EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

BRIEFING HELD AT DARWIN
WEDNESDAY, 4 NOVEMBER 2009

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

<001> L/4

Briefing commenced at 12.03 pm

MACKINOLTY, MR CHIPS
Manager, Policy and Strategy, Aboriginal Medical Services Alliance Northern Territory,
PO Box 1624,
Darwin, Northern Territory 0801, examined:

Mr P.B. WATSON: Welcome to our inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. We appreciate your time this morning. This is just a briefing. Nothing you say can be used in a verbatim sense. We are looking at what your job is here and how you go about it, your successes and maybe some of the things that you have tried that have not worked. We want to get a better understanding of what AMSANT does.

Mr Mackinolty: AMSANT is the Aboriginal Medical Services Alliance Northern Territory. AMSANT is less of a mouthful. It was established 15 years ago. The organisation's 15th birthday is this month. It is the peak body for the Aboriginal community-controlled health organisations in the Territory. We have 12 members and 14 associate members. The full members are fully fledged, properly constituted independent organisations whose sole purpose is the delivery of comprehensive primary health care. We have a number of associate members, some of whom are working towards that status. I will get on to that in a second. Some of them will never be deliverers of primary health care as such. For example, the Western Desert dialysis group does not do primary health care but it is very much under our tent. We are hoping in the future, through constitutional changes, that we will be taking other groups on, like alcohol and other drugs groups, mental health groups and professional groups like Aboriginal health workers and Aboriginal doctors, to join as affiliate members if they choose to.

We have coverage from central Australia through to the Top End. As I said, it was established 15 years ago. We have some of the oldest community-controlled health organisations in Australia, particularly the Central Australian Aboriginal Congress in Alice Springs. Wurli Wurlinjang was also established in the 1980s in Katherine. Danila Dilba is here in Darwin. We also have two members, Katherine West Health Board and the Sunrise Health Service, both headquartered in Katherine, which came into the game via the commonwealth coordinated care trial program, which gave them resources and so on to be where they are today delivering comprehensive primary health care across that region.

Subsequent and consequent to the Northern Territory emergency response, considerably more money has now been made available through the Commonwealth, through the Office for Aboriginal and Torres Strait Islander Health into primary health care. Part of the process involves—I can email this to you; it is being launched by the Commonwealth, the Territory and us next week—having comprehensive community control, primary health care, available throughout the Territory. That will involve about 14 regions across the Territory in what we call health service delivery areas.

Mr P.B. WATSON: With this community control, who accesses the funding? Do they put in business plans for what they want to do?

Mr Mackinolty: Yes. We have to perform according to an agreed set of KPIs and so on. There is a very good report, if you want to read it, called the Overburden report, which was done out of South Australia. I could email that to you as well. The burden of some of the bureaucratic stuff is very high. For example, last year the IT people in AMSANT had to do 42 activity reports, not counting quarterly financials and so on. That was just to OATSIH alone. One organisation had to do eight

activity reports and four financial reports on a program worth less than $100 000. Clearly, something has to be done about that, especially if you are sourcing money from the Territory and the Commonwealth and maybe different departments in both jurisdictions. We are moving to work out some way around that. That would take a huge burden off public servants as well. Frankly, we prefer seeing the public servants doing their job rather than churning through paperwork for very little practical benefit. Even they acknowledge that it is very time-consuming.

Mr P.B. WATSON: What is the answer?

Mr Mackinolty: The answer to?

Mr P.B. WATSON: To too much paperwork and bureaucracy? Does an overriding body overlook it or do you just cut down the crap?

Mr Mackinolty: We would rather have funding for core services as a primary health care delivery. If you have additional funds, whether they come from AGs, FaHCSIA or whoever, those additional funds get rolled into that and there are identical reporting requirements. That is putting it very simply. In the long term the primary health care sector needs to be seen as an intrinsic part of the health system, not as some kind of add on that you have to justify. Hospitals do not have to go for annual and triennial funding all the time; it is accepted that that is a part of the system. Obviously, you have to be transparent and you are still subject to review, just the way hospitals are. No-one pretends that they are fiefdoms that can be permanently independent. I think it is changing with the National Health and Hospitals Reform Commission, which is looking at primary health care as a growing federal responsibility. Whether you agree with that or not, our primary health care needs to be seen as an intrinsic part of the system rather than as an add on or as a weird second cousin sitting out there in the scrub somewhere.

