

Effective community control – the way forward for improving Indigenous health

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INTRODUCTION

A community controlled health board operated on the Tiwi Islands from 1998 to 2003. The activities of the board and the services it provided together with the acclamation it received were indicators of the value placed on this strategy towards a new wave of movements to improve Aboriginal health. It was hailed by politicians and praised by other communities.

The World Health Organization report *Shaping the Future* (1) said the Board had achieved the following:

- Community control, by the establishment of the Tiwi Health Board, which now determines health policy and expenditures;
- Increased community awareness of health issues among Tiwi islanders, and greater community input into service delivery;
- Improved prevention services, especially those tackling urgent local problems;
- Increased number and improved quality of primary health services;
- Reduction in avoidable hospitalization.

The events that lead to the success and demise of the Tiwi Health Board are now revisited as they bring to the surface the factors that caused this debacle. The strength of the Tiwi board members was in identifying and articulating needs – social health and well-being needs of their people. The administration and financial management was in the hands of the white managers. They, as this paper will show, were not given a good start and were never able to get on top of a deficit situation that emerged after two years of operation.

Questions must be answered before the story of the Tiwi Health Board is put to bed. Questions such as:

- Why did the Commonwealth and Territory governments not resource the Board with the funds it needed to meet maintenance, insurance and replacement costs of plant and equipment brought on by a run down set of buildings, motor vehicles and medical equipment?
- Why did the Tiwi Land Council, with its projected millions of income from a forest industry, and which sponsored the establishment of the Tiwi Health Board, take such a passive attitude in 2001 as things went bad?
- Why did the NT Government deny knowledge of the financial plight of the Tiwi Health Board after the event, when it had known since 2001 it was funding an insolvent private company that was acting illegally by staying in business? Even in the last three months it

handed over a cheque for \$700 000 for the first quarter of 2003–04 and in doing so sought from the Board Management Committee an assurance it would not go into bankruptcy.

- Why was the total population of the Tiwi Islands not acknowledged in the original funding formula rather than the lesser figure of a population of 1800 when in reality by all sources it was closer to 2500?

“Population based” was the description used by the bureaucrats and the people involved with the Tiwi Health Board. This was dropped in 2002 when it was apparent that the real population of the Tiwi Islands was not going to be accepted by the people in Canberra. Real mistrust set in and honesty with each other brought into question.

In February 2004 former THB employee Rob Curry wrote in *Partyline*:

... in 2000 the Commonwealth made a decision not to fund THB for its full population, capping its funding at 2,000 rather than the true Tiwi population of some 2,600. This was a critical decision of the Commonwealth and one that many at THB believe has led to chronic under-funding and the current financial failure. On what basis did the Commonwealth choose to withhold significant funds? Was this appropriate support for a new organization attempting to establish itself in a vital but complex field of service development? This surely needs investigation.(2)

The opportunity was there to improve health in the long term but that opportunity was allowed to slip away because of policies, personalities and bureaucratic inertia.

THE TIWI ISLANDS

The land

Bathurst and Melville Islands are the haven for much wild life, rewarding fishing and some beautiful springs, swimming holes and more recently a resource for forests, mining and fish hatcheries.

The islands are divided into eight countries of the main clan groups showing their links to the past. It is mostly lush tropical forest, beautiful white sandy beaches and a feeling of remoteness that is strengthened by the knowledge that it will always be this way.

The timber trucks, mining dredges and tourist buses traverse the country to remind the ancient culture that it is moving into a new world – slowly.

The people

The Tiwi people number some 2500 although in calculating the per capita funding for the Tiwi Health Board the number of 1818 seemed to create a barrier beyond which the health bureaucrats were unable to count.

A profile of this population shows that in the 100 years since 1901 it has not changed in the proportion of people in the young, middle and aged categories. In the same period the Australian population has dramatically aged.

This is shown graphically using figures provided by the Australian Bureau of Statistics. (3)

The reason for the deplorable health of Aboriginal Australians is the inability of successive governments to recognise the fact that putting health clinics, doctors and nurses into remote

places will not in itself improve health in the long term. It is only over the past 10 years that the concept of social determinants of ill health (4) has been recognised. The European way of life and its consumer driven TV advertising has produced a situation where informed decisions are hard to make by people who have been brought up in a culture where lifestyle choices are made against a different set of values.

