

2013 Lowitja O'Donoghue Oration

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Healing the Fault Lines: uniting politicians, bureaucrats and NGOs for improved outcomes in Aboriginal Health.

ABSTRACT:

A little known positive aspect of the Northern Territory Intervention was a significant increase in resources to Aboriginal Comprehensive Primary Health Care. This, along with parallel initiatives under Closing the Gap, gave some hope that the decades long demands from our sector for substantial extra resources in primary health care was at last being heard. However, while we have been making some advances in the Northern Territory, we face the potential for a “race to the bottom” in Aboriginal health where the interests of politicians, bureaucrats and NGOs potentially outweigh the evidence of Aboriginal community control. Prominent Aboriginal Territorian and the current CEO of Danila Dilba Health Service, Olga Havnen argues that the “fault lines” between these groups and the Aboriginal Community Controlled Health sector must unite to make a real difference.

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Healing the Fault Lines: uniting politicians, bureaucrats and NGOs for improved outcomes in Aboriginal health

Olga Havnen, CEO, Danila Dilba Health Service, 28 May 2013

[CHECK AGAINST DELIVERY]

It is an honour and privilege to be invited to deliver this address – the 7th Lowitja O’Donoghue Oration hosted by the Don Dunstan Foundation.

I acknowledge the traditional owners – the Kurna people and thank you for your very warm welcome here today.

Dr O’Donoghue - Lowitja and Don Dunstan have shared much in common – their courage, leadership and vision for better futures and vibrant communities. Their life long commitment to justice and social change is beyond question. They are truly honourable people whose legacies will be enduring.

As is ever the case, between the asking and the giving, things change: even since supplying the Abstract for this speech, things have changed and moved on—not the least the events surrounding the Indigenous round of the Australia Football League last weekend. But then again, some things haven’t changed a bit.

In recent weeks I have been taken by an African-American phrase which I understand comes from Washington DC. It certainly has some religious overtones to it, but it goes along the lines of “to tell the truth is to shame the devil”.

And the devil that must be shamed may be many things.

The devil may be in the casual racism of a football game, and the abuse hurled at our players.

The devil may be in the *measurements* of outcomes, such as that around health, housing, education, employment, incarceration and the like.

Or the devil may be in the *consequences* of those outcomes, such as is reflected in lives that are shorter, less productive, and less happy.

And the devil, of course, is not just in the detail, but in how the detail is measured out in terms of who benefits, and those who don’t.

The truth can be a slippery concept, as the devil well knows.

For myself, the truth is grounded in my childhood and the sense of duty and obligation that has been drawn from personal experience. I was a direct beneficiary of the Whitlam policies that allowed us to go to boarding school under Abstudy and for my mother to gain access to a university education as a mature aged student. My mother—who could be a somewhat fierce woman when the mood took her—was in the 1980’s Director of the Centre for Aboriginal Studies at the Darwin Community College as it then was, and active in Aboriginal community affairs. My sister Ingrid and I were in our 20s, and mostly interested only with our social lives with little thought to tomorrow.

But for mum, tomorrow was a meeting at Bagot (a still impoverished and neglected Aboriginal community in urban Darwin) as part of establishing a combined organisations movement in the Top End. Mum had told us the night before that she expected my sister and I to attend this meeting despite our plans for a late night out – it was Saturday night after all! The next morning the old girl had a hissy fit insisting that we attend the Sunday meeting within the next ½ hr.

As you can imagine, facing the prospect of a long, all-day meeting in the middle of a hot wet season day in an un-air conditioned crowded room at Bagot was not pleasant—made even less so by the jobs she, as Committee member, delegated to us in terms of organising the next meeting. It mattered nothing to mum that we were dying from a lack of water and the over indulgences of the night before.

But for her, it was about “giving back” to a community—in the broadest sense—from which we benefited, and to which we had obligations and duties. The idea of “commitment” was ingrained in us by a mother whose passion for the community had always been paramount.

That “commitment” has—in some ways unfortunately—been something my children have had to put up with. As Lowitja may recall, for them it meant sleeping on floors in Canberra’s parliament house during the Wik Native Title debate. It was a parliamentary experience a far cry from that you might see on television. There were death threats delivered to my homes, and windows smashed in our offices. It was not good—I recognise—for our kids to go through such experiences. I wonder, sometimes, whether I have infected them with the same sort of “commitment” delivered through my mother now that my girls seem to have become what some might describe as ‘bleeding hearts’.

