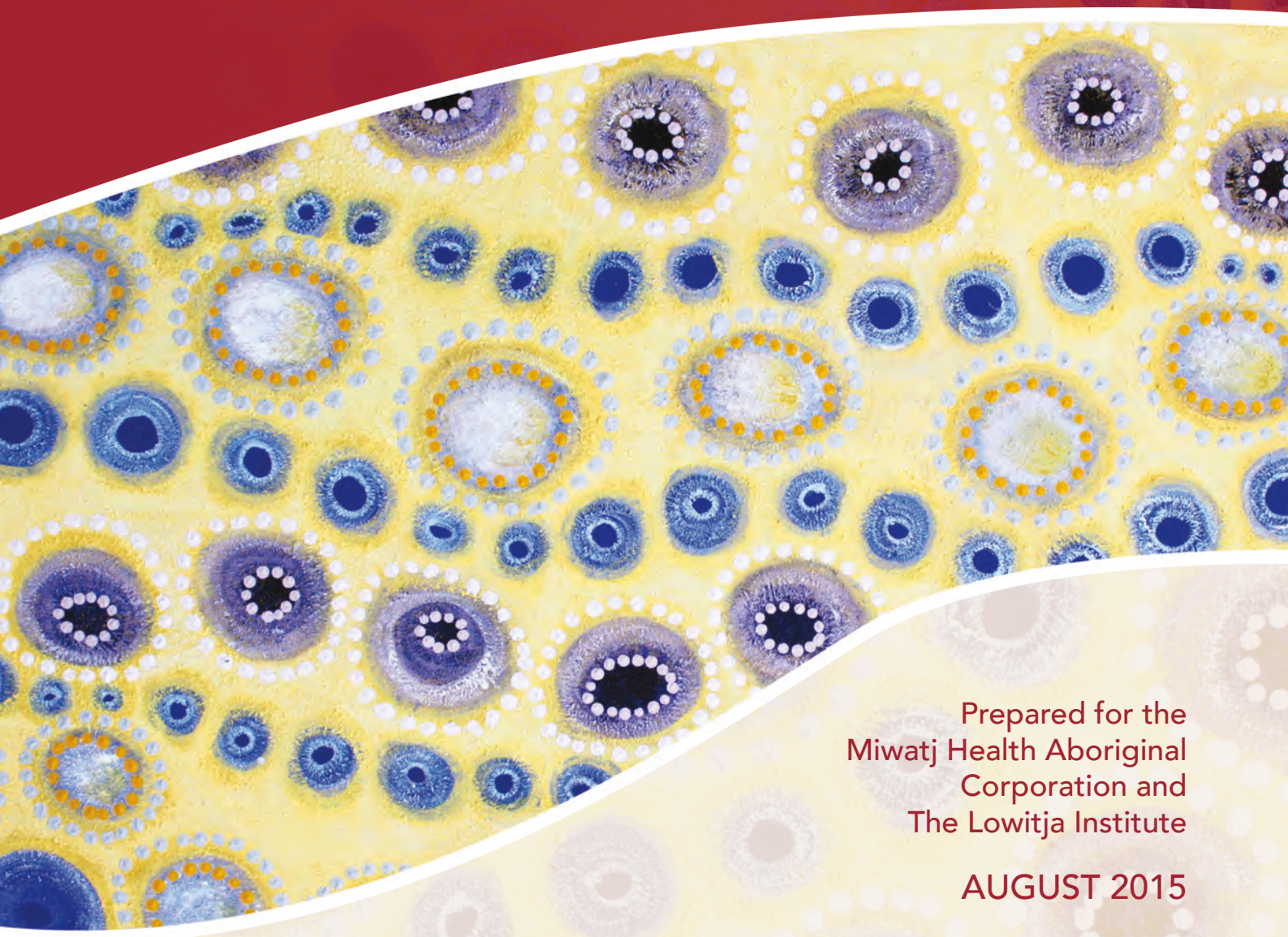
Miwatj and East Arnhem: Case study

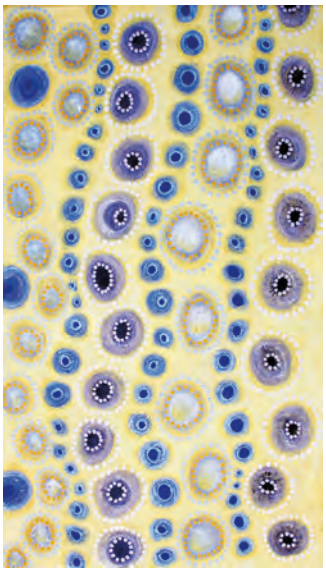


Prepared for the
Miwatj Health Aboriginal
Corporation and
The Lowitja Institute

AUGUST 2015

Paula Myott
Angelita Martini
Judith Dwyer

ARTWORK



About the artist
Karen Kulyuru was born in 1969 and raised in Ernabella (Pukatja) on the Anangu Pitjantjatjara/ Yankunytjatjara Lands. Karen first learned to paint by watching her mother, and comes from a family of batik silk artists. She started painting at Ernabella Arts and Crafts many years ago. Karen lives in Adelaide with her family and children and regularly attends professional development workshops at Better World Arts. Her paintings have been exhibited extensively across Australia.

About the artwork
Tjukula (Rockholes) 2012
Acrylic and sand on canvas
61 x 107 cm
Better World Arts catalogue KKU0073