This is highlighted through a chart included in a submission made by Dr Wendy Hoy (Menzies) and others to the NT Government Public Accounts Committee (5) in 1996 alongside figures relating to the recall of TV advertised products shown in prime football viewing in the winter of 2001. (6)

The problem for the people is that they have not been there before. As each generation comes into the world, and at a more frequent rate with a low maternal age, they strike a new set of circumstances that cannot be measured against what the parents or guardians experienced when young themselves. They did not have the same strong expectations for education and employment, money problems or domestic violence fuelled by alcohol and gunja (marijuana). This is a huge barrier to enabling a resolution to today's problems for these communities. Guidance is needed; mentoring made possible; trust given and received; and above all – honesty with each other. The philosophies of the Tiwi Health Board were to try and move in this direction and through the paid staff and consultants gain this trust. This was community control in action – a mix of community control and practical reconciliation.

Unfortunately the events do not suggest an exchange of honesty – and if there is one element of trust that must be gained it is the belief in each others desire to improve the lot for the whole population. Not just 1800/2500 or 70% of the population.

The governance

The **Tiwi Land Council** (TLC) was formed in 1977 in a response to the introduction of the Aboriginal Land Rights (Northern Territory) Act 1976. The founding Traditional Land Owners saw this as a way of becoming in the main self sufficient and with an economy that would be strengthened by local industry.

Such an ideal was fine – the implementation has fallen short with social capital suffering at the expense of financial reserves. The Annual Report of the TLC in 2002–03 (6) tells that the Tiwi Island Community Trust has assets of \$25 million. A quoted \$20 million will be brought in by a timber industry in 2004–05 (7).

Social infrastructure should be a prime target for the use of this money and the development of local initiatives and control. Communities must be encouraged not to expect governments to do it all – the track record is not good.

THE TIWI HEALTH BOARD

Early beginnings

The Tiwi people still use bush medicines and eat bush tucker. Often now when a person is sick they will take themselves out bush and spend a couple of weeks living off the land to get better. This is the way they lived before colonisation and even to the last 50 years. In the space of 40 000 years this is a flash in time yet we expect them to have moved a long way with very little help and guidance.

The mission days with the Roman Catholic Church on the Tiwi Islands from 1911 to 1992 saw a caring, understanding and mentoring way and a time of learning. Health clinics were able to dispense antibiotics and give pain killers for injuries. Then along came welfare payments, TV advertising, fast food, grog and gunja.

The challenge began for doctors, nurses and health bureaucrats to devise ways of stopping the steady incline of chronic diseases described by one renal physician in 2002 as an epidemic that if occurring in an urban community would be classed a “national disaster” – referring to end stage renal failure.

An NT Government Health Service

In 1992 the Catholic Mission handed the health services over to the community and they were managed by the NT Government. In 1996 the Commonwealth Government decided the Tiwi Islands should be a part of an experimental program known as the Co-ordinated Care Trials (CCT). This brought together all government funding and the community in an exercise to see if community control would work.

Tiwi Land Council forms/fails health board

The success of the CCT resulted in the establishment of a community controlled organisation known as the Tiwi Health Board. It was formed by the Tiwi Land Council at the request of the two sponsoring governments. For a short time the Secretary of the Tiwi Land Council was the Executive Officer of the health board until recruiting Bill Barclay from New Zealand to take over the role of Chief Executive in January 1998. At the same time the TLC went along with the employment of a person as Executive Officer to Barclay whose appointment turned out to be an added problem for the Board as it struggled to frame a financial plan with an inadequate funding base. Towards the end of the financial year ended June 1999 at which time the THB had assumed responsibility of the Milikapiti and Pirlangimpi Clinics from THS, its finances, compiled by the EO, were not being recorded, computer systems started to crash regularly and Chief Executive Barclay became unable to establish the financial state of the business. After a further 12 month period police were called in to investigate the Executive Officer who was found guilty of embezzlement and imprisoned.

