Remote Area Health Services In The Northern Territory: Matching Resources To Needs

Dr Robyn McDermott
Australian Rural Health Research Institute, Menzies School of Health Research, Alice Springs

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Abstract

One of the goals of Australia’s health care system is to achieve equity of access (according to need) with the ultimate aim of achieving statistical equality of health for all Australians. The Medicare system, which purports to increase equity by removing financial barriers at the point of service-delivery, fails in remote areas so that State and Territory are then charged with this responsibility. Services to bush people are fragile and a policy vacuum with respect to resource allocation means they are often subject to arbitrary budget cuts, resulting in great unevenness in per capita funding to communities and gross under-resourcing of services where needs are often greatest. This paper examines some of the policy and political economy issues behind remote area health care resourcing and offers some solutions.

Introduction

I’d like to introduce this talk with the work of a famous Australian epidemiologist who is virtually unknown in this country but whose work, I believe, has relevance to our discussion about Aboriginal health in remote areas. Jack Caldwell has spent his life investigating the process by which populations in poor countries achieve, or do not achieve, good health, and he has identified two conditions which are major determinants of reduced mortality. One is female autonomy and the other is a political tradition of egalitarianism and populism. (1)

It is around these two ideas that I’d like to structure this talk, and how we might think about the health of Australians who live in remote areas, as both service providers and commentators on social and health care policy. I’d like to explore one idea of how Aboriginal autonomy might find expression within a post-colonial society and also about how our notions of equity are revealed in our allocation of resources.

Egalitarianism In Australia?

When I first came to the Northern Territory in 1985 I believed, like most Australians, that I lived in an egalitarian society. I soon found this was not so, that if it was egalitarian, it was defined by its exclusions: Aborigines, women, Asians, homosexuals and so on.
I was then put in charge of an under-resourced health service and told to cut the budget by 17%. I decided this probably would not have happened in my home town of Canberra, but the whole process proceeded without a whimper (or only a few quiet ones) because it was Aboriginal bush people getting the cuts. These people are virtually invisible to the Northern Territory Government.

Resources are allocated for health care in the public sector principally through inertia, where historical budgeting processes tend to reward over-, rather than under-expenditure, and this year’s budget will resemble last year’s with minor adjustments. This mechanism tends to perpetuate existing biases toward the urban, hospital sector which will always tend to overspend, at the expense of the rural and community health sector. Other drivers of resource allocation are past investments, for example, large hospitals or diagnostic centres which may be inefficient, but have only a small margin for discretionary spending. Donor-driven (Canberra) agendas can predominate in project allocation and may be inappropriate to the local situation. One example in the Northern Territory was the Federal decision to cease the national tuberculosis campaign in the 1970s, despite continuing high incidence of the disease among Aborigines. Political voice is a powerful determinant of the direction of the health dollars, and Aboriginal health is a big loser here. As ex-Senator Graham Richardson observed, “Ignoring Aboriginal health incurs no electoral penalty”.

Economists have entered the fray by defining methods by which resources might be allocated to maximise health gains (efficiency) at the margin, although the main problem with these methods seems to be in determining the true effectiveness of most health care and which health states society might prefer over others. The final mechanism which we might consider to be operating in the allocation of health care dollars is some consideration of equity or fairness. This seems to be the most problematic in terms of definition and social consensus and is generally given a nod in policy documents but never explicitly detailed, measured or accounted for except in the general horizontal equity clause of “equal access for equal need”.

Remote Australia is very different from suburbia with respect to health care delivery. Whereas over 70% of Australians live in suburbs, less than 1% live in remote areas. These are largely Aboriginal people living in poverty and “beyond the economic frontier” with poor access to basic services of all kinds which are major determinants of health (water, sanitation, housing, transport, good food supplies etc.) Because of the fee-for-service nature of Medicare, doctors are concentrated in urban areas where income can be maximised. This results in easy accessibility and good choice of primary health care (PHC) in the towns and services largely driven by consumer demand (tending to overservice the worried well).
In remote areas, by contrast, services are supplied by Governments whose budgets are capped and subject to discretionary cutbacks in times of difficulty and there is a relative shortage of all kinds of service providers, especially doctors.\(^{(4)}\) Also, in spite of the high levels of illness among Aborigines, demand for services tends to be lower, due to lower expectations from past adverse experiences\(^{(5)}\) and cultural incompatibility between service providers and consumers. Most importantly, remote areas have only a small political voice, so that achieving “fairness” in service provision cannot be got at the polls, but must rely on other arguments, principally those of equity.

It is often said that Medicare provides equal access to health care by removing financial barriers at the point of service delivery. Clearly this fails in remote areas and we must look at alternative ways of ensuring equity of access according to need for bush people.

It is interesting in this context to look at actual expenditure juxtaposed with some need indicators for the Northern Territory in 1990/91. Despite making up only 25% of the population, Aborigines accounted for 40% of hospitalisations and 53% of hospital bed days. While the all-causes standardised mortality ratio (SMR) was 3.8, the all-causes hospital separation ratio for Aborigines was only 2.2, suggesting that Aborigines were only accessing hospitals at half the rate needed as indicated by mortality. While theoretically an increased investment in primary health care in Aboriginal communities might have reduced the incidence of illness and thereby reduced the need for hospital care, average per capita spending on PHC in Aboriginal communities (excluding transport) was $503 compared to a national average of $606 for the rest of Australia.\(^{(6,7)}\)

Getting actual expenditure data is extremely difficult and some States have poorly developed health information systems with which to measure need, especially for Aborigines. Nonetheless, a resource allocation formula which directs money to where it is really needed (as measured by SMRs) is being implemented for regions and hospitals in NSW and Queensland along the lines of the UK Resource Allocation Working Party (RAWP) formula.\(^{(8)}\)

