The Northern Territory Aboriginal Health Forum: A historical review

Jeannie Devitt
Judith Dwyer
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Edward Tilton

ARTWORK
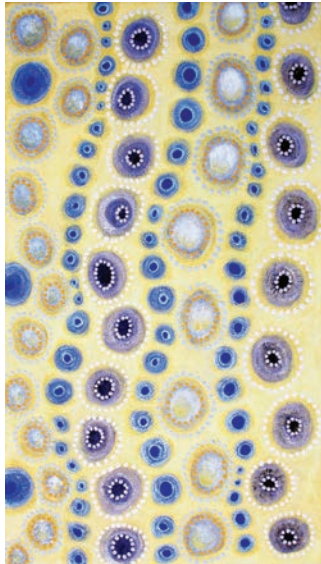
About the artist
Karen Kulyuru was born in 1969 and raised in Ernabella (Pukatja) on the Anangu Pitjantjatjara/Yankunytjatjara Lands. Karen first learned to paint by watching her mother, and comes from a family of batik silk artists. She started painting at Ernabella Arts and Crafts many years ago. Karen 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
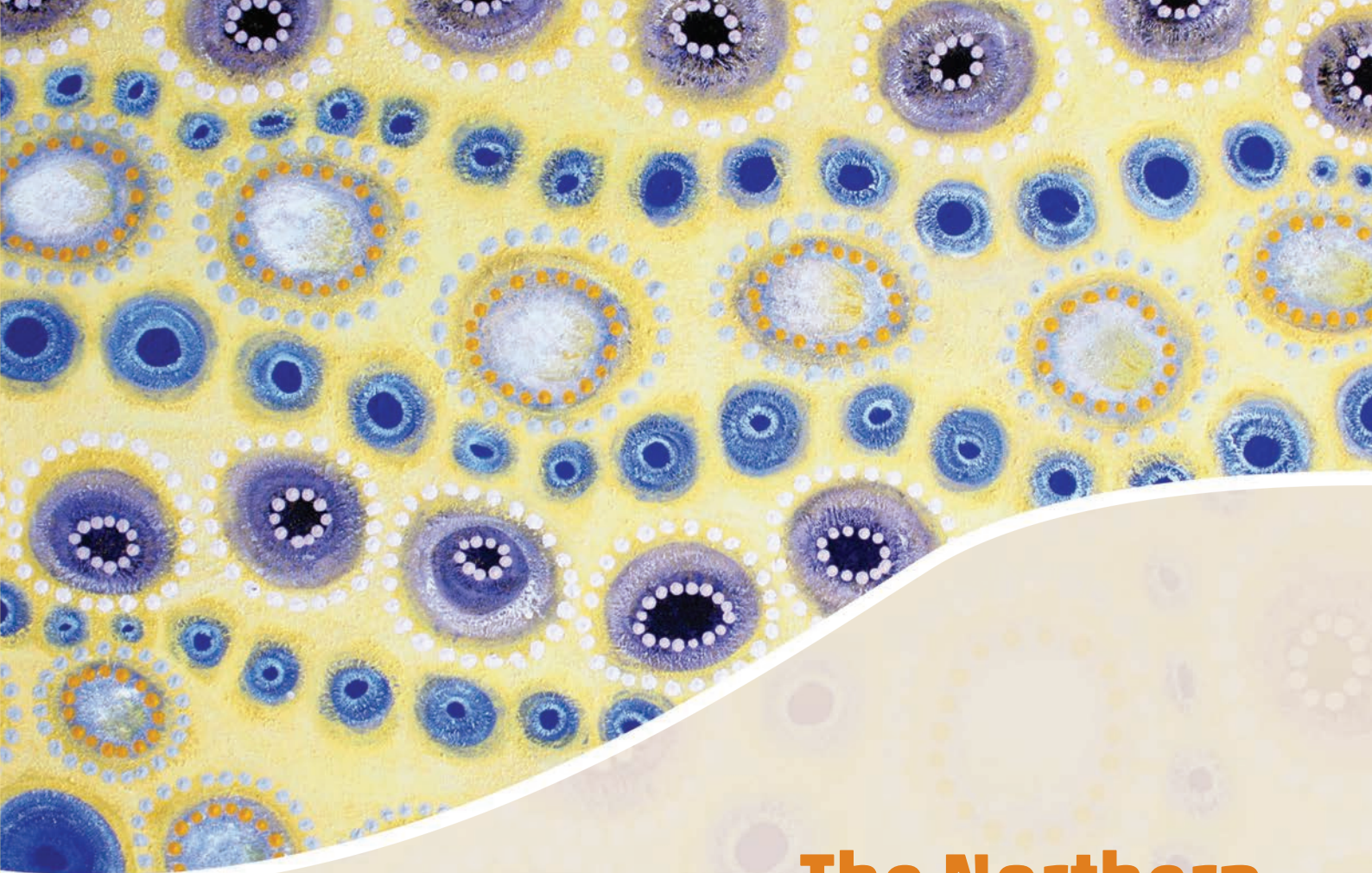61 x 107 cm
Better World Arts catalogue KKU0073

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.

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Design & layout: Inprint Design, Adelaide

Australian Government
Department of Industry,
Innovation and Science

Business
Cooperative Research
Centres Programme

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Acknowledgments

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.

During the life of the Northern Territory Aboriginal Health Forum both Northern Territory and Commonwealth Departments of Health have undergone several name changes. This report uses the current designations throughout: Northern Territory Department of Health (NTH) and Commonwealth Department of Health (DH).

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, of which this is one, and a 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.
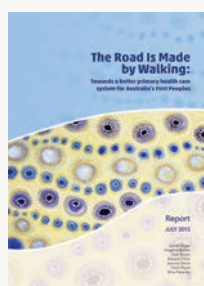
Project report:

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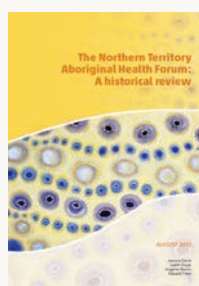
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ISBN 978-1-921889-42-4

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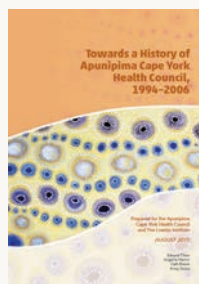
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Edward Tilton, Angelita Martini, Cath Brown and Kristy Strout
ISBN 978-1-921889-45-5

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
AHKPI	Aboriginal health key performance indicator
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSIC	Aboriginal and Torres Strait Islander Commission
CARIHPC	Central Australia Regional Indigenous Health Planning Committee
CCT	Coordinated Care Trial
CEO	Chief Executive officer
COAG	Council of Australian Governments
CQI	continuous quality improvement
CRC	Cooperative Research Centre
CRCATH	Cooperative Research Centre for Aboriginal and Tropical Health
DH	Department of Health (Australian Government, 2013–)
DHAC	Department of Health and Aged Care (Australian Government, 1998–2001)
DoHA	Department of Health and Ageing (Australian Government, 2001–13)
EASC	East Arnhem Steering Committee
EHSDI	Expanded Health Service Delivery Initiative
FAR	Funding, Accountability and Results
HSDAs	Health Service Delivery Areas
KPI	key performance indicator
NACCHO	National Aboriginal Community Controlled Health Organisation
NGO	non-government organisation
NTAHF	Northern Territory Aboriginal Health Forum
NT	Northern Territory
NTH	Northern Territory Department of Health
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PHC	primary health care
PHCAP	Primary Health Care Access Program
PHRG	Primary Health Reform Group
TERIHPC	Top End Regional Indigenous Health Planning Committee
UPIs	Universal Performance Indicators

Introduction

This report examines the history of the Northern Territory Aboriginal Health Forum (NTAHF or the Forum) and its contribution to policy making and to system development for Aboriginal health in the Northern Territory (NT) – from its founding in 1998 until 2009 with the commencement of work to implement the newly completed Pathways to Community Control framework. Subsequent events are covered in the NTAHF case study that forms part of our main report of this project (Dwyer et al. 2015).

Purpose and scope

The NTAHF is a formal partnership between key stakeholder organisations concerned with service delivery to address Aboriginal health status in the NT, with a particular focus on primary health care (PHC). During the period of this historical review, the members of the Forum were:[1]

- Aboriginal Medical Services Alliance (AMSANT), representing the Aboriginal community controlled health organisations (ACCHO) sector

- NT Department of Health

- Commonwealth Department of Health, principally during this period the Office for Aboriginal and Torres Strait Islander Health (OATSIH).

This report provides an account of the origins, structure, history and activities of the NTAHF with a focus on its role in making policy for Aboriginal health and health service delivery in the NT.

Data sources and limitations

There are five principal data sources for this document:

- NTAHF minutes and agenda papers

- recollections and perspectives of 19 current and previous NTAHF members and/or participants as recorded in formal interviews

- an analysis of key documents, identified by Forum members or through NTAHF minutes, plus relevant national and NT Government policy and planning documents

- written observations and commentary on NTAHF activities by those involved and some external observers.

The main limitation to the completeness of this data is the relative paucity of accounts by current public servants. We have attempted to address this limitation both through interviews with people who have recently left public service positions, and using the notes of business meetings with some of those currently involved. Several individuals have also kindly reviewed this document in draft form, and have responded generously to our request for corrections and additions.