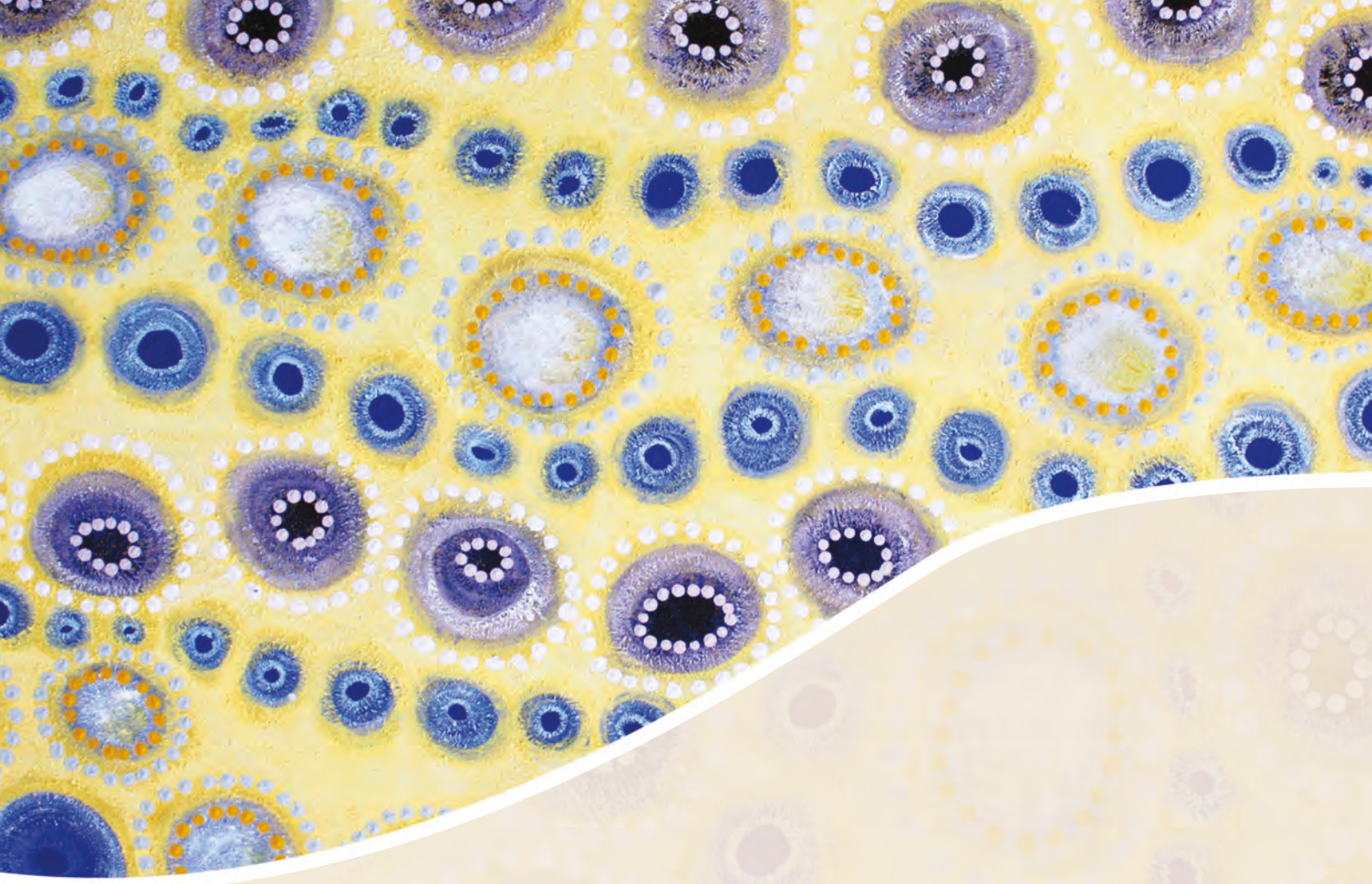
This painting was produced during the 'Manta' (earth) workshops. Karen describes her painting as Walka. Walka is any meaningful mark or pattern and may be an image on a cave wall, on rock or on sand and has cultural and ritual significance. It is used on the body during inma or ceremony. This painting is reminiscent of the designs that are created on batik. Karen's work is heavily influenced by the beautiful batik designs she painted alongside her mother Angkuna and sister Unurupa from the 1970s onwards in the Ernabella craft room.

Batik designs evolved from a mixture of traditional imagery, Indonesian influences, as well as the early Walka drawings painted at the Ernabella mission school in the 1940s and 50s. Karen's mother Angkuna was prolific in her craft making and produced beautiful lengths of fabric, many of which are in public and private collections. Karen painted batik for many years and this influence is still visible in her highly decorative, detailed paintings today.

Important traditional symbols are still placed within these works, including tjukula (rockholes represented by concentric circles), creek beds and bush foods for harvesting. This painting depicts rockholes (tjukula), and sandhills surrounding them. Karen is influenced by the beautiful colours and shapes of the landscape. She uses both desert tones and brighter hues in her works and often illustrates aspects of nature from the desert country where she grew up, to the flora here in Adelaide, where she has lived for many years.

REPORT TITLE

The title is taken from Antonio Machado's poem 'We make the road by walking' in *Selected Poems of Antonio Machado*, Louisiana State University Press, Baton Rouge, LA, 1978.



Miwatj and East Arnhem: Case study

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the Lowitja Institute
Australia's National Institute for Aboriginal and Torres Strait Islander Health Research

MIWATJ HEALTH ABORIGINAL CORPORATION

Flinders UNIVERSITY

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The team gratefully acknowledges the funding of this study by the Lowitja Institute CRC and the support of Flinders University.

About this report

This publication is one of five that report on the work of the **Funding, Accountability and Results (FAR)** project, all published by the Lowitja Institute in 2015.

FAR is a study of reforms in primary health care for Aboriginal and Torres Strait Islander communities in the Northern Territory (between 2009 and 2014) and Cape York, Queensland (between 2006 and 2014). The study background, its aims and methods, case studies, findings and conclusions, and the suggested essential elements of reform are reported in the project report and the summary report.

Two brief histories and this case study of our research partner organisations have also been prepared in order to contribute to the record of development of the broader Aboriginal community controlled health sector in Australia, to give context to the larger research study, and for our partners' own use.

Project report:

The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Report

Judith Dwyer, Angelita Martini, Cath Brown, Edward Tilton, Jeannie Devitt, Paula Myott and Brita Pekarsky

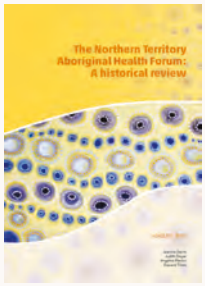
ISBN 978-1-921889-43-1

Project summary report:

The Road Is Made by Walking: Towards a better primary health care system for Australia's First Peoples – Summary Report

Judith Dwyer, Angelita Martini, Cath Brown, Edward Tilton, Jeannie Devitt, Paula Myott and Brita Pekarsky

ISBN 978-1-921889-42-4



The Northern Territory Aboriginal Health Forum: A historical review

Jeannie Devitt, Judith Dwyer, Angelita Martini and Edward Tilton

ISBN 978-1-921889-46-2

Miwatj and East Arnhem: Case study

Paula Myott, Angelita Martini and Judith Dwyer

ISBN 978-1-921889-47-9

Towards a History of Apunipima Cape York Health Council, 1994–2006

Edward Tilton, Angelita Martini, Cath Brown and Kristy Strout

ISBN 978-1-921889-45-5

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSIC	Aboriginal and Torres Strait Islander Commission
CEO	Chief Executive officer
CPHAG	Clinical and Public Health Advisory Groups
EASC	East Arnhem Steering Committee
EHSDI	Expanded Health Service Delivery Initiative
FAR	Funding, Accountability and Results
FRP	Final Regionalisation Proposal
ICT	information and communications technology
KPI	key performance indicator
Miwatj	Miwatj Health Aboriginal Corporation
NGO	non-government organisation
NTAHF	Northern Territory Aboriginal Health Forum
NT	Northern Territory
NTH	Northern Territory Department of Health
PHC	primary health care
PwC	PricewaterhouseCoopers
RPU	Regional Planning Unit

Terminology

In keeping with usage in the Aboriginal Community Controlled Health sector, the term 'Aboriginal' is sometimes used in contexts that may also apply to Torres Strait Islander people. The term 'mainstream' is used to mean non-Indigenous institutions and organisations.