However, in the Primary Health Care (PHC) sector, where a real difference can be made to disease incidence and therefore health outcomes, there is a policy vacuum with respect to resource allocation equity which allows the worst kinds of bureaucratic arbitrariness.\(^{(9)}\)

What is needed is a resource allocation formula for remote area PHC services which takes account of morbidity, locational disadvantage and the true cost of service delivery including realistic estimates of the person-time costs of travel. This is not a technically difficult thing to do.\(^{(10)}\)

**The importance of Aboriginal Autonomy in the production of health**

If we accept the proposition that increasing Aboriginal autonomy (in the sense of increasing the community’s locus of control) produces a health benefit (and Ernest Hunter described vividly yesterday some of the adverse health effects of policies
which remove Aboriginal autonomy), how might we know if and when it has occurred?

The clearest expression of Aboriginal self-determination in the Northern Territory since 1967 seems to me to be the movement of small groups of people back to their traditional country, the so-called homelands or ‘outstation’ movement.

In the 1991 census, the most comprehensive to date for Aboriginal people in Australia, 26,000 Northern Territory Aborigines were residing in small communities of less than 1,000 people, many of these in small outstations, averaging twenty-five persons. Comparisons between Aboriginal population distributions in 1970 and 1989 show a dramatic proliferation of these outstations, particularly in the East Arnhem and western desert areas west of Alice Springs. It appears this movement is sustained and increasing and is rooted in the strong desire of many Aborigines to escape the endemic violence and alcohol abuse of the larger settlements, increase their cultural autonomy and to strengthen the kinship networks of social control and nurture. Other benefits of outstation life include better access to hunting and bush foods (and therefore improved nutrition) caring for country, teaching children about the Land and Law, and reinforcing social bonds. These activities are health promoting, both socially, spiritually and physically.

The movement has been made possible by Land Rights legislation, the purchasing of pastoral leases for Aborigines, the creation of outstation resource centres funded by ATSIC, the spread of the Community Development and Employment Program (CDEP) to smaller communities, better access to welfare entitlements and, to a lesser extent, income from arts and crafts manufacturing and mining royalties.

The Northern Territory Government’s (NTG) response has been less than enthusiastic. In line with a general policy of “mainstreaming” of services, including health services, the NTG maintains that outstations lie beyond the economic limits of service feasibility and that it is not appropriate to cater for narrow sectional (Aboriginal) interests. This “mainstreaming” policy sees equity of servicing as providing the same services to all, and has been described as essentially a reworking of previous assimilationist policies. In 1987, the NTG announced that it would not provide services (except for water) to communities of less than fifty people.

While there is no doubt that the marginal costs of providing health services to outstations may be high (although this has not been tested except for the Urapuntja Health Service where per capita expenditure is actually lower than average), this refusal to consider outstations as a legitimate service client group reveals an unduly narrow focus for health policy, takes no account of the social production of health and no account of revealed (Aboriginal) community preferences.

Why is NTG policy apparently so antagonistic to the aspirations of Aboriginal people? Stephen Kunitz has compared the health and social histories of indigenous populations in Canada, USA, New Zealand and Australia. While the other countries have been able to reduce the gap in life expectancy between indigenous and non-indigenous people to between three and eight years, in Australia the gap remains a massive twenty years and is widening.
Kunitz argues that the major determinants of the differences in contemporary indigenous health are the different ways in which governments have dealt with indigenous peoples, and that one of the factors contributing to the better health of native Americans in the USA is the existence of one Federal agency, the Indian Health Service (IHS), with direct responsibility for Indian health.

He goes on to say that “having State Governments assume responsibility for native affairs is not unlike using a fox to guard the chickens, for State Governments have even more direct conflicts of interest over land rights than do Federal Governments”. The NTG in particular sees Northern Territory Land Rights legislation as a barrier to development, especially mining, and argues that this is a disability requiring Commonwealth compensation. This is largely forthcoming and 80% of NTG revenue is from the Commonwealth.

Kunitz also describes the clash of cultures between the States’ “development-at-all-costs” frontier paradigm and the more liberal socially progressive centralist paradigm operating in the south-east corner.

So why have we failed to improve Aboriginal health in line with other similar countries? Because, it seems neither the Commonwealth nor State and Territory Governments accept sole responsibility, and Aboriginal health remains a hostage to Federal/State rivalries and buck-passing. The recent review of the National Aboriginal Health Strategy (NAHS) found that all Governments had reneged on their expenditure commitments and the Strategy had never been effectively implemented in any State or Territory.

Why is the “political will” to resource adequately health services to Aboriginal Australians lacking in every sector? Why is all the rhetoric and political posturing not matched by money?

I think this issues raises uncomfortable questions about the myth of Australian egalitarianism. The Economist magazine recently ranked Australia as the second most inegalitarian nation among the rich countries, measured as the ratio of the income of the richest 20% to the poorest 20%. For us, this ratio is nearly 10:1. Only the USA, where the ratio is 11:1, has greater inequality.

For our health system, is the best we can say of it, that things are worse in the USA? For indigenous health, we are a long way behind them. We need to examine urgently our flawed and inadequate notions of equity in public policy. Specifically, we need clear resourcing goals for remote area health services which are transparent and enforceable.

The following actions are needed:

- That Medicare agreements are more explicit with respect to measurable equity criteria for hospital and non-hospital care.

- That State and Territory expenditure on Aboriginal health is transparent and is reported in annual financial statements.
That States and Territories develop resource allocation formulae for PHC services to rural Aboriginal communities which are adjusted for need (morbidity and mortality), locational disadvantage and the real person-time costs of travel.

References