To get back to AMSANT, as well as being an advocacy organisation, we also are very much involved with establishing the patient information recall systems. That is really critical to the way we do our job, especially with chronic disease monitoring and treatment and so on. In fact, the Aboriginal control sector is far more advanced than the Department of Health and Families in remote area PIRS. We are setting up quite sophisticated satellite systems. You might have five, six, seven or eight clinics in a particular region, with people moving between those clinics, so you have access to people's patient records wherever they are. It probably did not affect you, except someone from Western Australia was responsible for it, but last year Telstra went down completely in the Territory. Almost simultaneously someone cut through a cable in Kununurra and someone cut through a cable in South Australia. The Territory was out for eight hours but our systems were still running because we have redundancies built into them. Us and the defence department were the only people that did not miss a beat. That is really critical. That feeds into e-Health stuff, which was originally called HealthConnect. It has now been rebranded. In terms of you guys, we are now finalising our link with Royal Adelaide Hospital, which is where a lot of our patients end up going but also more usefully in some ways with Kununurra District Hospital where people's records can be available at Kununurra hospital if someone from that side of the Territory goes across there. The deal with that is that they then send details back to the clinics where they have come from. We have the highest proportion of Aboriginal people signed up to e-Health in the country.

Mr P. ABETZ: How long has this been operational?

Mr Mackinolty: I remember writing the first submissions in 2000. The first enrolments would have been in about 2003-04 and well over 10,000 people are now enrolled.

[ERROR: The witness later told the Committee that he was wrong with this figure. when he gave his evidence- it was actually in excess of 33,000.]

Mr P. ABETZ: So it has been operational for a few years and it is working really well by the sound of it.

Mr Mackinolty: Yes, and more successfully than anywhere else in the country.

Mr P. ABETZ: So it is a great system.

Mr Mackinolty: Yes. It has been very complicated in terms of getting consent from people. A huge amount of work has been done in cross-cultural situations where people don't speak English as a first language and we need to work out ways to get consent and so on for records to be made available. We are moving towards people having something like a credit card which they can produce at whatever clinic or hospital they are at, which will make things even faster. My understanding is that the cards will not hold a person's records but they will be a key to those records being accessed. It might not just be the clinic in the Tanami Desert where a person lives but if that person spent some time in Katherine Hospital and ended up in Kununurra, that person could gain access. The aim in the long run would be for that to be a national system, except it seems to be slowing down a lot. We are certainly working towards being able to talk across the state borders with that.

Mr P.B. WATSON: You were talking about funding going to the communities. In one area we visited it seemed that one family would get the funding and the other family would not and they were at war with each other. Have you had that trouble in the Territory?

Mr Mackinolty: There are three reasons why all that stuff is possible and can happen and so on. Firstly, because they are going to be regional areas, it is far less likely that a particular faction or language group or whatever would come to dominate anyway. Secondly, a very high emphasis is given to governance of the organisations to have that as a continuous process, not just two or three months and then walk away from it. There has to be continual training and so on. The third safeguard is to meet the KPIs and so on. There is a very strong evidence-based approach to things. We have identified, in concert with the Territory and the Commonwealth, the key data sets that demonstrate whether you are doing a good, bad or indifferent job or if there are outlying reasons that no-one is quite aware of that are contributing to poor health in a particular region or even in a particular community. There is a really strong emphasis on accountability in that governance training. That is separate from clinical governance, which we are also very strong on in terms of what is called continuous quality improvement. That is very much based at the clinical level so that nurses, Aboriginal health workers, doctors and so on are constantly working to improve the way they go about doing things at a clinical level. That is parallel with the governance CQI.

We have had reasonably successful discussions with both the Territory and the new federal minister in moving towards backup support to health services that might be at risk. As Warren Snowdon, the new federal minister, said, by the time a file turns up on his table, it is basically a recommendation to de-fund an organisation, which is obviously fraught with a lot of problems if a health organisation is involved. We have data that shows when very small services have fallen over before, health standards have dropped quite precipitously. We need to work out a system whereby AMSANT would have the resources to monitor and help out groups that are faltering and so on. They are far more likely to falter if it is just one community health service but if it is regional, there is a much better chance of economies of scale. We define a health service delivery area as having about 3 000 people at a minimum. That works best in terms of accessing MBS and PBS moneys. Anything smaller than that starts getting dodgy in terms of having enough people around to pay for an extra doctor. Where we have had services, we have been able to put in extra doctors and extra nurses more than DHF, the state department here, has previously been able to supply. That includes supplying services to the pastoral and mining industries and, to a certain extent, the tourist trade. Some of our clinics that are on main roads that tourists go down are regularly used by tourists for basic GP-type things.