The names of all government departments and several other organisations have changed during the study. For simplicity, we use the names that were current in December 2014.

Introduction

This case study documents the engagement of the Miwatj Health Aboriginal Corporation (Miwatj) and the communities and leaders of the East Arnhem Region in the planning and implementation of the Pathways regionalisation program led by the Northern Territory Aboriginal Health Forum (NTAHF) from 2009 to 2014. The study is based on interviews with 20 people—14 Aboriginal Community Controlled Health Organisations (ACCHOs) staff (including three people who also served in community representative roles), five current and former government staff and one community representative—and on analysis of 98 publicly available or internal NTAHF and Miwatj documents.

East Arnhem, situated in the far north-eastern corner of the Northern Territory mainland, has a population of around 10,000 people, covers approximately 33,000 square kilometres, and comprises ten major remote communities (Milingimbi, Ramingining, Galiwin'ku, Gapuwiyak, Yirrkala, Gunyangara, Umbakumba, Angurugu, Milyakburra and Numbulwar), many homelands and outstations, and two towns (Nhulunbuy and Alyangula). Five of the 10 communities are located on islands, which exacerbates the challenges of providing services in this large remote region.

East Arnhem is culturally rich and linguistically diverse, with three major language groupings—Yolngu (Yolŋu), Nunggubuyu and Warnindilyakwa. Within each of these major language blocks are multiple local dialects and variants.

Primary health care (PHC) is provided to the people of East Arnhem by four organisations, including the Top End Health Service, an agency of the Northern Territory Department of Health (NTH), and three community controlled PHC providers: Miwatj, the Laynhapuy Homelands Association and the Marthakal Homelands Association. Figure 1 (see next page) shows the location of the health services.

Miwatj was established in 1992, with support from the Aboriginal and Torres Strait Islander Commission (ATSIC) Miwatj Regional Council. From the beginning, Miwatj's objectives have included developing a regional approach and ultimately controlling the development and delivery of health services in the region (Miwatj 2011), and it has approached the Pathways regionalisation program as a way of 'implementing the original vision of the founders of Miwatj: one health board to represent all Aboriginal people in the region' (Miwatj 2013).

Miwatj is governed by a regionally representative elected board based on the original three ATSIC wards—Barra, Bulunu and Mamarika. The current Miwatj Board includes the Anindilyakwa Land Council Chair and others from Groote Eylandt, as well as senior leaders from the Numbulwar region (Miwatj 2014).

Notwithstanding a period of difficulties in the early 2000s, Miwatj has continued to develop and diversify. It now provides PHC and public health programs across the region through four sites (Nhulunbuy, Gunyangara, Galiwin'ku and Yirrkala). It is funded from multiple sources, with the Northern Territory and Australian governments being the largest funders, followed by the Northern Territory Medicare Local (which is itself funding by the Australian Government). Funding for core PHC is provided by the Indigenous Health Division of the Department of Health and, since 2013, Australian Government funding for other health programs has been provided by the Department of Prime Minister and Cabinet.

The Top End Health Service operates Gove District Hospital and nine community clinics. Laynhapuy and Marthakal Homelands Associations provide PHC and other services to the smallest homeland communities/outstations. Laynhapuy provides mobile PHC to approximately 1000 people in 19 homelands,

Figure 1: East Arnhem Region health services

(Source: map by Primary Health Care Funding Policy Section, OATSIH, 18 February 2011, Commonwealth of Australia)

dispersed across an area of some 10,000 square kilometres, including one off shore island (LHAC n.d.). Management of many clients is shared by Miwatj and Laynhapuy's Yirrkala Health Centre and this arrangement requires a close working relationship between clinicians.

Marthakal provides mobile primary health services to a population of between 250 and 400 people living on 13 outstations located over an area of 15,000 square kilometres (Marthakal Homelands Resource Centre 2012). Marthakal Health and the (Miwatj) Ngalkanbuy Clinic at Galiwin'ku have formal arrangements to share care and patient records, and staff work closely together.

The regionalisation process

The people of East Arnhem approached the proposed regionalisation of health care with a well-established understanding of its potential benefits, arising from engagement with broader regional action, including through opposition to mining (Fitzgerald 2001:207–12) and experience with the ATSIC Regional Council and national leadership.

East Arnhem Regionalisation Proposal (2007–12)

In keeping with the long-held aspirations of the Yolŋu people for self-governance, and the original vision of Miwatj as a regional health service, Miwatj commenced work towards regionalisation prior to the development of *Pathways to Community Control* (NTAHF 2009). In 2007 the Miwatj Chair, the CEO and Mr Terry Yumbulul, a senior Yolŋu clan leader, made a regionalisation study trip to Katherine West Health Board, a successful regional community controlled health service established in 1998 (EASC 2010). Subsequently, in July 2008 Miwatj commissioned Mr Yumbulul as liaison officer to discuss the regionalisation proposal with communities across East Arnhem.

The East Arnhem Steering Committee (EASC) was established in September 2008 with the goal of preparing a detailed plan and proposal for regionalisation. The EASC met quarterly until the Initial Regionalisation Proposal was submitted in December 2010 (EASC 2010) and monthly from February 2011 to June 2012, when the Final Regionalisation Proposal (FRP) was submitted to the NTAHF. During this period EASC membership comprised 21 representatives from all major communities in East Arnhem (with the exception of Ramingining[1]) and representatives of the NTAHF partners (i.e. NTH, 2; AMSANT, 3; Department of Health, 2). Aboriginal Medical Services Alliance Northern Territory (AMSANT) provided secretarial services until July 2011. All participants were engaged in developing the FRP.

Regional activities were well underway in East Arnhem by the time the NTAHF, in late 2010, endorsed the Regionalisation Guidelines (NTAHF 2010). During the period 2008–12 the EASC worked systematically through the four steps of stage one (development), leading to submission of the FRP, as summarised in Table 1 and described on the next page.