Quotations from interviews in this report are followed by an identifier in brackets, which gives the sector position and a unique number for each speaker. Please note that to protect anonymity, the 'current' or 'former' status in the roles of individuals who spoke with us is not given, and both NT and Commonwealth staff members are described as 'government staff member'. The term 'representative' is used to denote those who were appointed as members of the NTAHF (representatives of their organisations).

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1   During the life of the NTAHF both the NT and Commonwealth Departments of Health have undergone several name changes. This report uses the current designations throughout: Northern Territory Department of Health (NTH) and Commonwealth Department of Health (DH).

Establishment of the NTAHF

The NTAHF was established under the terms of a national Framework Agreement structure, enacted in each jurisdiction between July 1996 and February 1999 (NACCHO 1999:1), with the NT Agreement being signed in April 1998. However, the origins of the Forum, and indeed the national Framework Agreement structure, go back to a period of sustained advocacy in the early to mid-1990s by the ACCHO sector in the Northern Territory and nationally for sustainable joint health planning processes that involved all key service delivery, policy and funding agencies (AMSANT 1995).

In tracing the policy ancestry of the Framework Agreements, Anderson (2004:266) notes how they aligned with the earlier (1992) commitment by the Council of Australian Governments (COAG) to improve the outcomes of programs and services provided to Aboriginal and Torres Strait Islander people. The COAG document stated that:

- governments share responsibility for services (and outcomes)

- there needs to be maximum flexibility and discretion at state/territory and local government level

- there is a preferred role for Aboriginal and Torres Strait Islander people and organisations in service provision

- cultural diversity is recognised, and requires flexibility and adaptability (in service delivery)

- planning and consultation processes need to be adapted to local need (COAG 1992, cited in Anderson 2004).

The national Framework Agreement structure formally underpinned collaboration between the Commonwealth Health Department, the relevant state or territory Health Department, the state-level ACCHO representative body and the Aboriginal and Torres Strait Islander Commission (ATSIC). The Framework Agreements had initial three-year life cycles and committed the signatories to actions that would:

- increase the allocation of resources to reflect need

- improve access to health services and programs (ACCHO and other)

- establish joint planning including regional planning – and jointly identify priorities

- improve data collection and evaluation (Anderson 2004:256).

Through this structure, Forums were set up in each state and territory to coordinate decision making and to drive improved planning and collaboration to address Aboriginal health status. Jurisdictions tailored both the Agreements and the associated Forum structures to suit their particular situations and, over time, the Forums have evolved differently across the country. States/territories and the Commonwealth were all required to report to the Australian Health Ministers' Conference on progress in implementing their respective Framework Agreements (Anderson 2004:267).

The NT Aboriginal Health Forum held its inaugural meeting in Darwin on 1–2 June 1998. Membership at that time comprised representatives of the major stakeholders: AMSANT, ATSIC, the Northern Territory Department of Health, and the Commonwealth Department of Health (including OATSIH).[2]

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2   Membership was reduced to three parties when ATSIC was disbanded in 2004/5.

By agreement, AMSANT chaired the NTAHF meetings. The NTAHF members attending the inaugural meeting included:

- AMSANT: Pat Anderson (Chair), Wes Miller, Frank Ansell
- NTH: Kevin Williams, Trish Angus
- DH/OATSIH: Michelle Capitaine (DH NT), Marion Kroon (OATSIH NT)
- ATSIC: Josie Crawshaw, John Kelly.

Throughout the period covered by this review, the NTAHF met regularly 3–4 times a year (see Appendix). During these meetings, official members of the Forum were usually accompanied by observers, advisors, experts and visitors who contributed to discussion in an advisory capacity only.

Along with the input of its numerous sub-committees, working groups and experts, the NTAHF enterprise, therefore, represented a major investment by all stakeholders in the joint planning, development and resourcing of primary health care for Aboriginal communities, particularly, but not only, for those in regional and remote NT.

Overview of NT Framework Agreements

The Framework Agreement is the key formal statement underpinning both the relationship between NTAHF members and the agreed scope of their activities.

Despite the prominence of AMSANT in advocacy at the national level for a reformed funding and planning system to address Aboriginal and Torres Strait Islander health,

the Northern Territory was the last jurisdiction to finalise its Framework Agreement. This delay occurred at least partly because the then NT Government resisted the Agreement's requirement to fund a viable community controlled umbrella body – apparently on the basis that it would constitute a duplication of services. Nevertheless, the first Northern Territory Framework Agreement (1998–2001) was eventually signed in April 1998. That first Agreement was re-signed in April 2001 and later, by mutual agreement of parties, its life was extended to 2003 (ATNS 2007).

Although the 2003 Agreement lapsed without re-signature, a further Framework Agreement was signed in April 2007, the expiry of which was dependent on the signatories agreeing (in writing) to either terminate it or substitute it for a new Agreement. It remained in force until 30 July 2015, when a new NT Framework Agreement, covering the period 2015–20, was signed.

The 2007 NT Framework Agreement

Unfortunately, a copy of the original Framework Agreement could not be located to inform this review, so the 2007 Agreement has been referred to in the preparation of this report. In its Preamble, this Agreement notes the need to address the causes of poor health through multiple avenues, across agencies and sectors of government. It acknowledges (Preamble 1.5) that the 'availability of effective and culturally secure comprehensive primary, secondary and tertiary services is fundamental to good health'. Furthermore, it identifies 'community control, adequate funding, and a skilled workforce' as critical components of the approach.

The Agreement Preamble (1.7) further notes the Parties' intention to continue with foundational work begun under previous Agreements:

A key achievement of the Parties to the Agreement is the adoption of a set of services that constitute core services for Aboriginal comprehensive primary health care for the health sector in the Northern Territory (Attachment A) and a concomitant set of core performance indicators (Attachment B). This platform of core services for comprehensive primary health care and the corresponding performance indicators will continue to be implemented and further developed during the term of this Agreement.

The principal objective of the Agreement (3.1) is 'the achievement of sustainable and equitable health outcomes of Aboriginal and Torres Strait Islander people of NT'. A list of contextual papers (2.1) includes national policy documents as well as work commissioned by AMSANT before the existence of the Forum – the Central Australian Health Planning Study 1997 and the complementary Top End Health Planning Study 2000.

Evolution of the NTAHF

We have identified five phases in the evolution of the NTAHF (see Table 1) as follows:

1. Getting established (1998–2003)
2. Reviewing and re-shaping (2003–04)
3. Scaffolding for PHC reform (2005–07)
4. Large-scale PHC reforms (2007–11)
5. Challenges in uncertain times (2011–14).[3]

The duration of each phase is indicative only; some large-scale NTAHF activities or programs carried over two, or even three of these phases. For example, the Primary Health Care Access Program (PHCAP) was a significant focus of NTAHF business from the time of its announcement by the Commonwealth in 1999 through to early 2005 when the focus turned instead to the related issue of agreement on how to transition PHC services to a community controlled structure.

Table 1: Summary of phases in the evolution of the NT Aboriginal Health Forum, 1998–2014 (based on analysis of NTAHF Papers 1998–2013 and interviews with participants)

Phase and approximate duration	Phase characterised by	Some specific activities/projects of period
Getting established (1998–2003)	• Relationship building • New thinking, mutual benefit • NT-wide situation descriptions • Emphasis on equity • Optimism	• AMSANT takes on secretariat role of NTAHF • Field-based mapping of PHC services across NT (2 PlanHealth studies) • Defining socially coherent regional PHC delivery areas/zones • Increased PHC funds negotiated through accessing Medicare • PHCAP • Development of allocation formulas to deliver improved funding equity • Development of PHC performance reporting system
Reviewing and re-shaping (2003–04)	• Reflection • focus on NTAHF processes • adjustments • re-commitment	• NTAHF review and restructure • NTAHF business plans; practice principles • Loss of NTAHF member [when] ATSIC disbanded • Frustrations with PHCAP's slow progress • Development of Universal Performance Indicators (UPIs)

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3 Note that this phase is outside the scope of this historical review. The activities of the Forum during this period are addressed in the NTAHF case study in the main report of this project (Dwyer et al. 2015).

Table 1 cont...

Phase and approximate duration	Phase characterised by	Some specific activities/projects of period
Scaffolding for PHC reform (2005–07)	• Developing formally agreed positions on underpinning frameworks for NT-wide PHC reform • Focus on ACCHO governance capacity • High levels of collaboration	• Collaborative development of UPIs (became NT Aboriginal Health Key Performance Indicators or AHKPIs) • Framework Agreement signed off • Begin process to describe formally transitioning to Aboriginal Community Control (Pathways document) • Description of Agreed Core Functions for PHC services • Responding to upcoming local government reforms – creation of super-shires, loss of all local community councils
Large-scale PHC reforms (2007–11)	• Large-scale reform of NT PHC • Explosive increase in funds, personnel • Optimism • Very high level of activity	• Negotiating increased PHC access in response to Northern Territory Emergency Response • Expanded Health Services Development Initiative (EHSDI) through big increase in Commonwealth funds • PHC Regionalisation Program and process established • AMSANT increases staff and takes lead role in regional consultations • Updated PHC core functions agreed • 3 regions moving towards new regional structures
Challenges in uncertain times (2011–13)	• Challenging circumstances • Funding withdrawals • Perceptions of failure • Recrimination • Uncertainty • Loss of key foundational figures • Deteriorating relationships	• High-level evaluation of EHSDI reveals some problems with process and NTAHF approaches; remedies suggested, not taken up • AMSANT loses lead role in Regionalisation Program for NTAHF • The Senior Officers Group is established – ambiguous position in relation to NTAHF • 2 Final Regionalisation proposals submitted but stalled • 4 Health Service Delivery Areas (HSDAs) attempting to begin Regionalisation – stalled • NTAHF meetings irregular; lack of dedicated secretariat • Commonwealth and states drastically cut funds • NT Government undertakes major health services restructure

Getting established (1998–2003)

Following the signing of the Framework Agreement in April 1998, the NTAHF met in June, August and November of that year. AMSANT (itself only established in October 1994) provided the secretariat for the Forum, with funding for this purpose from NTH. The core business of the NTAHF was agreed and two sub-committees established – the already active Central Australia Regional Indigenous Health Planning Committee (CARIHPC) and a comparable Top End body, the Top End Regional Indigenous Health Planning Committee (TERIHPC).