I must also acknowledge the long term support and dedicated commitment of many non-Aboriginal people – health professionals, lawyers, anthropologists, accountants and the many other individuals who work with us and our

organisations. Their contributions have made it possible for the Aboriginal community controlled sector to deliver much needed services across the country.

So I am now back in Darwin, and still facing the truth of a society that in many, many ways has not delivered the benefits promised at that meeting in Bagot so years ago. We still live in a community in which Aboriginal people still experience outcomes that lag far behind that of the rest of society. Perhaps a rational person would have given up a long time ago.

But I am not a rational person, and the truth remains as slippery as ever.

I am currently the CEO of Danila Dilba Health Service in Darwin, which has not long ago celebrated its 20th anniversary. We are an Aboriginal Community Controlled Health Service—and part of a broader, national movement of community controlled comprehensive primary health care that has its origins in Redfern some 42 years ago.

At the core of what we have achieved over those many years has been an aggressive approach to basing our work on evidence. Our accumulated achievements have always been based on what works—in clinical as well as social practice.

At the heart of what we have strived to achieve is the development of a practice—both clinical and social—that displays our strong and central commitment to comprehensive primary health care.

This model was codified at an international level at Alma Ata in 1978, and subsequently endorsed by the World Health Organisation (WHO) and the United Nations:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Primary health care is socially and culturally appropriate, universally accessible, scientifically sound, first level care.

It is provided by health services and systems with a suitably trained workforce comprised of multidisciplinary teams supported by integrated referral systems in a way that:

- gives priority to those most in need and addresses health inequalities;

- maximises community and individual self-reliance, participation and control and;
- involves collaboration and partnership with other sectors to promote public health.

Comprehensive primary healthcare includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation services.

So that's what we do, but how **well** do we do it?

Is **what we do** any better than, say, than the conventional primary health care services supplied by a suburban GP?

The oft-touted "Gap" between Aboriginal and non-Aboriginal health outcomes is no secret, and reflected in massive differences in life expectancy, infant mortality rates and the toll of chronic diseases. It's a story that tells—in dramatic terms—of fourth world outcomes in the midst of one of the most prosperous nations in the world.

For example, kidney disease increasingly affects all Australians—from Darwin to Hobart, from Perth to Sydney. But, it is something that affects Aboriginal people in the Northern Territory—and in the traditional lands that lie just beyond our borders—at greater rates than anywhere else in the nation. In some areas, at greater rates than anywhere internationally.

However, some recent data shows that it is possible to close the gap in Aboriginal life expectancy—indeed according to a recent COAG report "only the Northern Territory is on track to close this gap by 2031 if the trend from 1998 to 2010 continues".

The major factor that has contributed to this improvement has been a large improvement in the health system—in which the Aboriginal community controlled primary health care movement has played a major role—along with substantial increases in funding for primary health care from the Commonwealth.

There is a good news story here: there are real improvements now happening for Aboriginal people's health here in the Northern Territory, and they have been happening for over a decade.

The headline improvement is that between 1998 and 2010 there has been a massive 26 per cent decline in the Aboriginal adult mortality rate in the Northern Territory, which is a strong proxy for improved life expectancy.

At the other end of life for our people, childhood immunisation rates in the Northern Territory are among the highest in the nation, and indeed higher than in many non-Aboriginal communities.

Just to put this into context - the NT faces some unique challenges in terms of service delivery. Approximately 80% of the NT's Aboriginal population lives outside the main urban centres of Darwin, Katherine, Tennant Creek and Alice Springs. There are more than 650 discrete, geographically dispersed Aboriginal communities across the Territory.

Despite these challenges recent data from the Australian Institute for Health and Welfare, documenting the "Healthy for Life" program indicates that achievements in Aboriginal health in the Territory leads the nation—and indeed the data strongly suggests the community controlled sector is largely responsible for those advances.

That is what the *evidence* is telling us, but these improvements, as tentative as they may appear, face major obstacles.

The first is a fundamental issue—and one that is universal—and that is a consideration of the broader social determinants of health.

The second is a disturbing cultural gap between our sector, and that of the bureaucrats and politicians and non-Aboriginal NGOs that interact with Aboriginal communities and organisations. (Non government organisations / not-for-profits)

First things first.

The health gains, and apparent closing of the gap, may well prove transitory. In other words, we fear that the gains in life expectancy may well plateau in the near future. The evidence strongly suggests that health interventions can only account for about 30 per cent of differences in health outcomes unless the social determinants of health are confronted.