1 The Ramingining representative had passed away and no replacement had been offered.

Table 1: East Arnhem regionalisation development timeline

STEP A	Initial Community Consultation	Mid-2008 liaison officer appointed, consultations carried out during 2008–09
STEP B	Establish Regional Committee	September 2008 EASC established
	Establish a CPHAG	February 2011 CPHAG established
		March 2011 Communicare Users Group established
STEP C	Develop Initial Regionalisation Proposal	December 2010 Initial Regionalisation Proposal submitted to NTAHF
STEP D	Broad consultation to develop FRP	July 2011 Regional Planning Unit established with two employees and 12 months' funding
		December 2011 community consultation report tabled at EASC (Christie et al. 2011)
		June 2012 FRP submitted to NTAHF

The East Arnhem Clinical and Public Health Advisory Group (CPHAG) was established in February 2011 and met regularly (every six to eight weeks). Its original role was to provide advice to the EASC on developing a regional health service plan and on improving coordination of services, and it continues with the latter function.

The East Arnhem CPHAG includes representatives from the PHC services and the NTH/Top End Health Service (including Gove Hospital). CPHAG is the first joint planning forum for Aboriginal PHC in the region and continued to be a successful collaborative structure, 'building very good relationships for service delivery in the region' (J. Woltman, personal communication, 12 June 2013).

CPHAG focused on some of the key building blocks for strengthening health systems (WHO 2007), such as workforce development, with the goal of increasing the numbers, skills and career pathways for Aboriginal staff. It also established a Communicare Users Group to support a regional approach to an electronic client information system. In July 2011 Miwatj was funded for 12 months under the NTAHF regionalisation budget to operate a Regional Planning Unit (RPU). The unit, with two full-time employees, supported the EASC and CPHAG meetings and coordinated work towards the FRP. Funding for the RPU ceased as of July 2012, but one position was maintained by Miwatj to progress the agreed NTAHF regionalisation program. The EASC was no longer able to meet due to the costs of bringing together representatives from across this large region.

Design of regional governance (2009–12)

The EASC and government representatives had different concerns about the structures and processes for regional governance, and tensions became apparent early in the process.

The question of whether to establish a new overarching regional board or to adapt the Miwatj Board was considered by the EASC (in a governance workshop held in mid-2009) and later at a special meeting of Indigenous EASC members and regional leaders. There was considerable debate on the wisdom of establishing yet another regional entity[2] and the meeting decided that the Miwatj Board would be the board of management for the proposed

2 At around this time, in mid-2008, the Northern Territory Government had moved to establish an East Arnhem Shire Council, which also sought representation from the region. By 2013 Mr Banambi Wunungmurra was both the Shire Council Chair and the EASC Chair.

regional health service (minutes of this meeting were not taken). A year later, following a second governance workshop in August 2011, the EASC formally endorsed the existing Miwatj Board (with adjusted representation) as the East Arnhem Regional Health Board (EASC 2011). The Miwatj constitution was subsequently amended so that at least one homeland representative from each ward would be included. Other changes were made to enable non- Indigenous people to become members of Miwatj and to enable the Board to establish committees and advisory groups (Minutes, Miwatj Annual General Meeting 2012).

As noted in the 2012 FRP (EASC 2012:25):

> It is important to keep in mind that the Miwatj Regional Health board is also made up of representatives from across the whole region and will include specific representation by Homelands people so they will all have a commitment to ensuring the best outcomes for the whole region.

This approach was contested in discussions with the Department of Health on the grounds of inadequate (male and female) representation of each community (ACCHO staff 502). Further concern was expressed about the way the EASC envisaged linking into the existing complex East Arnhem health service provider landscape. Government representatives preferred one regional ACCHO (as intended in *Pathways to Community Control* (NTAHF 2009)) and were concerned about the EASC decision to adapt the Miwatj Board for regionalisation rather than creating a single overarching board (to encompass governance of all three ACCHOs).

The EASC FRP outlined an alliance model (Figure 2) to provide a formal partnership with regional health service providers, Laynhapuy and Marthakal, which had opted to remain as independent organisations.

Specifically, the FRP noted (EASC 2012:24):

> Miwatj Health will continue to be a regional health service provider—transitioning NTH clinics incrementally. The Miwatj Regional board would develop a regional alliance agreement (similar in scope and function to [the Memorandum of Understanding]) with all the primary health care service providers in East Arnhem including NTH.