Establishing relationships

It was a new way of doing business and required a different kind of commitment:

> We set up the Forum to enable all of the main stakeholders to get together to discuss and do some sort of co-ordinated approach to primary health care delivery to Aboriginal people… It was new for everybody to sit down at the one table and talk openly about challenges and issues so it was a very tentative beginning… but nevertheless people still came, including the NT Health Department. OATSIH played a very positive role in the beginning – Helen Evans was heading up OATSIH and she actually made this all happen; but locally we [also] had a really good head of [DH]... (AMSANT representative 106)

Given the often-difficult relations at that time particularly between the ACCHO sector and NTH (CAAC 1997), individuals had a crucial role in creating a space where collaboration was possible. As one participant observed, over time, productive institutional relations within the NTAHF emerged from improved interpersonal relationships:

> This interpersonal trust was the interesting springboard that invested institutional trust in the Forum and – little bit by little bit – in the institutions that were members of it; I think it got to the stage where inside Forum… actors [members] trusted the institution of the Forum but we hadn't completely gotten to the stage where actors trusted the institutions that were members of it, if you follow what I mean? (Government representative 120)

There were two important contextual factors that contributed to a sense of energy and optimism during this period. First, three new regional Aboriginal community controlled health services were established – Katherine West Health Board, Sunrise Health Service and Tiwi Health Board – under Coordinated Care Trial (CCT) funding. This national program, initially running from 1997 to 2000 with a second round from 2002 to 2005, trialled new ways of coordinating care for people with complex and chronic conditions. Second, the election of a Labor government in the Northern Territory in 2001 after 27 years of Country Liberal Party rule, brought a period of optimism in relation to Aboriginal affairs in general, and an increased investment in the health system.

Primary Health Care Access Program

The problem of access to primary health care services in regional and remote areas had been a pressing issue for many years and, unsurprisingly, was on the agenda of the first NTAHF meeting in 1998. AMSANT tabled the OATSIH-funded, ground-breaking 1997 study by Bartlett et al. (1997) into the state of Indigenous primary health care across Central Australia. For the first time this study, based on field mapping, enabled a comparison of relative levels of services and of funding across the Centre. It proposed the creation of culturally and socially coherent regions that could potentially form the basis of regional PHC service networks. The NTAHF then commissioned a comparable study for the Top End of NT (Mtg#2 Aug. 1998), which was completed in early 2000 (Bartlett & Duncan 2000). These studies provided the necessary framework for a needs-based planning approach to health services development (AMSANT 1999).

Following consideration of a position paper, *Possible Funding Arrangements for the Development of Aboriginal Primary Health Care Services* tabled by AMSANT (Mtg#4 Feb. 1999), NTAHF members collaborated on a detailed submission to the Commonwealth. In this they successfully argued for access to mainstream health funds through a Medicare 'cash out' arrangement, including agreed weightings to address geographic remoteness and the higher levels of ill-health among Indigenous Australians.

In the 1999/2000 Budget, the Commonwealth announced its intention to meet the health needs of Indigenous people more effectively through the PHCAP by:

- providing $78.8 million over four years to improve access to comprehensive primary health care

- funding regional planning through Framework Agreement structures to identify areas of greatest need

- continuing funding to existing Coordinated Care Trials and their evaluations.

The injection of new money through PHCAP, the direction of national policies and the expanding scope of work were all seen as beneficial, and promoted optimism within, and about, the NTAHF. Participants spoke positively of the achievements of the period:

> It was difficult, slow and tedious but there were enough committed people – and some intellectual capacity – from each of the partners that enabled it to happen. It was the best show in town, the only show in town! (AMSANT staff member 103)

And there was a sense that, especially from the time of the PHCAP program, the NTAHF was playing a leading role in national policy developments as well as in setting an agenda of reform in the Territory:

> PHCAP increased Commonwealth funding but it was also about reforming the system – joint planning, quality improvement, moving to community control… the NT [understood]

> that PHCAP was not just about increased funds but was about reforming the health system. (ACCHO staff member 109)

Definition of core PHC functions: Early work

The Forum also initiated work to specify the suite of services and/or activities that would constitute comprehensive primary health care under a holistic definition; that is, to answer the question, What do primary health care services actually need to provide to improve health? This was another dimension of the overall effort to understand and measure relative health care need more effectively in the NT regions. As a beginning, AMSANT tabled a two-page, dot-point description titled *Aboriginal Primary Health Care: Core Functions* (Mtg#3 Nov. 1998). It listed a number of items under three categories – Clinical Services, Support Services and Special Programs. Defining and refining the core functions of PHC remained a key strategic project for the NTAHF throughout the period documented in this review.

Engagement in research

Prior to the establishment of the Forum, in 1997 several NTAHF members also became founding partners in the first Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH), funded for seven years through the national Cooperative Research Centre (CRC) program of the then Department of Education, Science and Technology.

The two largest Northern Territory ACCHOs (Danila Dilba Medical Service and Central Australian Aboriginal Congress) represented the sector on the Board of the CRC, along with four other partners: NT Health Department, Menzies School of Health Research, NT University and Flinders University. Crucially this new research body had as its first principle of management 'a commitment to Aboriginal control of the CRC', and an explicit intention to undertake research that was 'in accordance with Aboriginal priorities as expressed through the Board' (CRCATH 1998:8). With its emphasis on community control

and Aboriginal priorities, the CRCATH provided significant additional strategic and research capacity that was seen by stakeholders both to be useful to the NTAHF, and to have bolstered the influence of the ACCHOs.

Early in its life, the NTAHF identified the evaluation of health services performance as a key development issue, and something the CRCATH could assist with (Mtg#14 Nov. 2001). During this early period (2002/3) the CRCATH funded a major research project to develop an agreed performance reporting system, which was to be used initially by the health boards that were expected to be established within the PHCAP health zones, and later, it was hoped, by all NT health services. The CRCATH report by Gollow for the NTAHF, completed in 2003, included an expanded, and most importantly agreed, definition of the core functions of Aboriginal comprehensive PHC. The NTAHF partners enthusiastically picked up the concept of indicator-based reporting as an essential bench-marking tool, and OATSIH funded a further round of work (Mtg#25 Sept. 2004). However, Gollow notes that at the time of writing 'none of the Health Boards in Central Australia proposed under the PHCAP funding were yet available for consultation' (Gollow 2003).

Emerging concerns about lack of progress

Despite the initial energy and enthusiasm generated by the Forum itself, its early successful initiatives and particularly its work on the PHCAP program, by 2002 the NTAHF was regularly debating a perceived lack of progress 'on the ground', especially when it came to establishing new PHCAP-funded services. Some of this lack of progress was blamed on NTAHF internal processes (see next section) but there were also emerging issues of significant disagreement between the partners. In particular, the unresolved financial difficulties of the Tiwi Health Board (funded through the CCT) in 2003, which ultimately led to the service being re-absorbed into the NT Health Department, was a major setback, particularly in the thinking of funding agencies. The early period of optimism was coming to an end.

Reviewing and re-shaping (2003–04)

Following the highly critical 1994 evaluation of the first (1989) *National Aboriginal Health Strategy* (National Aboriginal Health Strategy Evaluation Committee 1994), and the equally negative findings of the 1997 House of Representatives *Enquiry into Indigenous Health, published as the report Health is Life* (2000), the Commonwealth undertook to develop a revised national approach to Aboriginal health. This culminated in the endorsement (in July 2003) of a *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003–2013) (NATSIHC 2003). The Framework was seen as providing a more detailed set of strategies for actions agreed to within the various Framework Agreements (Anderson 2004:267).

During this period, the Commonwealth Government continued with some important initiatives from the earlier period, in particular the PHCAP, the Coordinated Care Trials Program and the development of regional health plans in accordance with the provisions of the Partnership Agreements. Each of these initiatives continued to have particular significance for the Northern Territory Aboriginal Health Forum.

Robinson Walden Review

By the end of 2002, the NTAHF had evolved into a complex structure of sub-committees, working parties and the like (Mtg#18 Dec. 2002). Each element was established as a mirror image of the NTAHF itself, in that each of the four stakeholder members needed to be represented. Under the auspice of the Forum there were:

- Two regional planning committees covering Central Australia (CARIHPC) and the Top End (TERIHPC), and, reporting to them, various action groups including Eye Health, PHC, Substance Misuse and Sexual Health

- Two standing committees (PHC and Preventable Chronic Disease and Social Determinants)

- Six working parties (Workforce, Renal, Male Health, Ear Health, Sexual Health, and Emotional/Social Well-being).