To quote a key document produced by the Aboriginal Peak Organisations Northern Territory—or APO NT:

The overwhelming body of evidence of the social determinants of health shows that our health and wellbeing is profoundly affected by a range of interacting economic, social and cultural factors. Key amongst these are:

- *Poverty, economic inequality and social status;*
- *Housing;*

- *Employment and job security;*
- *Social exclusion, including isolation, discrimination and racism;*
- *Education and care in early life;*
- *Food security and access to a balanced and adequate diet;*
- *Addictions, particularly to alcohol, inhalants and tobacco;*
- *Access to adequate health services; and,*
- *Control over life circumstances.*

Psychosocial factors, particularly stress and control, are critically important.

Put simply, the less control we have over our lives the more stress we experience. Stress is associated with anxiety, insecurity, low self-esteem, social isolation and disrupted work and home lives. It can increase the risk of chronic illnesses such as depression, diabetes, high cholesterol, high blood pressure, stroke and heart attack.

This evidence demonstrates that there is a social gradient of health that reflects and affects our opportunities to lead safe, healthy and productive lives for ourselves and our children.

Control is also central to a further fundamental determinant of our health and wellbeing—that of culture.

Culture is a universal aspect of human societies that gives meaning and value to individual and collective existence.

In the context of societies with dominant and minority cultures, such as Australia, the widespread and persistent suppression of minority cultural practices causes severe disruption, making our communities susceptible to trauma, collective helplessness and endemic maladaptive coping practices.

These can be passed on through the generations, as we have witnessed in relation to the processes of colonisation and past government policies such as those of the Stolen Generations.

We believe that we are also witnessing the generation of such impacts in relation to ongoing government policies, for example, the misguided, coercive approaches of the NT Intervention and Stronger Futures.

The final report of the World Health Organization Commission on the Social Determinants of Health highlighted the issues of cultural suppression and loss, social exclusion and lack of consent and control as key factors affecting

Indigenous populations.

In other words, we may be at the limit of health gains in the Territory that can be achieved by our sector alone unless we seek solutions to the social determinants of health.

And that brings me to my second point about the cultural gap between our sector, and that of the bureaucrats, politicians and non-Aboriginal NGOs that interact with Aboriginal communities and organisations.

In less than a month, we will mark the sixth anniversary of the then Federal government's Intervention into Aboriginal affairs in the Northern Territory. The Northern Territory Emergency Response, as it was known formally, has had substantial impacts on our people over that time. It's not my task here to describe the detail of the Intervention, or indeed the ways in which the emphasis of the NTER has shifted somewhat with its re-badging as *Stronger Futures*.

However, what I will point out is that the six years of the Intervention process has had profound psychological impacts on our people over a very short period.

Again, I'll make no judgement here on the NTER in itself, but make the following points.

First, the arrival of the Intervention was nothing if not dramatic, with the use of the army as a stark symbol of the determination of the national government in its actions. The army personnel involved were not armed, but it certainly engendered considerable fear and anxiety in the early weeks of the Intervention, with at least some documented episodes of people heading bush, and away from larger towns and communities. People's places of residence—from towns and communities to small outstations—were, and still remain, "prescribed areas".

Second, the NTER saw the dismantling, over a short period of time, of a significant number of Aboriginal organisations and structures which had been evolving over many years. This included bodies such Aboriginal Community Housing organisations but also the network of community government councils which were subsequently dismantled under Northern Territory Government restructuring of local government, from some 60-odd local government bodies to eight shire councils. Parallel with the abolition of these local community government bodies, many communities saw the introduction of federally appointed and controlled Government Business Managers—now billed as Government Engagement Officers.

As a footnote, the Government Business Managers—or GBMs—were soon nicknamed Ginger Bread Men by wits on communities. Their replacements are now known as Geckos.

Third, employment mechanisms—particularly through the CDEP workforce—were shattered, and now only exist in a rump form, with the current intention to have CDEP be allowed to wither away. Whatever one thinks of CDEP as a mechanism for people to engage in the labour market, it is difficult to imagine that such a move from work to welfare in a context where there is only a tiny market economy will be of benefit in the short term.

Fourth, the introduction of mandatory, universal income control and the introduction of the Basic Card—although welcomed by some welfare recipients—has nevertheless had a major impact on the ways people use and control their money.

Fifth, the NTER—ostensibly introduced in the name of child protection—effectively demonised Aboriginal men *and* women. It universally painted men as violent drunks, paedophiles and consumers of pornography, and women as passive, helpless victims.