Mr P.B. WATSON: Do they have those medicine boxes?

Mr Mackinolty: Most of the big stations have those white boxes. A lot of the smaller outfits do not because the health department is naturally reluctant to stick a white box into places where there is no training and so on. In Katherine West there is a mobile service run by the Katherine West Health

Board supplying doctors and nurses and so on on a regular rotational basis to pastoral properties and so on. There were a lot of fears about that from pastoralists when the thing was being built up in the late 1990s and now they are extremely supportive of it. The same thing is happening in the Barkly, where people have been getting visits from doctors from the Aboriginal service who have never had a visit from the state service. The closest they get is Medivac. At that stage they want serious doctoring, not GPs.

Mr P.B. WATSON: With the people coming from the Western Desert and the Kimberley, does that put pressure on the Alice Springs and Darwin hospitals?

Mr Mackinolty: I will stick to dialysis because that is topical at the moment. The Western Australian health department has paid for six beds at the Darwin Hospital for dialysis patients from around Kununurra and Wyndham way. That is what we are advocating should be happening in Alice Springs. Again, I will email you some stuff we brought out in the past couple of days, including a letter to our minister suggesting that we would be happy to also write to your minister and the South Australian minister. We have identified a way of taking the pressure off in the short term by supplying nocturnal dialysis.

Mr P.B. WATSON: What is nocturnal dialysis?

Mr Mackinolty: Staying overnight for dialysis rather than doing a morning or an afternoon session. It is not pleasant but dialysis is not. You do not really sleep, I gather, under full dialysis. There are advantages in that you need fewer nurses and so on. Our approach would be for WA and South Australia to sit down together and say, "If you guys fund a place in Alice, the Territory health department would run and operate it the way it runs the beds in RDH." At the moment there are 197 people under the machine in Central Australia and there is really only capacity for 175. We have a new set-up coming online in April, which will relieve it but it is growing at the rate of about 12 per cent a year. It is all fairly stopgap. It would be far cheaper for the WA and South Australian governments to fund something in Alice Springs than it would be to do it in Perth or Kalgoorlie. Kalgoorlie is full up anyway. Some people, by accident of history, are just inside WA. We have 29 interstaters undergoing dialysis in Alice Springs, 13 from Western Australia and 16 from South Australia. Because of increased pressure, the latest thing is to not accept anyone else. With nocturnal dialysis, that should change.

We had tri-state agreements for policing. We have Western Australian police based in the Northern Territory and we have Territory police based in WA.

Mr P.B. WATSON: How has that come about?

Mr Mackinolty: That has been an agreement between the WA and Territory governments. They have been given cross-border powers, not just in hot pursuit. We have one of our coppers at Warakurna or Wingelina or somewhere like that and one of your coppers is at Kintore. There seems to be no good reason why we cannot do the same thing for health. At the moment someone at Kiwirrkurra cannot drive to Kalgoorlie, let alone to Perth. The irony is that people would have to travel from Alice Springs and then fly to Perth to get dialysis 1 500 kilometres away from their homes with no family and no-one speaking the language.

Mr I.C. BLAYNEY: How often would they have to have dialysis?

Mr Mackinolty: For hemodialysis, it is three times a week, about four hours each time. The Territory government is moving, as you have to a certain extent in WA, to get dialysis facilities closer to home. We have two beds at Kintore, which is funded by the Aboriginal community. It auctioned paintings, raised $1 million and set up the facility there. Some of your guys from Kiwirrkurra contributed paintings to raise the money. It makes the current situation even more cruel in a sense that people from Kiwirrkurra go to Alice Springs for their normal health services and stuff like that, but for this particular thing, it is off to Perth. There is also peritoneal dialysis.

Mr I.C. BLAYNEY: That would not be very suitable though.