This increasing complexity was not, however, accompanied by attention to organisational processes. As a result, some members expressed concern that the NTAHF (and its committees) were not getting through the business sufficiently; for others the complexity of the processes was a barrier to Aboriginal participation in, and ownership of, the decisions being made (Mtg#18 Dec. 2002). The frustrating lack of progress with PHCAP also led to reflections on whether NTAHF's own processes and approaches were part of the problem, with the senior NTH representative voicing a concern that 'a lot of money is spent on planning and process and not on service delivery' (Mtg#19 April 2003). While others could agree with this, solutions were not immediately obvious.

In an attempt to address these concerns, the NTAHF engaged Robinson Walden & Associates (2003:3) to:

> review the structure of the Northern Territory Aboriginal Health Forum (NTAHF), assist in planning and make recommendations on structures and processes that will facilitate the business of the NTAHF and inform the next Framework Agreement.

Robinson et al. observed at the outset the sense that an Aboriginal health planning bureaucracy was emerging that threatened to bog down the processes in structures and red-tape of the Forum's own making.

The review presented only two major findings in its report to the NTAHF. Firstly, that the committee structures needed simplification. Secondly, that staff below the most senior levels of the respective partner organisations (that is, below those who actually attended the Forum meetings) had little understanding of NTAHF's role, and this was limiting communication between the organisations and weakening the Forum's capacity to carry out its agreed agenda.

To address these issues, the Robinson Walden Review recommended that both regional committees be either dissolved (TERIHPC) or formally disconnected from the NTAHF (CARIHPC), and that each NTAHF partner disseminate

information on the Forum's work to its staff and incorporate this information into its operational guidelines. Both recommendations were endorsed by the NTAHF (Mtg#20 Oct. 2003). The review also prompted the establishment of a Technical Reference Group to manage the Forum's business between quarterly meetings, and a three-member Executive to meet as required (NTAHF 2004).

The review reported that the NTAHF members' wish to simplify the planning structures was 'in the context of a very clear directional shift in the overall thinking of the Forum – from that of a concentration on strategic planning to that of vigorously moving to implementation' (Robinson Walden & Associates 2003:7). However, there was little apparent attention to the degree of shared meaning of these terms, or considered analysis of what 'implementation' meant and how it might translate in the context of a Framework Agreement structure comprising four agencies with very different responsibilities, capacities and constituencies. It remained unclear whether it was fundamentally an oversight body to specify, monitor and evaluate performance, or an operational body to design and implement programs, or some amalgamation of these roles. The review led to the removal of two committees and lifted some process pressure, but the role and functions of the NTAHF remained unspecified.

Ongoing problems with PHCAP

In 2004, the Forum's minutes reveal a sense of lost momentum. There was debate and tension about the goal of allocating PHCAP funds systematically according to regional need and agreed plans rather than through submission-based funding processes, and perceptions that the Commonwealth had 'changed the rules' in relation to this critical matter (Mtg#23 April; Mtg#24 May 2004). There was criticism that NT Health was not allocating funds quickly enough (Mtg#23 April 2004) or making the right level of contribution itself (Mtg#24 May 2004). And there were disagreements about funds pooling methods and the eligibility of urban ACCHOs (Mtg#19 April 2003; Mtg#22 Feb. 2003).

Perhaps most problematic of all, however, was the perception that primary health care, despite

the PHCAP, had ceased to be a priority for the Commonwealth. In September 2004, the NTAHF resolved to write to the Commonwealth Minister for Health outlining concerns about commitment to funding for primary health care, to the community control of services, and to a higher level of engagement by the DH with the Forum in relation to these matters (Mtg#25 Sept. 2004).

Commentators at the time and subsequently have observed that the national PHCAP was underfunded from the outset (Allen + Clarke 2011:103). With hindsight, it is clear that the Northern Territory PHCAP experience – starting with its frustratingly slow progress in achieving change on the ground – presaged much of what would occur several years later when the NTAHF attempted to implement the Pathways to Community Control framework.

Continuing lack of clarity and agreement on role of NTAHF

The 2003 internal review of the NTAHF saw some structural change but essentially sidestepped the more fundamental questions. Thus, despite its best intentions the NTAHF made little progress in formally reaching agreement on its role and function. Forum Chairperson Stephanie Bell sought to resolve this at the September 2004 meeting:

> I therefore seek your strong re-affirmation of the need for the NTAHF, of your commitment to the partnership, and your support for the major goal and objectives of the Forum. The Forum remains a key entity in raising the health status of Aboriginal people to that of the rest of the Territory community.

> As we move forward to re-establishing a strong and effective Forum I suggest that there are 2 major tasks before us:-

> 1. To sign off on a new Framework Agreement on Aboriginal and Torres Strait Islander Health which will confirm previous commitments that remain relevant, but which will also reflect progress, altered circumstances and new priorities.

> 2. To develop and implement the Forum's 5-year Business Plan and endorse the annual Operational Plan as a means of progressing Forum business in a strategic and coordinated fashion. (From Chairperson's address to Mtg#25 Sept. 2004)

Nevertheless, progress on these two key issues remained painfully slow. The first NT Framework Agreement expired in June 2003, and the NTAHF unsuccessfully sought to have it extended to 2005 with a view to significantly revamping the next new Agreement (Mtg#24 May 2004). This process took almost three years with the new Agreement finally being signed in April 2007.

Meanwhile, a process to finalise a NTAHF Business Plan and a set of NTAHF Business Practice Guidelines, originally to be completed by December 2003 (Mtg#20 Oct. 2003), continued intermittently until the project finally fell from the agenda around late 2008 (Mtg#52 May 2011).

Scaffolding for reform (2005–07)

The year 2005 was marked by the loss of one of the Forum's key partners, when ATSIC was abolished in March. The period was characterised by the Aboriginal and Torres Strait Islander Social Justice Commissioner of the time, Dr Tom Calma, as one of unprecedented change. In his *Social Justice Report* of 2005 he called on Government to acknowledge the rapid rate of reform, noting further that:

> … in addition to the significant changes introduced as part of the new arrangements, Indigenous communities are facing multiple government reform processes. I'm concerned that the cumulative impact of the parallel reforms currently taking place is overwhelming some communities and individuals. (The Aboriginal and Torres Strait Islander Social Justice Commissioner 2005:104)

However, far from slowing, structural change in Aboriginal and Torres Strait Islander affairs continued relentlessly.

Early work on transition to community control

In September 2004, with continuing frustration about the lack of progress with PHCAP, and recognising the lack of agreement among members on how to move from policy to practical steps on the ground, the NTAHF began a more analytic approach to the complexity of its task (Mtg#25 Sept. 2004). Importantly, this included the question of how a community or region might successfully transition to fully managing, or at least significantly shaping, its own health services.

The meeting considered a set of 17 Capacity Indicators, which were later worked into a series of milestones against which progress towards transitioning services to community control could be assessed. These milestones were to be embedded in a Memorandum of Understanding that would provide a pathway for the transition of NTH services to community control. To support this, a concept paper, *The Transitional Arrangements of Health Services MOU*, was prepared, which outlined five different potential forms of health boards. These ranged from a 'basic' level, where a local health sub-committee is attached to the regional health services provider, through to one that holds funds and provides all regional PHC services.

This proposed method for transitioning services was the focus of considerable discussion during 2005 (Mtg#27; Mtg#28; Mtg#29; Mtg#30), but by 2006 government partners were expressing scepticism. NTH identified capability and capacity as 'standout issues' when considering the transition of their services to community control (Mtg#31 March 2006), and there was discussion about the complexities and difficulties of the process (Mtg#32 June 2006). The subsequent meeting records the Commonwealth's anxiety about ACCHO viability, noting that OATSIH had a nation-wide concern about the number of ACCHOs in financial trouble and, therefore, about the viability of the community controlled model (Mtg#33 Sept. 2006).

Development of Key Performance Indicators

Work continued on what were then termed the 'Universal Performance Indicators' for all NT PHC services to report against, and by 2005 there was an agreed set of 19 performance indicators (Mtg#28 May 2005). In 2006 a steering committee and the NTAHF Technical Reference Group developed a data collection and reporting system to be used within NTH – with Commonwealth funding. The project culminated in an operational NT-wide reporting system, the NT Aboriginal Health Key Performance Indicators (AHKPI). Along with reporting data to government, the indicators were to provide reports and feedback to communities on their data in a number of user-friendly formats.

From the outset, the Commonwealth emphasised the need to concentrate on the 12 clinical indicators (out of the total of 19), since the other domain indicators (management and support services, linkages, policy, advocacy and community involvement) had a 'less well developed evidence base' such that the 'effort and resources needed for their development is likely to detract from the commitment and energy needed to implement the initial twelve [clinical] indicators' (Letter Asst-Sec. OATSIH to Asst-Sec. NTH, Mtg#34 Nov. 2006). However, the bedding in of the (clinical) AHKPIs was successful, and in 2011 the NTAHF set a timetable for the first public report based on the accumulated AHKPI data (Mtg#53 Aug. 2011).

Planning and the need for data sharing

From its foundation, and in accordance with the mandate of the Framework Agreement, the NTAHF had focused on the planned development of a primary health care system for the Aboriginal and Torres Strait Islander people and communities of the NT. This goal was a shared one, but implementing it brought separate interests and priorities into focus as well. It also highlighted the need for the sharing of expenditure data, and for the pooling of funds from Commonwealth and NT sources.

