGION AND ITS LOCATION IN THE NT

Firstly, a Health Board was established consisting of elected representatives from all the Aboriginal communities in the Katherine West Region. It's one thing to say this in a quick sentence – it's another thing to actually do it. It took many many months of hard slog on the ground in communities, arguing and discussing the pros and cons with everyone, how it would work, what was in it for Aboriginal people, and so on. Many Aboriginal people were sceptical – they'd had enough of government promises.

But finally it happened, and then the new Board set about learning how to manage money and all the other rules that an incorporated organisation had to follow.

Now an Aboriginal community perspective had control of decision-making about health programs in the region.

The next important thing was that the Commonwealth Government finally acted on the recognition that Medicare was not an effective way of using health care subsidies to address Aboriginal health problems.

In a major policy shift, the Commonwealth agreed to 'cash out' the entitlements of Aboriginal people of the Katherine West Region to the MBS and PBS schemes. This money was given to the new Health Board to spend on health services as it wished, calculated as the national average rate of use of these schemes by all Australians. This MBS and PBS 'cashout money' was **new** health money being injected in the Region by the Commonwealth.

So much for the Commonwealth's role. The Northern Territory Government, for its part, agreed to give the money which it would otherwise have spent on health services in the Region to the new Health Board.

So there was this **pooling** of money from the Commonwealth and NT Governments, to the new Health Board. The Health Board could then choose to use this pool of money to either run its own health services in the Region, or purchase health services from any provider it wished.

SLIDE THREE – PREVIOUS FUNDING SYSTEM MAZE

So the old problem of uncoordinated funding and the 'maze' were really eliminated through this **pooling** process. It was the elected Board which now had the job of coordinating **all** health programs in communities.

Thus, in the Katherine West Region, in the short space of just a few years we have gone from a situation where health services were managed and provided by the NT Government to one where local Aboriginal people have real power and control. Not only that, the new Health Board potentially had a lot more money at its disposal than had previously been spent in the Region on health. This was because of the new Commonwealth Money flowing to the Board as a result of the cashing out of the MBS and PBS schemes.

SLIDE FOUR – COORDINATED CARE TRIAL FUNDING MODEL

As things turned out, the Board spent this new money sensibly. Compared to the time before the Health Board's existence, community clinics now have reasonable staff numbers. GPs – employed by the Board – now live and work in the Region for the first time ever, the level of such public health services as nutrition and environmental health has increased several-fold, the number of Aboriginal Health Workers entering training has increased, and so on.

An interesting side benefit has been that the Board greatly improved access to health services for the non-Indigenous people of the region – the families and workers of the pastoral and tourist industries.

The Health Board now **directly** manages all clinical and public health services throughout the Region, and **directly** employs all resident health staff in the Region.

And the Board members themselves have become skilled at understanding 'the money story'. They have become increasingly confident about their decisions and the direction they are going.

The point is that by changing the fiscal relations between governments and Aboriginal people, we've really promoted genuine community development and set up a situation where improvements in health status are likely.

Of course it hasn't been all smooth sailing, and we've all undergone traumas. Mistakes have been made, but they've learnt as they went along. From the viewpoint of the Board, some of the key lessons have been :

- A huge amount of time and money has been put into training of the Board members in things like managing money, understanding decision-making processes, and all the whitefella knowledge which has been kept 'secret' from them. The knowledge they've gained from this training has given them added confidence to do their job, and has been fundamental to good decision-making. I can't overstate the importance of this sort of 'capacity building' for Aboriginal community organisations. Without it, we're just setting up Aboriginal people to fail. There is no point in Aboriginal people having power to make decisions unless we make sure they have the **knowledge, skills and capacity** to make those decisions.
- To borrow an old Australian phrase, there is a need equity when dealing with governments – and Aboriginal organisations have to have the capacity to deal with and monitor governments.

- Many times the Health Board had to go to either the Commonwealth or the NT Government and say “You promised you’d do this. But now you’re doing something else.” Particularly when this involves the handing over of money. Governments can be confusing – Aboriginal organisations need to have the capacity to keep a check on what they are up to.
- The most important lesson we’ve all learnt is that Aboriginal people **can** manage their own affairs if they’re just given the **opportunity, the knowledge and the skills** to make decisions. The way in which the Katherine West Health Board members have committed themselves to improving the health of their people is truly moving. Illiterate old stockmen with sweat-stained hats and broken boots; little white haired ladies bent over from the hard work they’ve done all their lives; all those people with almost no possessions but with endless grace and dignity– they all give their time and utmost effort to the Health Board, they are proud of their own organisation which has achieved so much in such a short time.
- Recognising that to seriously improve health it is necessary to take a strong stand on **public health** issues in addition to clinical services. The condition of housing, the provision of good water and sewerage facilities and so on, must form part of the agenda of any health service provider which wants to do more than give out bandaids. These things cannot be left to government agencies.
- A recognition that health is tied up with economics and politics. Unemployment, lack of education, and poverty are endemic in our communities and have been identified in many studies around the world as having a big impact on health status. The Katherine West Health Board wants to build a formal relationship with the Education Department in recognition of the fact the health and education are inextricably linked.
- The Board has commenced formal discussions to this end, and hopes that in the near future an MOU will be developed between the two bodies. This means that interaction at the local level won’t be dependent on personalities or individuals, but rather through agreed policy.

The plain fact is that economic self-sufficiency is not a viable option in the Katherine West region, now or in the foreseeable future. For example the cattle industry while it is doing well at the moment cannot realistically be significant in terms of future employment and income for young people. The only possible role for a health service in this situation is to join with other community bodies to develop a strategy, which would combine economics, community development and health. This is the challenge for the future.

Lastly, I’m pleased to say that the Katherine West Health Board example has been taken note of by the Commonwealth Government. Under the new Primary Health Care Access Program, the plan is to establish community-based Aboriginal health boards all across the Northern Territory, to be funded by the pooling of Commonwealth and NT funds.

And the most recent statement of expert opinion on the funding of Indigenous services, by the Commonwealth Grants Commission, endorses this broad policy direction.

What we have here in the Katherine West Health Board is a serious success story, a model that can be adapted and evolved to deliver services across functions such as education, regional enterprise development and local governance as well as health.

So there are some good things happening in Aboriginal health policy – in the NT at least – for the first time in decades. Policy and practice for both the Commonwealth and the NT **is** moving slowly in the right direction and the potential for real progress is there – but only if things are done ‘properly’.

Thank you.