Sixth, the introduction of alcohol controls across all prescribed areas of the Northern Territory has affected all local mechanisms—legal and informal—over alcohol control. Again, while the new controls have been welcomed in some areas—along with an increased police presence through the so-called Operation Themis—there have been unintended consequences.

Many communities had voluntary alcohol restrictions in place for years prior to the Intervention. The hundred or so locally initiated “dry areas” were abolished in favour of blanket restrictions that have driven drinkers into unsafe drinking behaviours in towns and drinking camps.

Finally, there was a substantial—thus far largely unrecorded and unremarked—impact on the working lives and careers of Aboriginal and non-Aboriginal people across many work places and professions.

Take, for example, those in the primary health care setting of regional and remote health clinics. The massive expenditure on child health checks, operationalised through doctors and nurses recruited from interstate that had no or little experience of the north, carried with it an explicit condemnation of those health professionals such as Aboriginal Health Workers and nurses who had been working in difficult and under-resourced situations—often for decades. It carried

with it the message that they had failed to detect child abuse, and failed to deliver health services to children and others in their communities. For many, the psychological impact has been devastating. In effect, they were being told that their careers had been rubbish.

And it is that final point that I wish to raise—although I see no ready solution.

The psychological impact of the NTER has gone by almost completely unnoticed and, as is the way of these things, is likely to play out its effects over many years.

It will affect many people over a long time. Given the thus far marginal benefits that many have experienced flowing from the NTER, we may yet see effects on people's emotional well being that could be deleterious. Only time will tell—and thus far I see no attempts to deal what could be looming problems for a great many people.

In other words, while considerable money is being spent—some very well, some less wisely—remarkably little attention is being paid to the emotional and social impacts of the NTER and the coming program of *Stronger Futures*. While much is made—in the corporate and public service worlds—of “change management”, we don't see much in the way of fostering change management in the Aboriginal communities and organisations so profoundly affected by the massive disruptions of the last half decade.

As I mentioned, one of the key “disruptions” of the Intervention has been to the viability of Aboriginal organisations in the Northern Territory—but this has not been an artefact of the Intervention alone.

In 1996 the Commonwealth Government dealt a half billion dollar cutback to ATSIC. The first programs to go from a male-dominated Commission were many outstation resource centres, along with Women's programs. The abolition of ATSIC itself in 2004 accelerated what APO NT in an ongoing research study has described as “the decline and decline” of Aboriginal organisations in the Northern Territory. By the time the Intervention arrived on our doorsteps, the rot had well and truly set in. While the outcomes of that research have not been finalised, the strong evidence is that the number of organisations has dropped markedly, and the capacity of remaining organisations has been dramatically compromised.

What this has meant is that, with the exception of Aboriginal health services, land management bodies and art centres, Aboriginal *community driven* service delivery has in many parts of the Northern Territory simply disappeared.

In its place—and this has accelerated dramatically under the Intervention—has been a rapid growth in the involvement of non-Aboriginal NGOs in service delivery to our people. Many millions of dollars has gone into resourcing what have been dubbed NINGOs—or Non-Indigenous NGOs—or BINGOs—or Big International NGOs.

So what has all this meant?

First, Aboriginal control of service delivery in many areas has withered on the vine. Despite jurisdictional, national and international evidence that community control over service delivery achieves better results, with control being a key element in the social determinants of health, for example, we have gone backwards.

Second, the massive expansion of NGO involvement in service delivery—often undertaken with scant or non-existent evidence bases—has added to this acceleration in decline of community capacity.

Third, and perhaps more importantly, it is a process which has allowed government agencies to quarantine themselves from what they too often ascribe as “risk” in funding Aboriginal organisations. The agency’s response has all too often been to protect themselves and their political masters by taking the apparently safe way out, and hand the resources across to the BINGOs and NINGOs, whether the programs they run are effective or not.

We are all aware of the bureaucratic and corporate mantras of “risk management” and “risk aversion”. They are not necessarily bad ideas in and of themselves, but what has developed is not just “risk aversion”, but what should be termed “the doctrine of risk intolerance”.

By this I mean that nothing is done, or can be done, that might in any way shape or form come back to haunt politicians or bureaucrats at a Senate Estimates hearing or their state and territory equivalents.

It is important that Aboriginal community controlled organizations critically review and strengthen our management and governance arrangements. We need to lead and initiate reforms that will ensure that community controlled organizations are viable, dynamic and efficient, capable of delivering the best possible services to our communities.