These matters were described as major issues in 2004 (Mtg#25 Sept. 2004), and were regularly on the NTAHF agenda, not without tension.

In the 2004/05 financial year, the Commonwealth introduced the Expansion and Enhancement Program, which provided additional funding that was based more on the planned approach advocated by the NTAHF. The Program used needs-based allocation, with a formula incorporating population size, geography, potential to gain additional funding through Medicare (the Medical Benefits Schedule) and remoteness. The NTAHF was given the role of setting priorities for the distribution of the available funds under these new arrangements (Mtg#26 Dec. 2004). Technical work undertaken by the relevant NTAHF sub-committee (PHC Finance Working Group) highlighted the complication of overlapping, unclear or undetermined geographic zones, and the need to define the scope of PHC services to be weighed in the priority-setting process. However, these matters were not resolved (Mtg#31 March 2006).

At this time OATSIH, concerned about the organisational and financial viability of small, remote community controlled health services (see next section), advocated a new regional planning approach based on larger regional zones than were used for PHCAP. NTAHF members expressed urgency in clarifying zones and funding, and the Financial Reform Working Group was tasked with establishing the per capita Aboriginal primary health care funding for the current 21 PHCAP zones, and reporting back to the first NTAHF meeting in 2007 as a basis for further work (Mtg#33 Sept. 2006; Mtg#34 Nov. 2006). However, this was not achieved, presumably because of reluctance by the parties involved to share their financial data. OATSIH subsequently agreed to circulate its PHC expenditure data. NTH also undertook to circulate its data, with a disclaimer noting that the expenditure figures would not 'represent the full Departmental effort towards Aboriginal primary health care', including its capital expenditure for facilities and equipment (Mtg#35 April 2007). In June the Commonwealth announced the Northern Territory Emergency Response (NTER or the Intervention). But the need to share data, and reluctance to do so, was a continuing theme.

Governance in the ACCHO sector

The perceived vulnerability of ACCHO governance was a continuing concern within OATSIH (based on its system of categorising services that were seen to be at risk because of failure to lodge reports on time and other indicators). In 2005 OATSIH commissioned a consultant, John Mero, to develop a Northern Territory strategy for maintaining and developing governance in community controlled health and substance misuse services, a strategy aimed at their Boards and individual members as well as their managers (Aboriginal and Torres Strait Islander and non-Indigenous). Although the final report (Mero 2006) was not endorsed by the NTAHF (Mtg#33 Sept. 2006), it was considered by the Forum's Workforce Implementation Committee, which recommended establishing a multi-agency group to progress several governance issues. These included payment to Board members, guidelines for Boards, the development of an accredited governance curriculum for Boards, and a panel of accredited training providers.

In the meantime, the relevant national legislation, the *Corporations (Aboriginal and Torres Strait Islander) Act 2006* was passed, and the Office of the Registrar of Indigenous Corporations established. The NTAHF decided to seek advice and assistance from this agency on many governance issues, though significantly the Forum rejected the concept of Board member payment (Mtg#35 Feb. 2007).

Large-scale reforms begin (2007–09 and beyond)

'Close the Gap' and the Northern Territory Emergency Response

The year 2007 was a watershed one, not just for the Forum and for Aboriginal and Torres Strait Islander health in the Northern Territory, but for the history of Aboriginal and Torres Strait Islander affairs in Australia.

It started with the concept of 'Closing the Gap'. Building on an idea by Tom Calma in his 2005 *Social Justice Report* (The Aboriginal and Torres Strait Islander Social Justice Commissioner 2005), in April 2007 the National Aboriginal Community Controlled Health Organisation (NACCHO) led a coalition of stakeholders in promoting awareness of the continuing unacceptable disparity in life expectancy between Aboriginal and Torres Strait Islander people compared with other Australians. The campaign to 'Close the Gap' (in life expectancy and other measures) by 2030, also launched in April, subsequently became the foundation for a concerted national policy effort to improve Aboriginal and Torres Strait Islander health and wellbeing across the nation, including through a number of National Partnership Agreements between all Australian governments.[4]

In June 2007, the Commonwealth Government declared there to be an 'emergency' in Aboriginal affairs in the Northern Territory, ostensibly in response to the findings of an inquiry into child sexual abuse in the NT (Anderson & Wild 2007). Under legislation passed in August (*Northern Territory Emergency Response Act 2007*), the Commonwealth exercised its powers to override the NT Government and introduced measures aimed at addressing child abuse, neglect and ill health in 73 prescribed areas covering much of the jurisdiction.

The NTER (or 'Intervention') was initiated without consultation with either the affected communities or the NT Government. Many of the measures – including compulsory child health checks, quarantining of welfare payments to Aboriginal people, removing Aboriginal control of entry to their lands and the suspension of the *Racial Discrimination Act 1975* – were deeply divisive, and remained so throughout this period and beyond (see, for example, Anderson 2009). Initial opposition centred on the ethical and technical aspects of the proposed compulsory child health examinations for sexual abuse (Allen + Clarke 2011:41), which were never implemented.

The impact of the Commonwealth Intervention was immediate and dramatic as, apparently, was intended.

> The speed and size of the intervention were seen as important influence[s] on the approach taken… so that it would, in the words of one government official, 'radically change the direction of Commonwealth/state relations, the approach of the last 40 years, and surprise and overwhelm the system to set a new direction'. (Allen + Clarke 2011:39)

The effects of the Intervention on Indigenous communities throughout the NT can hardly be overstated. The NTER also represented a very public vote of 'no-confidence' in the NT Government: 'a number of government officials… put forward the view that the NT Government did not have the skills or competency to manage the situation effectively' (Allen + Clarke 2011:39).

The NTER as opportunity

Despite the controversy surrounding many of its seemingly unrelated measures, the NTER was also accompanied by unprecedented increases in funding and personnel, providing an opportunity for the Forum to move on the stalled progress of primary health care reform.

The strong, well-founded opposition by the NT health sector to compulsory child health

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4   Government programs use the title 'Closing the Gap', and the sector/NGO campaign the title 'Close the Gap'.

checks had created a situation where, in return for the sector's support and involvement, the Commonwealth was prepared to make substantial alterations to the health package attached to the NTER (Allen + Clarke 2011:43). AMSANT – with support from the NTAHF – played a leading role in convincing the then Minister for Health (Tony Abbott) that the way forward was 'an improved primary health care system that can sustainably and routinely deliver better health care for children' (Boffa et al. 2007). It argued that the NTAHF was not only the appropriate body to manage the task, but was well positioned through the work it had already completed. Within a few weeks of the announcement of the Intervention, the NTAHF had put a proposal to the Commonwealth for a fully funded and sustainable solution to the 'Child Health Emergency' that included the establishment of a PHC Zone Planning Unit auspiced by the Forum (Mtg#36 July 2007).

In this way, the NTAHF set out to ensure that the funded programs proposed by the Commonwealth were fitted within the trajectory of the Forum's existing agenda, to build the scaffolding to support systematic reform – as well as expansion – of the PHC system in the NT. Nevertheless, there was a sense among some that the sudden flood of resources had substantially increased the pressure on the Forum. As one AMSANT representative reflected, it was not really a credible option to say, 'No, we're not taking your money because we philosophically are opposed to what you're doing' (AMSANT representative 106). On the other hand, as the speaker went on to say:

> It's understandable that people would make some decisions that in hindsight now have kind of bound them up in a way that perhaps if the Intervention hadn't have happened they wouldn't be in that position. (AMSANT representative 106)

The Expanded Health Services Delivery Initiative

The Commonwealth's response to the need to improve PHC services in the Northern Territory, as a foundation for dealing with child and adult health, was contained in the 2008/09 Budget delivered by the newly elected Federal Labor Government. Under the Expanded Health Services Delivery Initiative or EHSDI, the Commonwealth committed $99.7 million over two years from July 2008 to expand and improve health service delivery in remote areas, with specific funding for:

- Expanding PHC services (mainly through additional staff employment)

- Developing Health Service Delivery Areas and moving service delivery in these towards community control

- Establishing the Remote Area Health Corps (recruiting short-term staff)

- Capital and infrastructure development

- The development of hub services

- Evaluation.

These objectives had been agreed between the three Forum partners outside the formal structures of the NTAHF in April 2008 (Allen + Clarke 2011:209), and the Forum was formally advised about them in a presentation by the DH representative at the June 2008 meeting (Mtg#40 June 2008). This included advice that high-level strategic direction would be provided by a CEOs' group, which would take over the existing collaborative approach previously used by the Forum.

There was considerable discussion of how the governance of the EHSDI initiative and other NTER-related activities would link in with NTAHF, and concern that key items such as the formula for funding allocations and the delineation of regions were now being decided elsewhere (Mtg#40 June 2008). Although the reasons are not documented it seems that this discussion, and the value of the NTAHF as a

platform for detailed work on implementation, were influential. In September, governance and management of the EHSDI program was formally handed over to NTAHF (Mtg#41 Sept. 2008) and the CEOs' group apparently ceased to meet, but was not formally disbanded.