<002> L/4

Mr Mackinolty: It is difficult because of hygiene and so on. The Kimberley has been very successful in having peritoneal patients at home. One of the models that is being looked at is to have dialysis nurses based out bush so people can live at home but get their peritoneal servicing happening at the clinic or whatever and also to move more hemodialysis out to more remote places and to train people into self-dialysing wherever possible. The real key is to find existing spaces or construct a space in the communities so that happens under the watchful eye of trained people and so on. AMSANT and one of our members, the Western Desert mob, are working closely with Baxter, which is a major supplier of PD chemicals, to work on increasing the level of home dialysis and PD available. I will give a really good example of why you would want to do that, apart from the fact that it is nicer to be at home. Western Desert trained a person to home dialyse. He is a very senior man from a desert community. When he went home—this happened about six weeks ago—it meant that 28 other people went home with him, the extended family. It freed up three housing commission places in a town where there are housing shortages. What's really needed is proper economic analysis of relative cost. The indicative stuff that we have is that dialysis at home or in a community costs roughly $70 000 a year and it will cost $250 000 a year to have people dialysed in town. It is not just the chemicals; it is the added social costs of housing and the rest of it. You guys would know—I worked here for seven years so I know too—that it is really difficult to persuade Treasury, Finance and so on that spending money now will save a lot of money in the future.

Mr P.B. WATSON: That is common sense.

Mr Mackinolty: Have you ever noticed how the guys in Treasury are not called public servants? Treasury people are always called officials. From PAs up, they suddenly transform into officials. They operate on another plane.

Mr P.B. WATSON: How does AMSANT relate to the Royal Flying Doctor Service?

Mr Mackinolty: AMSANT itself does not; we do not have a formal relationship. RFDS is an evacuation service essentially. RFDS recently received money to supply mental health workers out bush. We have problems with that because it is not its core business. It does not come from a comprehensive primary health care background. The money for that has been coming through FaHCSIA federally, which puts things out to tender. I do not think it has the expertise, frankly, to assess the stuff properly. In one case here a local community had been locally operating mental health workers for some time in a town with high suicide rates and real progress has been made. That appears to have been handed over to the RFDS. We have found a few outside groups like that have won a contract because they can do stuff cheaply and then they have turned around to get training for their staff in how to do it, which is very frustrating.

Our approach with things like mental health and stuff that you are looking at in terms of alcohol abuse and so on is that properly they should belong to a holistic comprehensive primary health care setting not as a series of silo programs. I am not sure if you aware that there is a lot of federal money to provide tobacco health workers and various other new categories of people out bush. The real danger is that they will operate as a series of silos. We are currently negotiating with DOHA to be part of integrated teams concentrating very much on family settings. It is very difficult, as you would be aware, even in a European context, to change the lifestyle and health behaviour of an individual if the rest of the family is on the grog or whatever. In the long term, success will be achieved on a level of dealing with whole families or, in another context, a whole football team sort of thing—going in as a team to do it rather than this week a guy tells you not to smoke and next week he tells you not to drink and that sort of thing. It does not work.

Mr P.B. WATSON: Just getting back to dialysis, you were saying that it goes up 12 per cent a year. Are people dying because they are not being diagnosed?

Mr Mackinolty: I am not a medico but my major advice is that the Baker Institute has just brought out figures which suggest—this would go into parts of WA as well and the Pitlands—that —Central Australia has the highest level of diabetes in the world. Something like 30 per cent of all Aboriginal people have diabetes and 50 per cent of people over the age of 50 have diabetes. We have the highest level of arm and leg amputations in the world. It is really grisly. One of the things that we are looking at and working with the Baker Institute on is earlier diagnosis, obviously, but also earlier and more aggressive treatment. That can extend by considerable lengths of time before you get to end stage renal disease. From talking to doctors in the centre, the feeling is that they have not been proactive and aggressive enough in treatment and so on.

Mr P.B. WATSON: Will it get to a stage where it will just become hereditary and people will be born with diabetes because it is so ingrained into generations?

Mr Mackinolty: I do not have the expertise. I do not think it is.

Mr I.C. BLAYNEY: It is an environmental trigger. Diet has a lot to do with it.

Mr P.B. WATSON: When we were in Tasmania, they said because of various things that happen over there, people are born with it.

Mr Mackinolty: You may have conditions that you are born with as a result of low birth weight and so on, which makes you more predisposed to any number of chronic diseases, including diabetes, but there is no evidence of it being heritable per se. Certainly, if a mother is ill-nourished and smokes and drinks, that will lead to low birth weights, which can lead to a range of problems at much earlier ages.

Mr P.B. WATSON: What is the major health challenge in the Northern Territory—alcohol or illicit drugs?

Mr Mackinolty: Alcohol by a long way.