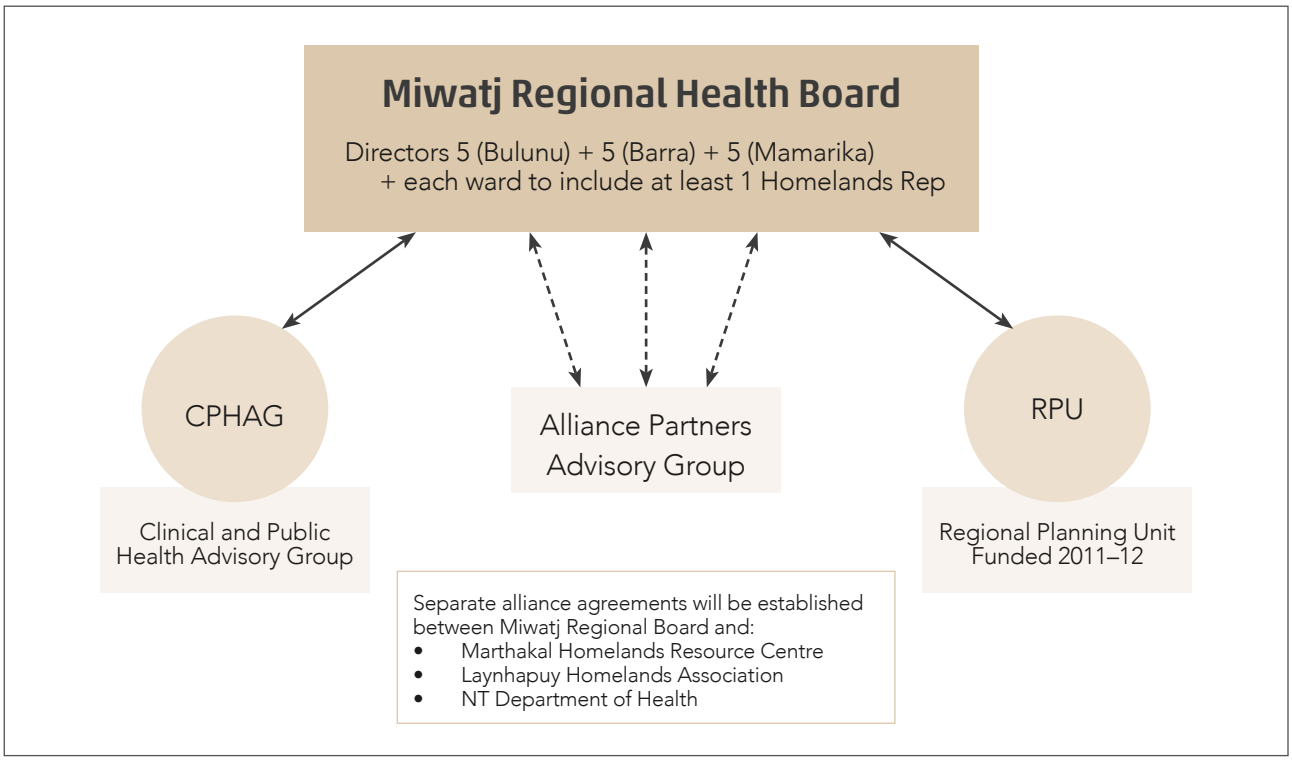


Figure 2: East Arnhem Region Alliance Model

The alliance agreement would be signed by the board of each organisation, or a senior delegate in the case of the NTH, and would include guiding principles and provision for sharing data and linking the clinical information system (Communicare), as well as for collaboration on shared concerns. It was envisaged that joint working groups would address issues and opportunities for all service providers and make recommendations to the Miwatj Board.

Under this arrangement the Miwatj Board would be the regional lead entity and the funds holder. The EASC argued in its FRP that within the proposed alliance model there would be a cultural component of reciprocal obligation between the Miwatj Regional Health Board and the East Arnhem Alliance partners when they committed to this approach. Asked directly whether communities were concerned that Miwatj was 'taking over', a senior EASC member noted that EASC members 'are on a lot of committees, they know what's happening; we're not taking over all the clinics and services, we're concentrating on funding and access to services everywhere' (Community representative 503).

It was also envisaged that parties to the agreements might change over time, allowing for an incremental approach to service transition. In particular, the Groote Eylandt people might eventually choose to establish their own regional health service. However, at the time of the FRP they were represented on the EASC and the Miwatj Board.

Formal community consultation (2011)

In mid-2011 the EASC commissioned Charles Darwin University to undertake a community consultation on regionalisation with the results to be included in the FRP. The consultation was conducted in local Aboriginal languages, by East Arnhem Aboriginal staff who were trained and supported by experienced academics. The consultation survey methods included a sampling strategy to achieve coverage of all relevant groups and the overall goal was to consult with 360–70 adults across East Arnhem 'to establish a reasonable level of agreement on a regional PHC service model and governance structure' (Christie et al. 2011:11). Clinic staff and non-Indigenous community members were not included, in the expectation that the NTH and AMSANT would also conduct consultations with their staff/stakeholders (Christie et al. 2011:12). Ultimately, 401 men and women were surveyed. As well as reporting community views, Christie et al. (2011:10) also spelled out the complexities of community consultation and communication in the region, noting that 'the story behind the health reforms is complex and multi-layered, and the reform process constantly changing and evolving'.

Although about half of those participating were positive about the regionalisation proposal, others wanted more information. The authors reported that 'the more informed people felt about the health reforms, the more positive and supportive they were of the reforms and the regionalisation process' (Christie et al. 2011:1). The authors noted that the survey was conducted late in the process when some important decisions had already been made by the EASC and community leaders (Christie et al. 2011:11).

Regionalisation proposal not endorsed by the NTAHF (2012)

The submission of the FRP in June 2012 coincided with a period of disarray in the NTAHF, and the EASC did not receive a formal response. The Miwatj CEO wrote to the NTAHF in September 2012 to report that although he had been advised that the government partners had concerns, his requests for specific concerns to be communicated had been unsuccessful.

The NTAHF decided that the members should provide separate written responses to Miwatj and noted that the NTAHF itself was no longer empowered to endorse FRPs (see Case study 1 for more information). The Department of Health (Northern Territory office) responded promptly with a short letter advising that further work would be required and addressing the perceived conflict of interest for the Miwatj Board in its

capacities as 'a sub-regional provider and a regional board' (letter, Department of Health (NT) Manager to Miwatj CEO, 10 October 2012). The letter also requested that EASC/Miwatj prepare a plan for 'health reform activity' and further community consultation. Details of the EASC's endorsement of all components of the FRP were also requested, and a provisional offer of further funding (up to $200,000) was made.

Some of these requests were seen as unreasonable or already addressed in the FRP. All NTAHF partners were represented at and participated in the EASC meetings during 2011–12, when the FRP was developed and endorsed, and the community consultation process had been thorough and well conducted. The Department of Health considered that a detailed plan for implementation was required prior to sign-off on the FRP, whereas the EASC considered that sign-off was needed first, given the significant investment (of resources and community good will) that would be required and also given the CPHAG's existing work on key aspects of regional health system reform. Differences on the question of a single ACCHO board for all services in the region and the role of the Miwatj Board were unresolved.

On 22 January 2013 Miwatj (RPU) provided a response to a senior Department of Health officer (via email and a discussion paper (titled 'Miwatj Discussion Paper January 2013'), giving detailed attention to the issue of potential conflicts of interest and the mechanisms designed to ensure maximum participation and transparency. The paper detailed changes made to the Miwatj constitution and drew attention to the reality of the multiple 'kin and clan', cultural and organisational linkages among the senior regional leadership (such as the presence of board members of both Laynhapuy and Marthakal on the Miwatj Board) and the members' preferences for the existing arrangement.

A further letter in March 2013 from the Department of Health to Miwatj described the alliance agreement model as 'a solid first step in building a governance approach that represents the East Arnhem communities' and outlined further requirements, including a detailed five-year plan and timeframe for 'bringing new communities into the governance structure' and for 'efficiencies produced by shared purchasing arrangements for health services and administration' (letter from Department of Health (NT) Manager to the Chair of the EASC, 12 March 2013). The provisional offer of funding, to be provided after the completion of the work, was also affirmed (subject to receipt of a revised budget proposal).

No further developments in relation to the FRP occurred during the period of this study, although Miwatj has continued work on the development of a regional PHC service.

Transitioning Yirrkala Clinic (2012)

At the same time as the FRP was submitted (mid-2012), Yirrkala Clinic transitioned from being an NTH service to being a community controlled service as part of Miwatj.

Yirrkala is a small township located 15 kilometres from Nhulunbuy. It has a population of around 1000 and is the largest Yolŋu community on the East Arnhem peninsula (PwC 2012:5). The town site was established by Methodist missionaries in 1934. Mission staff later established a small hospital, which was handed over to the Northern Territory Government in the mid-1970s with a staff of Aboriginal Health Workers and one nurse from the Nhulunbuy Hospital (Read 1983:19–23). There had been discussions about transfer to Miwatj since the 1990s, when the clinic was noted to be underfunded.

Discussions commenced again in 2008 and an agreement on the transfer of Yirrkala to Miwatj was completed by December 2011, with Miwatj taking over day-to-day management of the clinic in July 2012.