To lead the implementation of the EHSDI program, the NTAHF established the Primary Health Reform Group (PHRG) as a sub-committee with formal Terms of Reference and protocols (Mtg#41 Sept. 2008). To support this initiative, OATSIH provided a senior officer to chair this group and to expedite decision making. The PHRG was also able to establish and monitor collaborative working groups, planning committees and consultancies. However, this major development was not without tension between the NTAHF partners. AMSANT voiced its concerns over funding decisions and, more broadly, the relationship between the Forum, PHRG and the CEOs' group (Mtg#44 April 2009). Questions of authority and control were to remain active concerns throughout the life of EHSDI and of PHRG (Allen + Clarke 2009).

But by 2009, the NTAHF had agreed to the following eight EHSDI program goals (Allen + Clarke 2011:209,22), which clearly positioned the EHSDI initiative within the broader reform objectives of the NTAHF.

1. To increase access by Aboriginal people to core PHC services.

2. To establish agreed HSDAs as a basis for more sustainable services.

3. To improve PHC service coordination and integration through (a) developing and delivering against a coordinated service delivery plan in each HSDA; and (b) moving towards integrating existing service delivery to a single health service provider in each HSDA.

4. To increase the uptake of quality improvement activities (clinical, governance, management and workforce) across the PHC sector.

5. To raise the number of Aboriginal people involved in the delivery, management and control of PHC services at a range of levels.

6. To increase the involvement of Aboriginal communities in health decision making following the principles of the Pathways to Community Control framework.

7. To allocate resources equitably and efficiently to support service expansion in line with agreed priorities.

8. To include the effectiveness of, and progress towards, the program goals in the evaluation of the EHSDI.

The wisdom and effectiveness of this strategy was endorsed in the Commonwealth's evaluation of EHSDI undertaken by New Zealand consulting firm Allen + Clarke, which contrasted the relative success of EHSDI with the other major health program, the Child Health Checks (Allen + Clarke 2011:22). Unfortunately the release of their final report in March 2011 coincided with the departure of a number of key government players. The NTAHF received a formal briefing on the draft of the final report (Mtg#49 Oct. 2010) but no discussion was recorded.

Development of Pathways to Community Control

In parallel to the momentous changes set in train by the NTER, the Forum continued work on a key policy document setting out an agreed meaning for the concept of community control, along with potential pathways to transition government-run health services to Aboriginal community control. This work had commenced much earlier (in 2005 – see Section above) in relation to the PHCAP program, but the NTER gave it an impetus and urgency. As a result, much of the substantive work was carried out from 2007 onwards, with increasing pressure to get it finished (Mtg#38 Nov. 2007).

The final document, now called Pathways to Community Control, was endorsed by the NTAHF at its meeting of September 2008 (Mtg#41 Sept. 2008), but it was another year before the framework was publicly launched in December 2009. The content and process of implementing this critical agreement is documented in detail in the NTAHF case study that forms part of our main report (Dwyer et al. 2015).

Pathways to Community Control became the key policy document that underpinned subsequent attempts to transition whole regions of the primary health care system to community control. As two public servants and one AMSANT leader explained:

> [It was] signed off by all the partners of Forum and underpinned everything that the Forum did. (Government staff member 105)

> I know it was a long, tortuous process in the development. That was a really important document for Forum and a very important document for PHRG; it was used quite actively by PHRG in terms of the development of the reform process and… with regionalisation. (Government staff member 108)

> First of all it was a document that promoted what the partners at the Forum had agreed to in terms of the regionalisation process. And I think that was important so there was no misunderstanding across not just the partners but the staff who work in the three partners… And [compared to the Regionalisation guides] the community Pathways document was at a language level that… the community could see that they are also equally important in the process. (AMSANT representative 104)

Conclusion

The period from 2010 to 2014 is documented in detail in the main report from the project (Dwyer et al. 2015). Thus, we conclude this historical review with a brief update on subsequent events, and an analysis of the NTAHF record of achievements and difficulties from its inception in 1998.

What happened to Pathways/Regionalisation?[5]

The final Allen + Clarke (2011:28) report summarised the situation in late 2010 in the following words:

> [T]he Regionalisation component of EHSDI has been under-scoped and under-resourced and… the partners' roles in the process have not always been clear… the reform is on the right track, but the process needs to be reinvigorated.

The report's seven key findings were largely positive about the existing NTAHF structures and processes, the AHKPIs, the commendable partnerships that were in place, and the more equitable distribution of increased funding. While the NTAHF itself was in difficulty, some of its initiatives continued to operate well throughout this period, including work on the AHKPIs and continuous quality improvement (CQI).

Speaking in 2013 a participant noted:

> … So that is happening and we've had a number of collaboratives [workshops] which usually occur twice yearly, one in Alice and one in Darwin… since 2010 – they [staff of NTAHF partners] continue to meet… so the KPI groups continue to meet and the CQI process is continuing. (Government staff member 108)

On the other hand, the authors found insufficient policy capacity in the NT for the complex tasks involved in Pathways/Regionalisation (Allen + Clarke 2011:8–9). There were 17 recommendations to 'support the development of a PHC system that can meet the needs of remote Aboriginal communities' (Allen + Clarke 2011:44–7), on the assumption that the Pathways/Regionalisation Program would continue, and offering suggestions as to how it could be re-invigorated, how NTAHF could be more effective and how further value can be drawn from the work already undertaken by the NTAHF.[6] As documented in the NTAHF case study that forms part of our main report (Dwyer et al. 2015), the Forum's leadership of the Pathways/Regionalisation Program effectively stopped in 2012/13, although sporadic work continued in some regions. At the time of writing, work has recommenced under the auspices of the Forum and within a new NT Framework Agreement.

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5   As is the way when concepts are contested, the new term 'regionalisation' came to be used to describe the planned changes. Presumably, this term was intended to de-emphasise the community control aspect of 'pathways'.

6   We found no formal response to the Evaluation either by DH/OATSIH (the commissioning agency), the NTAHF or its partners AMSANT and NTH. The total cost was in the vicinity of $700,000.

Frameworks and forums: A positive development?

As early as 1998 (when the NT Framework Agreement was still awaiting signature) the Australian National Audit Office in a review of Commonwealth Aboriginal and Torres Strait Islander Health programs described the Framework Agreements as lacking:

> any detail committing the parties to undertake specific action, provide a level of funding or achieve quantifiable outcomes within an agreed timeframe. Furthermore there is no recourse for DHAC [DoHA] where States and Territories do not comply with the requirements of the Agreements. (Auditor-General 1998:96)

Having noted these observations, the House of Representatives Standing Committee Inquiry into Indigenous Health also concluded:

> while the Commonwealth has tried to ensure some consistency in its arrangements with the States and Territories it has failed to ensure real compliance. (House of Representatives 2000:26)

NACCHO, reporting in 1999 on its evaluation of the Framework Agreements model, observed that there had been improved inter-sectoral collaboration in several jurisdictions, progress on regional health plans and some improvement in resources to ACCHOs. However, it also observed that decision making regularly by-passed the Forum structure, there was no capacity to require accountability, funding remained well below need and, perhaps most significant of all, the community controlled sector was unable to be an equal participant in the partnerships due to capacity and information barriers (NACCHO 1999).

Nevertheless hopes were high, especially in the ACCHO sector, with the Framework Agreements described by the Central Australian Aboriginal Congress as:

> One of the most important things undertaken by the Commonwealth Department since it accepted responsibility [back from ATSIC] for Aboriginal and Torres Strait Islander health… and are essential for unravelling the 'bureaucratic maze' that has grown up around Aboriginal health administration. (CAAC 1997)

Seven years later, Anderson (2004:271) noted the limitation of such a jurisdictionally based approach to Framework Agreements compared with developing a 'whole-of-government' decision-making approach capable of better addressing the multi-causal nature of Aboriginal and Torres Strait Islander ill-health. The lack of a dedicated funding allocation also weakened the Framework program and led to less oversight and/or interest from central agencies. However, Anderson emphasised that the distinction of these Agreements was their *direct engagement of Aboriginal community stakeholders* facilitating their inclusion in joint planning. He concluded that:

> One of the fundamental achievements of the Framework Agreements is that they have set the foundations for structured and formal partnership arrangements, at the national and state/territory level. (Anderson 2004:271)

There has been no further evaluation of the Framework Agreements model or analysis of its outcomes in the intervening 10 years, nor has reporting (as intended) against these Agreements been consistent. We have only been able to locate one finalised jurisdictional report (2000–02), although the NTAHF records do document recurrent requests from various parties and intentions to complete these reports.

Significance of the NTAHF

Most participants commented positively on the significance of NTAHF – that it was often difficult, but ultimately contributed to significant and enduring achievements.

> I think it's been very significant… It's a bit like democracy, you know, it's not perfect but it's as good as it gets… with all its imperfections there was some very

valuable work that went on there and some achievements that came out of it. (Government representative 110)

I think the benefit has been that the expertise of people attending allows that kind of robust debate. I think the robust debate and discussion then move towards a policy framework that then leads to health system changes. I think it's been an outstanding position that this Forum has been able to establish. (AMSANT representative 104)

Pragmatically, it was also seen as the best option going:

It goes to that question about 100 per cent of nothing or 60 per cent of something! And the pragmatic political smarts of people around the table on all sides came down on the side of 60 per cent of something – that you were in this for the long haul. (Government representative 120)

Participants identified a wide range of projects, policies and activities as evidence of the significance of the NTAHF.