I have not really talked about the forum. Next week we are having an alcohol workshop for our membership, which will be a major thing. As well as getting experts, we are working with our members on the kind of approaches they are taking to it. Yes, there is dope out on communities and evidence that there are increasing levels but by far alcohol is the greatest problem. We follow very strongly evidence-based things like the findings of the World Health Organization on alcohol and ways of preventing and minimising abuse. The keys to that are price, availability and policing of underage drinking. In Alice Springs we have persuaded the government to minimise the level of really cheap wine being sold. We have had quite a significant reduction in pure alcohol being drunk in Alice Springs as well as a reduction in hospital admissions and so on. The Liquor Commission is looking to extend that to Palmerston and Darwin rural. Non-Aboriginal people get really upset about it but they also get extremely upset about drunks in the street and so on. My personal argument is that if you cannot organise to get your takeaways when the takeaway is available, maybe you should look at your own drinking patterns and capabilities. If there is no takeaway until midday, so be it; you either buy enough the day before to get you through or you wait until 12 o'clock. Unfortunately, setting a floor price for the cost of alcohol is a federal power under excise and so on. The states cannot do stuff with it directly. States can control supply through opening hours.

Mr P.B. WATSON: What do you think about what has happened in the Kimberley and how you can only get low-strength alcohol in Fitzroy Crossing?

Mr Mackinolty: Similar things have been done in the Territory. We have some really fantastic stuff happening on Groote Eylandt, Yirrkala and Gove where takeaway alcohol has been banned completely or basically you have to carry a licence to drink. You can only buy low or mid-strength beer. It has had a huge impact on absolute alcohol consumption in terms of pure alcohol as well as those things like criminal behaviour, antisocial behaviour and so on. You could chase up through the Liquor Commission the stuff it has done at Groote and so on. The Liquor Commission here is of

a mind to have Territory-wide restrictions on certain kinds of alcohol, opening hours and so on. It will cause a lot of fuss. You only have to speak to the doctors who work in the hospitals who see the trauma firsthand or the paramedics who extricate people from cars and so on to really have it hit home the damage it causes everyone. There are more stab wounds per capita in Alice Springs than South Africa, but that has been going down since the new restrictions.

I want to briefly turn to the forum. You have one too. It is a tripartite thing between AMSANT and the Commonwealth and Northern Territory governments. As I said, we are signing off and launching Pathways to Community Control, which I will email to you. It meets six times a year and it involves senior people from AMSANT and the commonwealth, people who can make decisions on things. We have blues and arguments and so on but it is a very powerful setting in which a lot of these things are thrashed out. On my reading and from talking to people interstate, it is probably the most successful of the forums in the country. Sure, we have some hideous arguments sometimes but it was not possible to imagine where government and the sector would be sitting down with each other and signing off on things and, yes, having arguments about things and so on would not have been possible 10 years. It has just been a huge advance. It would be great to see things happen like are happening interstate and for them to be elevated to the same level of importance. I guess it is easy here because it is much more obvious and 30 per cent of the population are Aboriginal. It is a way for Aboriginal groups to have direct access to senior levels of public servants plus also to their ministers.

This is the second time I have been here today. We had our quarterly meeting with the health minister here and we have similar meetings with the children's services minister, likewise with the federal minister and so on. It is a really positive way of dealing with things because it leads to officer to officer stuff. If something bad is happening, we can go straight to someone in family and children's services or in the health department instead of just hitting a brick wall. It is very good for those sorts of personal relationships. Alongside that, we have developed very strong relationships with groups such as the AMA, the General Practice Network and a whole lot of groups such as the Council of Remote Area Nurses and so on, plus really good relationships with research groups such as Flinders University and the CRC here in Darwin. I worked here for six years as a ministerial adviser. I am working four times harder now.

Mr P.B. WATSON: You probably get more results where you are now.

Mr Mackinolty: It is a long haul. No-one pretends that it will be solved tomorrow but we are getting results, and it is starting to be demonstrated through the data that real things are happening out there.

Mr P.B. WATSON: We have probably learnt just as much this morning as we have the whole time we have been here. Thank you very much for coming. I think we would all agree that we have probably learnt more this morning about the issues in the Top End than we have from people a little further away from the grassroots level that you are at.

Mr Mackinolty: Our standing joke is that the most remote community in Australia is Canberra.

Mr P.B. WATSON: Thank you very much for your time.

Briefing concluded at 12.43 pm