Which brings me back to the devil of the detail, and how the detail is measured out in terms of who benefits, and who doesn't.

A direct consequence of risk intolerance is that there can be no innovation or change, especially innovation or change that threatens the cosy relationship between governments and public servants, let alone the easy comfort of dealing with NGOs that are headquartered in the southern cities.

Risk intolerance, in fact, is a long distance from risk management—and that is where the devil in the detail lies.

The advances in delivery of Aboriginal comprehensive primary health care that I have outlined have not occurred in a climate of risk intolerance. These advances have occurred first, because they have been based on increased resources being made available to community controlled health services.

Second, they have occurred because the activities of those services have been strongly grounded in the evidence of what works well, and what does not.

And third they have occurred, because those services have developed innovative and progressive approaches across both health system design and delivery.

A key part of this, for example, has been in the development and use of Clinical Information systems. These have been used, even in our most remote services, in individual patient monitoring and recall systems, as well as the development of public health data that informs our health services in their day-to-day operations as well as in setting local, regional and jurisdictional primary health priorities. It is no accident that, as I have mentioned, that our childhood immunisation rates are among the best in the nation.

Increasingly, these data is being used at regional levels. For example, one region of the Northern Territory, in sharing data sharing data across a number of clinics, detected are worrying spike in childhood anaemia—which in turn has led to a determined focus on the condition among the kids of that region.

This small example demonstrates that our sector has fostered innovation and change. None of this would have occurred in a climate of risk intolerance—indeed the *real* risk of childhood anaemia may well have gone unnoticed, with obvious consequences. The devil really is in the detail!

So what I am calling for is a fundamental change in the relationship between Aboriginal service delivery in the Northern Territory and elsewhere, and the politicians, bureaucrats and NGOs who are involved in the process.

I am calling to heal the faultiness – the ‘tighteners’ and ‘straighteners’ and the inefficient, ineffective competitiveness that has developed between these groups. Increased monitoring, reporting and rigidity associated with grant management does not ensure better use of resources and improved accountability – it simply increases the costs of delivering the service.

In the late 1990s and early 2000s, there was a significant expansion of Aboriginal community controlled primary health care in the Northern Territory with the establishment of the Katherine West, Tiwi and Sunrise health boards. These services came about not because of Aboriginal-specific funding, but through innovative—dare I say risky—approaches contained in what were known as Coordinated Care Trials. Each of these organisations ran trials that were measurably very successful—and indeed in evaluations of the Coordinate Care Trials, were far more successful than similarly funded trials run by non-Aboriginal health services. The measure of that can be seen in that two of these health services—Katherine West and Sunrise—still prosper, and deliver high quality services to their people.

However, one service—the Tiwi Health Board—failed. It did not fail because it was not delivering high quality services, but because of financial mismanagement of which the Tiwi people were largely ignorant of, and certainly not responsible for. The reason why the Tiwi Health Board was dismantled was because of risk intolerance by governments of the day—from both sides of politics—were unwilling to continue down the path of community control because of the risks it might engender to the bureaucrats and politicians responsible for what occurred. It is no accident, in my view, that the investigative report into the Tiwi Health Board collapse has *never* been made public.

What the events surrounding the collapse does say is that governments have been risk intolerant ever since to actively encouraging and facilitating community control since then. In the last decade there has been only one new community controlled health service established in the Northern Territory—and it is still a significant distance away from being an active service deliverer; and in the last decade there have only been two remote clinics handed across to community control.

What has changed is risk intolerance. In the development of Tiwi, Katherine West and Sunrise, both Commonwealth and Territory public servants were actively engaged in finding solutions wherever obstacles arose, and were enthusiastically engaged in innovative approaches to change.

That spirit must be revived if we are to improve health outcomes.

During that same period, to the extent politicians were aware of developments in community control at all, they were supportive of such initiatives. In a little known episode in the late 1990s it was a Northern Territory CLP health minister, Steve Dunham, who directly intervened in the successful development of the Sunrise Health Service in the face of bureaucratic obstruction.

In other words, it can be done.

The politicians and public servants can be agents of innovation and change if they abandon risk intolerance.

Similarly, the response of NGOs to the last decade or so of reaping the benefits of government funding into Aboriginal service delivery must also change. Both I in my former role as Coordinator General in the Northern Territory, along with my Commonwealth counterpart Brian Gleason, strongly focused on this trend, and the deleterious impact it was having on Aboriginal community and organisational capacity.