A shared commitment among partners

The establishment of the Forum in 1998 created a structure in which planning for Aboriginal health in the Northern Territory could be achieved, and ushered in a period that, although it had its tensions, was founded on principles of collaborative decision making among the key policy, funding and service delivery agencies. Ending a long period marked by conflict, it crucially established a space where the parties got to know each other and could develop relationships of greater trust. Participants agreed on the importance of establishing those relationships in a safe environment:

I think there was a genuine attempt and I think everybody kind of wanted to get as much money as we could into the Territory – we knew that we needed to do a bit

more planning around that, of where it was going to go and what were the expected outcomes and all of that. It was very energetic in terms of people all working together. We didn't all like each other; we had lots of tense meetings for all kinds of reasons. (AMSANT representative 106)

Look, I think the strength of it is – and this is why I personally believe it made huge inroads or significant gains in the Northern Territory – because we have a structure and a framework such as Forum that brings together all the key stakeholders, service deliverers and policy makers, the Aboriginal health leadership here in the Northern Territory sitting around the table and discussing – from policy development, design of service delivery or program delivery, reviewing, evaluating all the data and the KPIs... all that sort of stuff is tabled at a place called Forum and everybody, each key stakeholder, gets an opportunity to have their input. (AMSANT staff member 114)

And as a senior public servant explained:

I don't think people could overestimate – particularly in that period – the significance or importance of it [NTAHF]… The Forum in the Territory, in my view, had moved beyond the arguments about positional dogma and moved to the point of actually talking about the things that mattered; that was its significance and its importance. It was, in some ways, a more honest engagement in the issues than occurred either in the Department or, I think, in the community sector by themselves. (Government representative 120)

These relationships were further strengthened by recognition of the deep knowledge of primary health care service delivery held by those around the table:

… the players were close to the actual delivery of services on the ground and knew the Territory, literally and figuratively, very well. That was very valuable for

OATSIH, in particular OATSIH Canberra, to actually hear directly from people that were much closer to the coalface of service delivery. (Government representative 110)

Commitment to equitable funding principles

From the beginning, and consistently throughout its activities, NTAHF worked to establish several processes for rational funding allocation based on shared principles of equitable funding and objectively measured need. In contrast with earlier approaches, funding allocations were intended to be both needs and evidence based, and to achieve equity across the jurisdiction with appropriate loadings for the costs of remoteness. These principles were instrumental in achieving agreed formulas for PHCAP (based on the Central Australian and Top End Planning Studies of 1997 and 2000 respectively). These formulas were then constantly under review, and were applied and further refined as new funding arrived (for example, EHSDI):

> That sort of funding allocation model was one of those invisible sort of platforms around service equity and service quality, a bit like the KPIs. The KPIs were about stewardship of the system and learning how to do things better. The funding formula, again not perfect but getting more so, and that again builds on the work and the trust that had gone on through the Forum prior to the Intervention. (Government representative 110)

Towards a definition of core services of PHC

Closely related to the commitment to equitable funding was the iterative development, beginning in the earliest days of the NTAHF, of an agreed set of core services of primary health care. Agreement on these definitions provided an agreed theoretical basis for progress, where previously there had been much conflict around competing models of PHC (broad and comprehensive versus narrow and medical). It also provided the basis

for an evidence-based approach to meeting the health needs of Aboriginal communities across the Northern Territory:

> We'd agreed a core set of services that essentially must be delivered from both government and community sector health services – a minimum set; not 'the set' but a minimum set that could be added to because of regional variations, other priorities, that sort of stuff – a core set. So we were then able to say, 'Right, which clinics, where, struggle to provide which core services? How do we then allocate these resources in order to cover those gaps?'. (Government representative 120)

Indicators for measuring progress

The development of an agreed set of indicators to measure progress and health care system performance in the Northern Territory, and as the basis for service-level CQI processes, was an achievement nominated by many participants.

> The development of a territory or state-wide system of KPIs is rare in the Australian health system. The shared NT AHKPIs are indicative of the high level of cooperation and trust between the parties, and the willingness to share information on a common platform. (Allen + Clarke 2011:106)

> That was very significant work and there would be nowhere else where you would have a forum where you could actually build up that trust between the three major partners to actually… collect that data, analyse that data and share that data with a group in a way that is seriously about stewardship of the system and learning about the weaknesses of the system. I think that the Forum provided leadership for that process and actually something that was very serious in terms of a building block of a good primary health care system. (Government representative 110)

Reforming the reforms: The NTER

The Commonwealth's Northern Territory Emergency Response, announced by the Federal Government in the lead up to the 2007 election, marked a profound shift in Aboriginal and Torres Strait Islander affairs in Australia (see pp.14–15 for more details). The process by which it was decided and the evidence upon which it was based, were (and have remained) largely unclear; even its motives, ostensibly about protecting Aboriginal children from harm, have been seriously questioned (Anderson 2009). Nevertheless, the NTER was transformative, and the Forum and its individual partners played a significant role in it. They did this, firstly, by successfully advocating for a more evidence-based and sustainable approach to improving health and, secondly, by positioning the Forum as the most competent body to shape and oversee the use of additional funds that subsequently flowed from the Commonwealth. Participants agreed:

Well the Intervention came with money. We [NTAHF] were able to make arguments through our reform ideas that you should actually not just intervene and control but you should actually fund – in health at least – you should fund reform, fund the development and expansion of Aboriginal primary health care services. That gave a real impetus to the reform ideas that we had. (AMSANT staff member 103)

Look, I think the most significant period for Forum was during – or prior to and during – the Australian Government Intervention. When it was made known to Northern Territory partners, particularly the health partners, that the government had decided to make an investment of $50m per annum to enhance and improve primary health care services in the Northern Territory the immediate question that all partners, I guess, asked was 'Well, how is this going to be divvied up?'. Now one exercise which Forum did agree to, and did achieve, was reviewing the formula. We had a formula, which actually, I might add, was designed during the old

PHCAP, the Primary Health Care Access program days, so we had that information there based on the old PHCAP regions. (AMSANT representative 113)

Pathways to community control

Prior to the existence of the Forum, policy thinking about governance structures for primary health care services in the Northern Territory tended to assume a simple dichotomy: either a service was community controlled or it was government-run. And there was open conflict as the ACCHO sector sought to have the recommendations of the National Aboriginal Health Strategy and other key documents supporting community control implemented in practice by governments that were resistant to doing so, despite having formally accepted those recommendations. In this situation, there could be little focus in policy on how to transition government services to community control.

By creating a collaborative space for all partners, the Forum allowed for the community control of health services to become a formally agreed policy goal, and for the process of transition to be thought about more systematically. Efforts to define the different models along a continuum from sole government control to full community control, and how to move along that continuum, began in 2005, culminating in the 2009 launch of the Forum document *Pathways to Community Control* (NTAHF 2009). This became the basis of the process for community control of regional health services in the NT, and participants were justly proud of the achievement:

… [T]he notion of creating a pathway to community control that both captured the aspiration of Aboriginal people around self-determination and the implications of that for health and wellbeing and for identity and all of those things – with the notion of government, the commitments of government around effective, efficient health services that provided equitably – and where accountability is held. That was a massive win, getting the Government –

and the Cabinet, the community sectors to agree, because there was give on all sides. (Government representative 120)

Limitations

The NTAHF had some significant achievements to its credit: the development of important relations of trust and the creation of a space for collaborative planning; a shared commitment to equitable funding of primary health care functions and what those functions might look like; an agreed way of measuring progress; and an agreed policy framework for the transition to community control of government-run health services. The Forum had also been instrumental in harnessing new Commonwealth funding towards sustainable and systemic improvements in health service delivery.

Despite these successes, progress was frustratingly slow, and early optimism was often replaced by tension, conflict and deadlock. Some of the key limitations of the Forum that contributed to these negative aspects of the NTAHF are outlined below.

The NTAHF had no formal authority

The shared commitment among the partners to constructive dialogue, systematic development and problem solving around the NTAHF table was partly made possible precisely because the Forum was deliberative rather than decision making. Particularly in the earlier period, the deliberative nature of the NTAHF allowed parties to range widely and supported the kind of relationship building that Forum members reported as being so significant. However, while decisions made at Forum were often carried through, this was based on the strong sense of a common purpose and the benefits of the NTAHF being effective – not because the partner organisations were actually bound by those decisions.

> … [I] think the weakness is that you have no authority to make those individual parties achieve it; that's the weakness. The Forum has no authority or delegation for

that, but that's why the importance of the representation and who comes becomes even more critical. I think some of the weaknesses were that we would sit at the table, we would have the discussions and then the challenge was to always ensure the task was followed through. (AMSANT representative 104)

> Forum being a consultative body – not a decision-making body, you know, was an issue that came up a number of times. The ability of each of the partners to take – if you call them – 'decisions' made at Forum or decisions influenced by Forum, away and ensure that their constituencies agreed and took the steps required, was not nearly as strong as the goodwill in the room at Forum at times. (Government staff member 111)

A compounding factor was the sense that the decision-making potential of the NTAHF was undermined somewhat by the irregular attendance of senior officers from some partners, especially NTH. AMSANT, in particular, felt that sending more junior personnel (rather than the CEO or senior executive) not only demonstrated a low regard for the NTAHF but also downgraded its effectiveness.

There were attempts to resolve this issue and to clarify the role and function of the Forum both during and after this period, but ultimately no solutions seem to have emerged. This may be a tension that is inevitable for Forum – its strength for the development of shared understanding and collaborative approaches may be possible because of, rather than in spite of, its lack of decision-making authority. This does not mean there are no solutions, but rather that the pathway between Forum and final decision making needs to be clarified and agreed.