Miwatj engaged PricewaterhouseCoopers (PwC) to undertake a financial and service analysis of the Yirrkala transition process. PwC reported that Yirrkala's key performance indicator (KPI) results were below average and it lacked accreditation by Australian General Practice Accreditation Ltd (AGPAL) prior to transfer (the clinic is now

accredited), and that a broader range of services (health promotion and illness prevention, chronic disease management programs) were offered following transfer (PwC 2012:21).

The transfer of operating funds from the NTH to Miwatj was contentious and delayed (letter, CEO Miwatj to NTAHF, 26 September 2012). The allocation of overhead costs (management and support costs such as information and communications technology (ICT)) was the focus of concern. The question of direct allocation by the Australian Government to Miwatj or allocation via the NTH was also debated. The funding was resolved (without a specific allocation for overhead costs) following a threat of a Christmas shutdown of the clinic.

Although the NTH had explicitly excluded the Yirrkala transfer from the NTAHF regionalisation processes (letter, CEO Miwatj to NTAHF, 26 September 2012), the stringent requirements of the Competence and Capability Framework were applied as a condition of approval to transfer. The framework was completed with support from PwC and showed good results. PwC noted that although all parties recognised that they were learning how to do transition, there was a 'high level of uncertainty that impacted on the relationship management of the transition process' (PwC 2012:22). It suggested that future such exercises should include clear agreements on financial and other data to be shared among the parties, including timeframes for delivery and early attention to ICT and data-sharing systems. PwC also emphasised the need for timely documented confirmation of all contractual obligations to be transferred, especially employee contracts and entitlements (PwC 2012:22).

This experience of transfer of a remote NTH clinic has highlighted some technical and relationship challenges that are likely to apply to future transfers. The relative paucity of local clinic infrastructure, such as ICT, and the challenge of quantifying and transferring overhead costs are important matter of concern to Miwatj and the Australian Government. It can also be expected that Northern Territory Government staff will resist a change in their employment arrangements in the absence of clear up-front guarantees of 'no disadvantage'. There was also a sense in this case that staff were not comfortable working for an Aboriginal organisation or lacked confidence in management capability—a view also expressed to a senior community leader: 'they said we didn't have the expertise' (Community representative 503)—or did not want the NTH to lose ownership:

> Well when we're talking about regionalisation… there'd also been that sort of resistance… I don't think Territory Health were particularly keen to transition. You know, these were their clinics. (ACCHO staff 116)

Miwatj funding contracts and performance

Given concern about the governance and management capability of Miwatj, it is relevant to describe its funding contracts and its performance.

Miwatj had experienced growth in funding associated with the Northern Territory Expanded Health Service Delivery Initiative (EHSDI) program starting in 2009–10, growing from total funding of more than $9 million in 2008–09 to more than $17 million in 2013–14. In the 2013–14 financial year it received funding in 14 separate contracts or schedules, requiring 167 reports. Reports were for a range of funders and were required quarterly, six-monthly and annually.

The Northern Territory Aboriginal Health KPIs (unpublished data, 2013) and Miwatj records document several indicators of effectiveness in provision of PHC:

- provision of a Medical Benefits Schedule health assessment that exceeds the national average (aged 0–4) in Galiwin'ku, Nhulunbuy and Gunyangara (Northern Territory Aboriginal Health KPIs)[3]

3 No comparative data for Yirrkala was provided until the following reporting cycle.

- the lowest proportion of babies born with low birth weight (11 per cent), compared to East Arnhem as a whole (19 per cent) and the Northern Territory (14 per cent) (2013) (Northern Territory Aboriginal Health KPIs)
- immunisation that exceeds the Northern Territory average rate in all age brackets (2011, 2012 and 2013) (Australian Immunisation Registry)
- significant increase in episodes of care at Yirrkala following transfer to Miwatj from the NTH; in 2013 the first complete calendar year that Yirrkala was part of Miwatj, episodes of care increased by 408 per cent to 11,420 (Northern Territory Aboriginal Health KPIs) from the previous level of 2794
- a significant increase in the proportion of patients whose allergy status was recorded in their files in Yirrkala, as required for accreditation; in May 2014 recorded allergy status had increased from 10 per cent to more than 60 per cent[4]
- increased employment of qualified Aboriginal and Torres Strait Islander people; of 139 employees, 79 are Indigenous workers (56 per cent).

We suggest that this is a typical pattern of performance by a competent ACCHO—managing complex program funding to deliver effective PHC.

Regionalisation work continues (2012–14)

By late 2012 it was clear to Miwatj and the EASC that the NTAHF regionalisation program had come to a standstill. The Miwatj RPU was no longer funded and the EASC was unable to meet. After intense investments of time and resources for almost five years, the regionalisation initiative was losing momentum in East Arnhem.

However, Miwatj retained regionalisation as a key organisational priority. It did not proceed with the formal alliance structure proposed in the FRP, but took the view that existing arrangements for working relationships with Laynhapuy and Marthakal functioned well and that Miwatj is well placed to manage any future transfers of NTH clinics.

Miwatj has actively canvassed support for regionalisation, including meeting in December 2012 with the Northern Territory Minister for Health (David Tollner), who gave a written commitment to transfer remaining Northern Territory clinics in North East Arnhem and, subject to agreement with the Anindilyakwa Land Council, those in South East Arnhem, specifically Groote Eylandt and Numbulwar (personal communication, CEO Miwatj Health, February 2013). The Minister lost the health portfolio one month later and senior staff of the department expressed concern about resistance to transfer among regional NTH staff whose jobs may have been affected by transfer. The existence of this concern has been confirmed (but not endorsed) by a senior officer in a meeting with NTH Minister Lambley in July 2014 (Miwatj Health RPU Manager, personal communication, 14 September 2014).

4 Extracted from the East Arnhem Communicare Database.

Miwatj is pursuing a strategy of incremental regionalisation through the transfer of willing clinics to the community-control model. In areas such as Groote Eylandt and Numbulwar, where community controlled services have never existed, there is scope for the development of a separate regional service. In the meantime, the regionally inclusive Miwatj Board structure offers senior leaders in the region an opportunity to participate in debate, to pursue the growth of health services and to assess the potential benefits of regionalisation for their own communities.

The CPHAG continued to meet and has established a Regional Clinical Governance Network to provide advice and support on clinical matters. The scaled-down RPU continued to function funded by Miwatj. The RPU has established a relationship with the Cape York-based Jawun Indigenous Corporate Partnerships program, which has enabled the development of an advocacy policy and supportive resources and a change management strategy for use in future clinic transition processes.