By the time Dave Morris had been recruited to the position of finance controller (April 2000) the rot had set in and the organisation was \$1 million in deficit. The auditors were unable to audit THB's books for the years 1998–99 or 1999–2000 and qualified their reports to the funding bodies accordingly. Early in 2001 in dire financial straits the THB board obtained legal advice that the company was insolvent and reported this to the two funding governments at this time.

Nothing happened.

\$1 million was verbally promised but did not come.

The Tiwi Health Board discussed declaring itself insolvent. The funders said "no – don't do that – we will fix it".

But they didn't.

At any time during this period the sponsoring parent – the Tiwi Land Council – boasting assets – could have assisted but failed to do so.

Interesting to note that the only time after the formation of the health board that the Tiwi Land Council took an interest was after a Voluntary Administrator (VA) had been appointed and was looking for support. The VA found it in the form of the Tiwi Land Council which put forward \$100 000 to enter into a Deed of Company Arrangement with the VA to avoid the path of liquidation. However no mention of this in the annual report of the TLC for 2003-04. Previous reports had spoken in glowing terms of the achievements of its offspring – but nothing after it failed.

Program development – innovations

Mental health

The approach to the problems of suicide and community disturbances brought on by behavioural problems was one of community control. Through the strong men and strong women's groups the community was brought together to train in identifying and counselling people at risk. The results were dramatic. Call outs of local people became the first line of approach when an at risk situation developed and the results speak for themselves.

Early childhood intervention

Teachers at the schools were asked to identify children who were showing behavioural difficulties and who may benefit from intervention and counselling with their parents or guardians in an attempt to bring to the surface problems that were caused by tension in the home environment.

This work was adapted from previously used models to the Tiwi society and was successful in bringing about significant changes to the attendance and attention to schoolwork by the individuals. Suicidal tendencies and aggressive behaviour was diminished and an overall improvement seen in the social skills of those concerned.

The work was hailed and sought after as presentations to conferences in other parts of Australia. (8)

Pharmacy upgrade project

The desire was to develop a pharmacy service that met the needs of a health service operating in a remote Aboriginal community and under the arrangements for Pharmaceutical Benefits that were available under s100 of the National Health Act. (9) This resulted in the development of systems that are now being promoted to other Aboriginal clinics in Queensland and Western Australia as well as the Northern Territory.

The pharmacy project showed that simple things could be changed to make a difference. The pharmacy was owned by the THB and staffed by Tiwi pharmacy technicians under the supervision of a registered pharmacist. The picking up of medicines by clients with chronic diseases at Nguuu improved from 8% to 65% in the space of two years by changing from dosette boxes to Websterpaks.(10)

Millions of dollars are spent to get doctors and nurses to remote Aboriginal communities so it makes sense to use the PBS to enhance the way the taking of medicines is viewed.

THE RESPONSE TO THE FINANCE PROBLEM

From the health board

The reaction to the offers and encouragement in the face of nothing happening was a matter of frustration. The board continued to put its emphasis on program development. Its administrators continued to thump the table, write letters, attend “monitoring meetings” and plea for mercy. Still nothing happened.

From the governments

Offer encouragement, promise more money, defend the past and protect from commitments for the future. The realisation was dawning on the bureaucrats after two years of nothing that while ever Bill Barclay was in the Chief Executive position they would not want to change the impossible situation the board found itself in, for whatever reason. Canberra didn't like him so Darwin didn't like him from the Commonwealth side – and if the Commonwealth didn't like him then the NT Government officials had to agree – they all thought he better go.

So the solution after two years was to offer to pay ALL separation costs for Barclay if the board agreed to terminate his contract or accept his resignation. The commitment – listen to this – was to put the board on a better financial formula if Barclay went. The future was starting to unfold – and without Bill it was looking good.

What brilliance!

NOTE TO READER

If the preceding statements sound as if they have nothing to do with improving Aboriginal health you are right – they do not. But this is the level of negotiation, discussion, gossip and innuendo that engulfs the thinking of government officers when they are given the power over community control and its funding.