The poor cousin: Power imbalance between partners

The Northern Territory ACCHO sector – although providing much of the thinking and advocacy that established the collaborative planning structures like the NTAHF – was not

in a position to enforce or even to monitor the decisions made at the Forum. From the outset, the power imbalance between the sector and the other partners in the Framework Agreement structures was identified as a significant structural weakness. Until the mid-2000s, when increased Commonwealth funding started to increase dramatically the staffing of AMSANT, the ACCHO sector had relatively little capacity to undertake analysis and drive change on the ground. As observed nationally (NACCHO 1999), decision making regularly by-passed Forum structures, there was minimal capacity to require accountability and the sector was not an equal partner in the partnership (at least partly due to capacity and information barriers):

> I think one of the issues with the Forums, wherever they were and irrespective of how they [worked] – (because in some places they didn't work at all – the NT was the gold standard… even with its issues). But it was uneven because the departments had all the power, OATSIH had all the money and AMSANT was the sort of poor cousin, you know, in terms of the power base. (AMSANT representative 106)

The role of the individual

The Northern Territory, while geographically large, has a small population of less than 250,000. Consequently, organisations tend to be small and processes relatively personal and less formalised. In this setting individual action can more directly affect outcomes, for better or worse, than in larger more complex situations. The metaphor of a 'big fish in a small pond' is often appropriate.

> Sadly, like a whole bunch of things in Aboriginal health, they rise or fall depending on the individual. Now I don't know why that's so pronounced in our area, in our environment, but if you get

somebody like Helen Evans[7] and Leonie Young[8] and what have you – things happen! Even if there's not the proper process and procedures, people like that go out of their way to make things work better and find a way through it. Like I say, a lot of the good stuff and the setting up would happen when there were those kinds of people around. (AMSANT representative 106)

This amplification of the influence of particular individuals is both a strength and a weakness. While influential, capable individuals can cut through and make things work better, when they are propping up a system or process that does not function adequately without them, they represent a potential weakness. The relative lack of policy and systemic capacity among all partners in the NT contributed to the importance of certain key individuals in the operations of the Forum. In 2000, for example, in one of three concluding observations, evaluators of the Katherine West Coordinated Care Trial remarked that the

> … achievements of the CCT have owed an inordinate debt to the sustained efforts of a number of highly committed people… Much of the effort has involved a commitment beyond the normal call of duty. In our judgement, it should not be taken for granted that, in another time and place, the same commitment would always be available. (MSHR Local Evaluation Team 2000)

A related problem was the extent to which Forum members representing the partners developed relationships and understandings that were not then shared or promoted within their own agencies. There was thus a danger that NTAHF 'agreements' were not being carried forward due to a lack of understanding or support further down the organisational line.

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7   Former head of OATSIH, until 2005.

8   State Manager, NT for DH, 2000–03.

> Trying to get the information out consistently after every Forum meeting is a feat in itself… So the people around the [NTAHF] table might all be saying all the right things, or the same things, but people then below them, around them, to the side of them, they're saying different things because it's based on what they've heard as opposed to them being involved in that conversation. So it's interpretation of messages as opposed to deliberately misleading people. (Government staff member 105)

This is a setting in which determined individuals of lesser seniority have opportunities to either assist or obstruct any undertakings made by the NTAHF.

Overload and lack of prioritisation

The work program of the Forum was large and complex, as the list of achievements above shows. This, combined with a lack of large-scale capacity in a small jurisdiction and the over-reliance on skilled individuals and their relationships, led to a real sense of overload on Forum participants, which increased exponentially in the period after the Intervention:

> Just overload and I think, you know, the size of the papers for each meeting… it was a seriously heavy sort of paper load but in a way I think that's partly to do with the Commonwealth in particular I think – because it [NTAHF] had been successful they put more and more through there… They [NTAHF] could have focused on regionalisation for a year. I'm not saying they should have but they could have – that alone could have taken their brain power. So lack of prioritisation – every so often they kept saying 'we need to look at what our role and our function is'. I think that they needed to seriously identify two or three key things and just go for it. (Government representative 110)

There was a level of burn-out of people as there were too many tasks and not enough people with relevant skills, as Allen + Clarke noted (2011).

Planned development versus funding opportunities

While the NTAHF had long agreed on the importance of allocating funding in a way that systematically and equitably addressed need, and was building a database and other systems to make that a practical possibility, the availability of funding was anything but predictable. The NTAHF frequently found itself having to set aside its commitment to determining relative need in order to make sure the NT, and the Forum, got a share of funding that was (perhaps suddenly) on the table. It was also a challenge to establish the data/evidence base needed for equitable allocation, partly because crucial aspects of the context (such as the delineation of regions) were liable to change. As Allen + Clarke (2011:44) noted, public policy processes are seldom tidy. While the ideal is for logical, evidence-informed consultative decision making, the reality is often a process of 'muddling through'.

Postscript: Renewal and future of the NTAHF

In August 2012, high-level decision-makers from the NTAHF partners participated in a teleconference to discuss its future. All parties agreed that they remained committed to the Forum and that, following the NT elections, they would meet again to review both existing agreements and the Forum's role and representation. It is not clear from subsequent meeting records (Mtg#57 Oct. 2012; Mtg#58 April 2013; Mtg#59 Aug. 2013), however, that this task was undertaken during that period. Participants interviewed at that time expressed deep concern for the future.

> Well, I think it's [NTAHF] at serious risk of disappearing altogether because really the group that needs it is the community controlled sector, is AMSANT. We need the Forum. Latterly the Territory Health doesn't need it, is not particularly inspired by it… We don't even have Forum meetings now. We're getting done over;

we're getting massacred because we don't have a partner discussion, a tripartite discussion on key Aboriginal health issues. (AMSANT staff member 103)

For it [NTAHF] not to be there now means that everyone just goes off and does their own thing and we're going to end up, you know, back to where we started, which was people doing their own thing and not getting any benefit on the ground, so it's a shame. I'm really disappointed that forum has fallen off… I'm just not sure who's around that will drive it in the way that it needs to be resurrected. (Government staff member 105)

I think it's still got to engage in planning, delivering implementing better PHC system – got to play a role in looking at all resources coming in and playing a role in how they are allocated – that's still a key role. The gains [so far] aren't lost but we won't go anywhere if we don't get back the Forum; we've got to have working groups – I think the message is really clear – Forum by itself cannot drive [implementation] – it can oversee a process. (ACCHO staff member 109)

Throughout the difficult years of 2012–14, Forum members were not ready to quit and, at the time of writing, their commitment to continuing is on a new footing. After a year in which no funding was available for Pathways/Regionalisation work, in 2014/15 NTAHF has regrouped its efforts, and in 2015 established a new Pathways to Community Control Working Group 'to progress the regionalisation process' (Scrymgour 2015:5). On 30 July 2015 a new Partnership Agreement was signed, consolidating the role of Forum for the period 2015–20.

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Appendix

Index of NTAHF meetings 1998–2013

1998				June #1	Aug #2	Nov #3
1999	Feb. #4	May #5	#6 NR			
2000	Feb. #7	May #8	#9 NR	NR 10		
2001		March #11	#12 NR		Sept. #13	Nov. #14
2002		March #15	#16 NR		Sept. #17	Dec. #18
2003		April #19			Oct. #20	Dec. #21
2004	Feb. #22	April #23	May #24		Sept. #25	Dec. #26
2005	Feb. #27	May #28	Sept. #29		Nov. #30	
2006	March #31	June #32			Sept. #33	Nov. #34
2007	Feb. #35		July #36		Aug. #37	Nov. #38
2008	Feb. #39		June #40		Sept. #41	Dec. #42
2009	Feb. #43	April #44	July #45		Oct. #46	Dec. #47
2010	March #48				Oct. #49	Dec. #50
2011	March #51	May #52	Aug. #53			Dec. #54 NR
2012	NR #55	Aug. #56	Oct. #57			
2013	April #58	Aug. #59				

NR= No Record located

Retrieved from AMSANT Files 01/35; 01/36; 01/37; and NTAHF papers

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Professor Judith Dwyer is Director of Research in the Department of Health Care Management at the Flinders University School of Medicine, and a former CEO of Southern Health Care Network in Melbourne, and of Flinders Medical Centre in Adelaide. She teaches in the Flinders' Master of Health Administration, and conducts research focused on health system governance and design, with a particular focus on Aboriginal health services. She served as a Research Program Leader for the Lowitja Institute from 2009–2014. Judith is the lead author of the popular text *Project Management in Health and Community Services*, 2nd edition.

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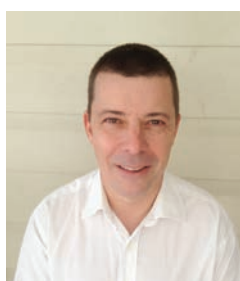
Mr Edward Tilton has more than 20 years of experience in the Aboriginal and Torres Strait Islander health field, with particular expertise in primary health care planning, community development, policy development and consultative processes. He has worked for the Aboriginal community controlled health sector at a local, jurisdictional and national level, as well as for the Northern Territory Government. He currently provides consultancy services to a wide range of Aboriginal community controlled services, government departments, and research agencies across the country, specialising in the complex and culturally diverse environments of northern and central Australia.

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