More importantly, the Aboriginal Peak Organisations Northern Territory, in partnership with ACOSS, NTCOSS and National Congress have developed a set of key principles that will guide participating NGOs in their relationships with Aboriginal service delivery. These principles were developed as an outcome of a major meeting of local, national and international NGOs held in Alice Springs in February this year, and have now been distributed for endorsement within the NGO sector.

In short, these principles cover principles of not competing with Aboriginal organisations for funding and resources; in building independent capacity in Aboriginal organisations that they partner with; and in having an exit strategy to allow Aboriginal organisations to take over service delivery.

I am told that, at the end of this week, some major NGOs will be announcing their endorsement of the APO NT principles at the NTCOSS annual conference.

In other words, this can also be done.

Risk intolerance cannot be part of Closing the Gap. The public sector, and their political masters, must engage with Aboriginal organisations in a renewed spirit of innovation—and the capacity to take the occasional risk that was seen with the establishment of Katherine West and Sunrise. This means a structural reform

in government approaches to Aboriginal organisations and communities.

I am tired of the media and public commentary that is of the view that the only Aboriginal people with intellect and ideas are those with a public profile—profiles which those same media outlets and public commentators have created. It's another form of risk intolerance—you get the views that you have cultivated and expect.

It is a disservice to those who contribute daily at the coal face of service delivery. It is a disservice, as well, to the notion of working from an evidence base, and analysing what works—and not what opinion leaders think might work. For example, early childhood development and well being has been at the forefront of concern within the Aboriginal community controlled health movement for decades, along with issues such as child neglect and abuse. Aboriginal health services have been campaigning for increased resources many, many years before the Intervention.

But instead of investing in what we know works, such as the nurse home visitation program, the Intervention saw an army led home visitation program. Instead of providing resources for parenting and family programs, which we know work, at far greater cost we have politicians pushing for compulsory adoption of our kids. Instead of controlling the supply of alcohol through mechanisms that are internationally proven, such as floor prices on alcohol, we have so-called leaders that tell us that grog and gambling should be protected as an integral part of our Territory lifestyle.

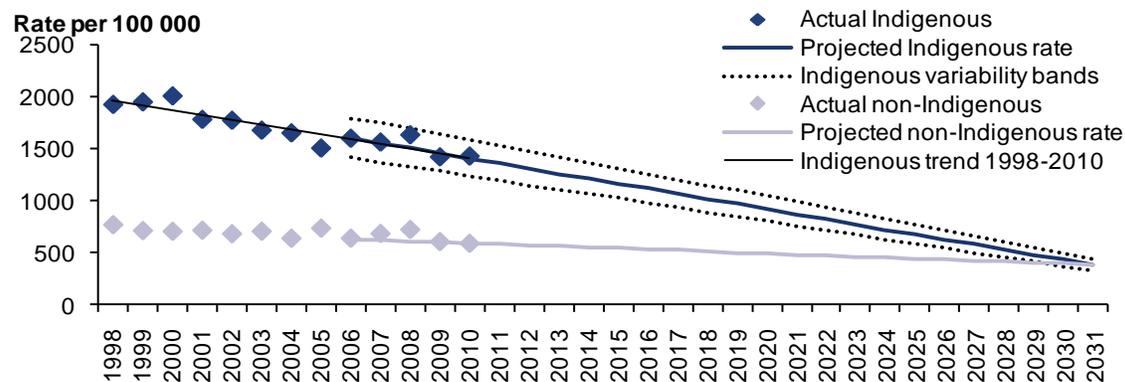
I said at the beginning of my remarks this evening that “to tell the truth is to shame the devil”. I'm not getting all religious on you—don't worry—but telling the truth is not the full story. There is also the Ninth Commandment about not bearing false witness—in other words—not lying.

In our dealings with politicians and public servants, falsehoods are too often the order of the day, and therein lies one of the major fault lines in improving Aboriginal health. We have to be honest with each other, and not hide behind the doctrine of risk intolerance. If we are to achieve real change, we must act on the evidence—in other words the truth of what works, and what does not.

But, as I said, the truth is a slippery beast.

Thank you.

Figure 2.4 Age-standardised death rate per 100 000, actual and projected rates, by Indigenous status, Northern Territory, 1998–2031¹



¹ COAG Reform Council 2012, *Indigenous reform 2010–11: Comparing performance across Australia*, COAG Reform Council, Sydney, Page 22.
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