The National Aboriginal Health Strategy (NAHS) & the National Rural Health Strategy (NRHS) in Dialogue

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For the past five years I have been the Senior Medical Officer at Anyinginyi Congress Aboriginal Corporation, an Aboriginal Community Controlled health service in Tennant Creek. I am currently President of the Northern Territory branch of the Public Health Association of Australia (PHAA), and am an active member of the Central Australian Rural Practitioners Association (CARPA).

In the absence of Shane Houston I was asked with Mr Kenny Laughton, the Assistant Director of the Institute of Aboriginal Development in Alice Springs, to give some impromptu thoughts on the current status of the National Aboriginal Health Strategy and its implications for us as we further elucidate and develop the National Rural Health Strategy.

I won't pretend to be able to fill Shane's shoes but, after discussions with Chris George, we believe it is important that we offer this forum our views for further deliberation.

Any conference which focuses on the health and well-being of rural and remote Australians must consider the ongoing appalling health status of Aboriginal and Torres Strait Islander (ATSI) people. As you are aware, ATSI people are the most marginalised and disempowered group within Australia and form a significant proportion of the population of rural and remote Australia.

The stark reality for ATSI people is that the NAHS is not being implemented, mainly because the partnership between all levels of government and ATSI people has failed to emerge since the inception of the strategy. The abject failure by all levels of government to implement the strategy has meant that there is a massive shortfall in the funds required - estimated to be more than four billion dollars! The exact nature of the bureaucratic barriers to the implementation of the strategy should be subject to an urgent independent evaluation process.

It is important to realise that the NAHS Working Party never envisaged that one government department, such as ATSIC, would ever be able to resource the strategy alone. The only way that the resources will become available is if all government departments across different sectors, both Commonwealth and state, work together to understand the principles and implement the recommendations of the strategy whenever services are being provided which affect ATSI people.

In view of the failure of NAHS/ATSIC resources to implement major recommendations of the NAHS such as the establishment of new Aboriginal Community Controlled health services and Aboriginal Community Controlled health worker training, existing Aboriginal Community Controlled organisations must look to government departments other than ATSIC for funding.

The attitude that any program relating to ATSI people must be funded by ATSIC is destroying any possibility of resourcing the NAHS.

In this regard, Mr Kenny Laughton, the Assistant Director of the Institute of Aboriginal Development will present to you an innovative proposal to RHSET for funding for Aboriginal...
Community Controlled organisations to establish a rural health training unit focused on Aboriginal Primary Health Care in Central Australia.

This proposal gives an opportunity for Commonwealth Health to implement the recommendations of the NAHS and resource Aboriginal Community Controlled organisations - even though the RHSET program is not specifically targeted at ATSI people! This approach is fundamental if the NAHS is ever going to be implemented. It is also important for the health professionals in this forum to understand that one of the major reasons for the failure of the recommendations of the NAHS to be implemented is because different health departments are following different, often irreconcilable, models of Aboriginal health promotion. In rhetoric most departments support 'Aboriginal Community Control' and 'Aboriginal self determination' but in practice they are following their own agendas.

Firstly, the NAHS and the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) adopt a model of Aboriginal health promotion based on the principle of Aboriginal self determination. This model focuses on personal and community development in a comprehensive primary health care approach. Greater social justice for ATSI people is a major objective.

The NAHS recognises that Aboriginal Community Controlled organisations are the major expressions of Aboriginal self determination and should be supported and strengthened by all of ATSIC funds. This has not been happening. Thus, Aboriginal Community Controlled organisations in health, housing, legal issues, land issues, language and culture, child care etc are struggling for their very survival, despite the recommendations of the NAHS and RCIADIC.

The second model of health promotion has been developed under the National Better Health Program (NBHP) and has resulted in a selective primary health care approach in many instances. Funds from the Commonwealth funded NBHP are being used in ways that contradict recommendations of the NAHS and RCIADIC.

For example, under the NBHP, funds can be obtained to set up cervical cancer screening programs, but not to establish Aboriginal Community Controlled women's health services as recommended in the NAHS. Funds can be obtained to employ mobile AIDS educators who travel into and out of Aboriginal communities, but not to ensure that all Aboriginal communities have both male and female Aboriginal health workers and a basic health service infrastructure. This approach is in breach of the recommendations of the NAHS.

Thirdly, in the Northern Territory, the Health Department is following a different model again. Their model of health promotion is based on the recommendations of the CRESAP consultancy - a restructuring of the Health Department in the Northern Territory, aimed at rationalising economic resources more than improving the health status of ATSI people. This approach is leading to the Aboriginalisation of NT health instead of resourcing Aboriginal communities and their organisations. Aboriginal self determination and the recommendations of the NAHS are often not compatible with this model.

And so, even within the health sector, moneys are being spent in contradictory ways because the principles of the NAHS and RCIADIC are not being followed. If the health sector is unable to understand and implement the recommendations of the NAHS what hope do other government departments such as DEET, Lands and Housing, Transport and Communications have? This is why the resources to implement the recommendations of the NAHS can't be found.

In conclusion, to implement the NAHS and RCIADIC recommendations, all government departments must work together to ensure that any of their programmes which will impact on ATSI people are being delivered in accordance with the principle of Aboriginal self determination as expressed in the NAHS.

As we in this forum further develop the National Rural Health Strategy we must ensure that the principles of the NAHS are understood and that the NAHS recommendations are incorporated into the NRHS. The National Rural Health Alliance must ensure that we do not merely pick up
on the rhetoric of Aboriginal self determination and Aboriginal Community Control without ensuring that adequate resources flow into Aboriginal Community Controlled organisations. Too often territory and state government departments are using the rhetoric of Aboriginal Community Control as a means of siphoning off funds from commonwealth programs instead of these funds being given directly to Aboriginal Community Controlled organisations. We must not let this happen with RHSET money.