At the time of writing, Miwatj was in discussion with the NTH about the possible transfer of the Milingimbi Health Centre to a community controlled model within Miwatj, with the support of the Minister of Health (Lambley 2014). Despite sometimes difficult relations with the NTH regarding regionalisation, Miwatj continues to take opportunities to progress its regional agenda, noting that 'to achieve the outcomes we all want, real partnerships are crucial' (Miwatj CEO cited in Lambley 2014).

Findings

Achievements

This case study documents the development in one region of a plan for regionalisation, and the challenges and achievements of the project. There was some practical progress, including developments towards regional community governance for health services, and the full transfer of the clinic for one community. But in spite of these achievements, the results fall short of success in efforts to implement the reforms intended in the original *Pathways to Community Control* document (NTAHF 2009). This section addresses the major issues influencing this outcome.

Regionalisation as a path to self-determination

Miwatj has demonstrated that it remains strongly committed to regionalisation because, from the outset, it has linked increased regional autonomy with self-determination and better health outcomes. East Arnhem Aboriginal people have a narrative of regionalisation and increased autonomy that reaches back more than 50 years to the Bark Petitions and the Gove Land Rights Case (*Milirrpum v Nabalco Pty Ltd* (1971) 17 FLR 141). That narrative continues to inform decision making and to draw in local leaders. The announcement of the EHSDI funding and the NTAHF decision to use some of the funds to establish regional community controlled health services presented the East Arnhem communities with an opportunity to progress their existing vision. Miwatj was well prepared prior to the release of the *Pathways* document, and by the time the NTAHF (2010) Regionalisation Guidelines were released in late 2010 leaders and the community had been working on their ideas for almost four years. They were unprepared for either the months of silence following the submission of their FRP in mid-2012 or the subsequent additional requirements that were apparently based on a perception by government officers that their regionalisation plans were ill-conceived and too risky.

Miwatj continues to see itself as having a broader role than the delivery of PHC, a view that is consistent with that of the ACCHO sector nationally. As a staff member explained:

> I think you've got to look at success in many ways. Service delivery is an important part, it's what we're funded to do, but it's more than that. It's what organisations like this do to the hope of people, I think that's the important thing, that people are proud to be… part of Miwatj in one way or another… Everyone that's got jobs are real jobs, so the community is proud of Miwatj… This is our organisation and I think that's really important and that's the way it's got to be if you're going to build people. (ACCHO staff 402)

Authority and decision making

The processes of regionalisation were seen in some ways as revisiting established community decisions and adding requirements for new consultations and agreements. There was considerable pressure to renew decisions already made, which led to some community conflict without leading to implementation of the desired reforms: 'So, you know, we wasted a lot of time and money and effort' (ACCHO staff 402).

The responses of government officers to the Miwatj FRP were also affected by the tight budget situation of 2011–12 (particularly for the Australian Government) and the apparent withdrawal of high-level support for the regionalisation process. During the period

covered by this study, changes of government at both the Northern Territory (August 2012) and national levels (September 2013) brought financial stringencies and the defunding of some health programs. There were several changes of Northern Territory Health Minister and a major restructuring of the Northern Territory health system.

There is some resentment in Miwatj and the EASC membership about what is perceived as a lack of respect for community authority and ways of making decisions. In the period after the FRP was submitted, there was a sense of new requirements being set rather than a genuine dialogue or engagement: as a senior community representative observed, 'the goalposts seem to be moving all the time' (Community representative 401). Invitations, including in writing, were made to the Department of Health (Northern Territory) and NTH staff to explain their requirements to the Miwatj Board, the EASC and the community, but none were accepted:

> we also challenged our fellow key stakeholders from the Department of Health and Community Services, 'could you come to the table and actually give us the feedback?' (Community representative 401)

This period led to perceptions of a lack of respect by government officials for community leaders and Elders and a lack of understanding of their essential role in progressing regionalisation:

> The fundamental things with the Elders—and [we'll] say over and over again—'engage with us, inform us but truly respect and value us because we are the solution to succeed and actually contribute to our society'. (Community representative 400)

> They need to start realising that we've done everything what's achievable and manageable. How many more [times] do we have to be scrutinised, continue what we're doing. And what about the Department of Health and OATSIH? They need to be scrutinised just as well because it is taxpayers' money. (Community representative 401)

Loss of commitment to regional community control, lack of trust in ACCHOs

There was an evident loss of commitment among the NTAHF government partners to the community control model (Allen + Clarke 2011:141). *Pathways to Community Control* (NTAHF 2009) is unambiguous, with its subtitle spelling out *An Agenda to Further Promote Aboriginal Community Control in the Provision of Primary Health Care Services*. The document goes on to state that 'Parties have agreed that community controlled governance of health services is the optimal expression of the right of Aboriginal people to participate in decision making' (NTAHF 2009:5).

The Pathways document does not use the terms 'participation' and 'community control' interchangeably. Rather, it argues that increased participation—in all phases and/or aspects of a community health service—is the pathway to community control. Participation is a means to an end, not an end in itself. The linking of regionalisation with community control was further clarified in an NTAHF agreement to use consistent terminology in all communications, specifically the term 'regional Aboriginal Community Control' (NTAHF Meeting #47 December 2009).

However, the document (NTAHF 2009:5) also discusses the complex meaning of 'community control':

> community control refers to the principle that Aboriginal communities have the right to participate in decision making that affects their health and wellbeing. It also refers to the organisational model of Aboriginal community controlled health services that has existed for more than 30 years.

The document also identifies the capabilities of Aboriginal communities and boards of management as threshold issues within this framework: 'These structures must be able to serve the community's interests, stay connected with the community's preferences and values and discharge strategic corporate responsibilities effectively' (NTAHF 2009:23). Here the emphasis is on the interface between community interests, preferences and values and the effective management of a corporate health entity. That is, effective governance of a community controlled service will reflect community values and require response to community preferences; it will be connected to its constituents.

But there were shifts in government commitment to these goals and ideas. Following a regionalisation workshop in Alice Springs in 2013, Allen + Clarke (the facilitators) reported that the NTAHF partners no longer shared an understanding of the relationship between the central concepts of community control and regionalisation, with Department of Health officers expressing the view that community control involves 'Aboriginal communities being given opportunities to participate in health service planning' and the NTH also emphasising community participation (Allen + Clarke 2013:4). Thus community control is conflated with participation, and regionalisation is separated. However, the NTAHF (2010:10) had previously indicated that the partners had an agreed definition and a shared vision for regionalisation, which is:

> Working together to improve health outcomes for all Aboriginal people in the Northern Territory through health system reform and the development of Aboriginal community controlled primary health care services which provide safe, high quality care and facilitate access to specialist, secondary and tertiary care.