Community control – Aboriginal community control – the white man has a lot to learn to get it right – do not blame the Aboriginal – he knows what he wants – an improved society – it is just a matter of how to get it once governments become involved.

Trials, pilots, experiments, tests and then evaluation, analysis, appraisal and all reported through discussions papers, issues papers, and options and so on. This all costs money – lots of money – to pay the people achieving, in this case, nothing. This all takes time – an inordinate length of time as if the ill health of Aboriginals will have to wait.

THE FINAL OUTCOME

A path was charted to get rid of Bill Barclay, pay his separation, and put in place a financial adviser and a clinical adviser to report on the state of play and move forward with a new funding formula. Sound good. But just one drawback – this is an organisation that is trading illegally – it is a company that has been insolvent for the previous two years! It is just not possible to go too far down the road to recovery before meeting someone who says “enough is enough”. That someone came in the form of Ernst and Young (as the financial adviser) who rightly saw it as their statutory role to tell the governments of the need for a Voluntary

Administrator and helped the Tiwi Health Board make a decision that it should have made two years prior – go into Voluntary Administration. The report of Ernst and Young to the Commonwealth caused it (the Commonwealth through OATSIHS) to withdraw the offer of separation costs for Bill Barclay just a day before his final settlement contract was to be signed.

Loss of empowerment

The Tiwis were left wondering what this is all about. My co-author, Barry Puruntatameri, Chair of the Tiwi Health Board at the time, said to me “This is white man’s way of sorting out problems – not ours – we just want to be more healthy”.

A sad state of affairs.

THE WAY AHEAD

For the Tiwis there is no clear path. The NT Government has taken over control of the health services. The community committee Barry Puruntatameri was asked to chair 12 months ago to plan a path back to community control has not met.

For the rest of the NT and Australia a close look needs to be taken of the governance surrounding community control. No community has to go through what the Tiwis have done over this debacle of a health board administration.

An examination of the most recent government policy towards Aboriginal affairs shows the mainstreaming of programs. This means that public servants are being asked to administer programs for Aboriginal (and Torres Strait Islander) people when they probably had no commitment or interest in the work engulfing ATSI people.

This is a major flaw – bureaucrats who did not join the public service to work on Aboriginal affairs programs are being asked to administer them and create policy. They are not committed to the cause.

There is a need for a new authority that employs committed people who understand the intricacies of remote community life and understand the generational differences to assist the local people. Government departments as they now exist hinder progress by placing obstacles in the path of progress as evidenced by the Tiwi experience.

The mentality of the public service is to have communities get organised to meet the guidelines of government programs (12) – rather than the guidelines developed to meet the needs of remote communities.

There has to be a better understanding of the reasons for community dysfunction and nurture programs that will assist development of social capital.

It is only by moving outside the departmental structure and pooling the finances of Commonwealth and State/Territory Governments that a direct approach to the Indigenous problem can be made.

CONCLUSION

The past 40 years has seen a breakdown in social capital in remote communities. The irony of this is that to rebuild it will take financial capital, employment and training and a vision of direction that is in tune with local needs.

Only local people know the answers and they must be given the trust, encouragement and support to be able to make this happen.

Employment, training, education and a sense of direction can all be achieved through a philosophy that says:

Gain economic strength through social development – build social capital and build a healthy community.

Before moving on with community control and the grand vision of 23 health zones across the Northern Territory one must ask who is going to oversight the activity.

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PRESENTER

Rollo Manning has been in the Northern Territory for eight years — first working in retail pharmacy and then as a government policy officer. He was involved with the introduction of the Section 100 arrangements for the PBS to remote health clinics. Following this Mr Manning worked with the Tiwi Health Board and during this time gained an appreciation of the depth of issues surrounding the question of improving Indigenous health. The demise of the Tiwi Health Board and subsequent events has allowed him to form some views on the merits of community control for health services. Mr Manning is currently working as a Consultant in Darwin for Mirrijini Pty Limited, a company formed to promote the concept of clinic-owned pharmacy services.