The impact of several high-profile governance failures or problems in Aboriginal organisations during this period added to a sense of concern about the governance capability of the community control model and influenced the thinking of politicians, as well as public servants.

The experience was a dispiriting one with particular consequences for continuing community engagement. Although noting that he and his countrymen are 'patient people', a senior community representative said that he worried about his board colleagues losing interest because they had not heard anything for so long; he added that when such intense work and discussion apparently lead to nothing changing, 'the criticism and blame falls back on us' (Community representative 503).

The Miwatj Chair commented on:

> what we feel is a very hard-handed, double standard approach you have taken to the regionalisation process in East Arnhem despite all good work the Steering Committee and Miwatj Health has done to reform health service delivery for our people of the past five years. (Letter, Miwatj Chair to Department of Health NT Manager, 17 July 2013)

Conclusion

Miwatj and the EASC vigorously pursued the opportunity to transfer PHC services to regional community control because it fitted well with their vision for the future. But it seems that the timing of the submission of the FRP—coinciding with a period of dysfunction in the NTAHF and indolence on the part of the Senior Officers Group, which was intended to speed up the process through effective decision making—led to its failure.

We have relied on documentary evidence to interpret the perspectives of government officers but have been unable to clarify why dialogue was lacking. It seems likely that the failure to secure agreement with the two existing ACCHOs in the region to amalgamate with Miwatj was an important barrier from government perspectives (in spite of the principle of no forced amalgamations). It also seems that the stated intention to accept FRPs was no longer being honoured, and government responses were designed to discourage persistence by the EASC/Miwatj.

Whatever the barriers, the fact that there were no opportunities for frank discussion among the parties seems to have sealed the fate of the FRP. This approach is reminiscent of the ungainly conclusion of the Primary Health Care Access Program (NTAHF Meeting #25 September 2004; Rosewarne & Boffa 2004).

A comment by Smith (2008:83–4) in relation to the abandonment of the Building Stronger Regions, Stronger Futures policy suggests that this is a recurring problem worthy of attention in its own right:

> What had happened? The sudden demise of the [Building Stronger Regions, Stronger Futures] policy owed much to the ideological dissatisfaction and implementation difficulties experienced by government bureaucrats in trying to accommodate Indigenous ideas about 'regions' and representation for local government, and their consensus modes of decision-making about these matters. Discussion and decision making took time, internal negotiation and sensitive facilitation—all of which challenged the capacity, commitment and resources of the NT and Australian Governments. The political imperative for fast results chaffed at the more measured pace of voluntary regionalisation, and in the meantime, several NT community and association councils had collapsed owing to poor financial administration and governance.

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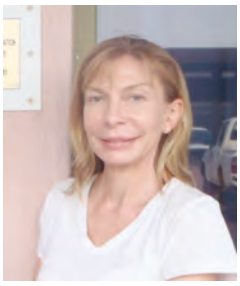

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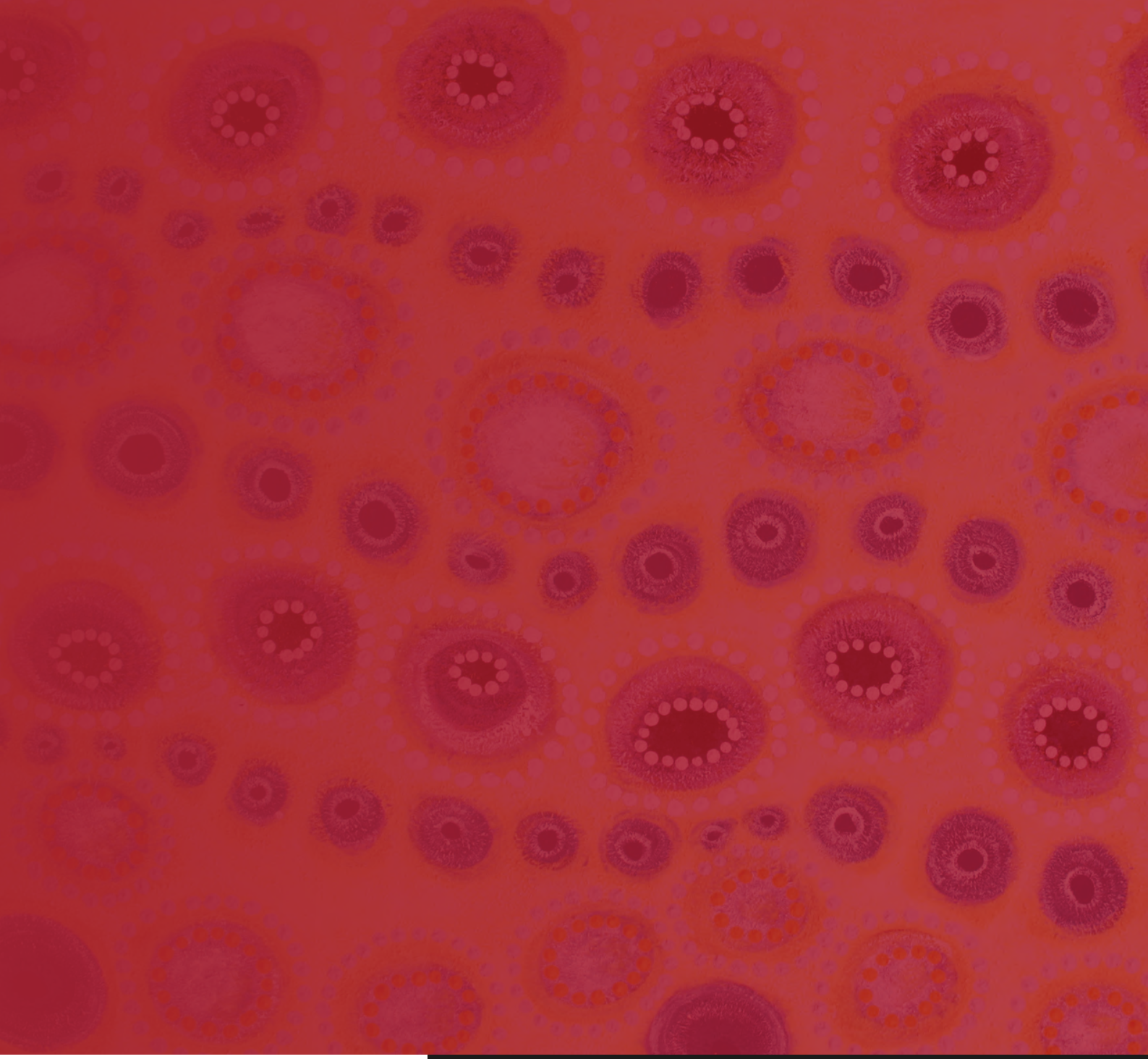

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