Opening Statement – Debbie Blumel

I acknowledge the Larrakia people as the traditional custodians of this land and their elders past and present.

Any views that I express today are based on my own knowledge and experience and I am not speaking on behalf of any other organisation.

I have worked as Executive Director in the NT Department of Housing since November 2014 where I am accountable for (a) grants and program management of both Australian Government and NT Government funding; (b) the Public Housing Safety branch; (c) Client Relations Branch which includes legal compliance, complaints and case management; and (d) Capability Development across the organisation.

Before my current role, I spent most of my career in Queensland Health and from November 2012, was the Chief Executive Officer of the Northern Territory Medicare Local (NTML) where I led the development and coordination of an equitable, comprehensive primary health care system and an engaged health workforce driven by community needs. During this time, the NTML's operational turnover grew from $16M to more than $40M and peak employment was more than 100 staff. NTML health programs were commissioned through contracted grants with service provider agencies (and independent contractors where health service organisations were not available), while workforce programs were funded through grants, incentive payments and service agreements.

Some key achievements during my two years in health system development here in the NT include working in partnership with a range of health organisations and peak bodies such as the NT Department of Health, AMSANT, Baker IDI, Aboriginal Medical Services, Aboriginal Community Organisations and others.

Some key achievements include:

- The NT's first Primary Health Care Needs Assessment (2013) and the After Hours Care Needs Assessment (2013) as a basis for planning services and service modelling and design.
- The NTML Health Atlas and comprehensive searchable health service data base for the Comprehensive Needs Assessment 2014
- New and renewed programs such as:
    - Medical Outreach Indigenous Chronic Disease program (2013-16)
    - Partners in Recovery 2012-16)
    - Access to Allied Psychological Services (program to support the first open tender and procurement process for engagement of service providers for 2013-14. In 2012/13, ATAPS delivered 3680 sessions to 833 clients. Also delivered a number of suicide prevention program initiatives that used a strengths-based approach.)
    - Mental Health Services in Rural and Remote Australia (MHSSRA) and negotiated with the RFDS to employ the clinical team. The program

delivered approximately 6200 sessions in 2012/13. Changed the direct service delivery model to a commissioned model
    - Closing the Gap (program increased the breadth and reach of care coordination and access to supplementary services for Aboriginal people. After a 20% growth in 2012/13, the program delivered 2022 episodes of care.)
    - Refugee Health Program (provided health assessments and follow-up services to 113 newly arrived refugees.)
    - Rural Primary Health Service program (which delivered allied health services within a comprehensive primary health care model in remote communities and homelands.)

With regard to health workforce development, we also

- Initiated a Practice Support Unit that developed a customer relationship management approach to providing a range of support services to service providers in the private and not-for-profit sectors.
- Provided a range of support services to clinicians and service providers to improve patient care including filling 13 GP vacancies, 2242 GP locum days for 53 GPs, placing 51 nurses and allied health professional under the Rural Health Professionals Program, administering four grants programs and running Continuing Professional Development as an accredited provider with the RACGP.

As a long term primary health care and public health professional, I am aware of opportunities and challenges around health system reform as well as the social determinants of health.

My two key strategic messages today are as follows:

1 As the health system continues to evolve, there is a significant need for <u>change management and capability development</u> around a negotiated but united vision for health service delivery. Sadly, there has been a view that new national initiatives can be implemented in the NT without change management processes that ensure empowerment and support of stakeholders. In particular as new elements are added to the health system such as MLs and now PHNs, there is a need to prepare the rest of the health system for their function to ensure it is supported.

2 Secondly, there is a significant need to link the action on public health issues with primary health care services and <u>ensure public health and primary health care approaches are coordinated at a place based level.</u>

Socioeconomic determinants which impact negatively on health and health service provision are prevalent. The Health Atlas found that environmental conditions, housing stress and the challenges of living remotely lead to health risks and adverse health conditions,

The availability of housing stock and the provision of safe, functional housing are critical to improving public health by enabling healthy living practices and reducing risks associated with breakdown of functionality. Public health risks are particularly associated with breakdowns in water and sewerage facilities, poor domestic waste management, overcrowding, damage to the building and poor maintenance of the built environment. These risks can lead to injuries, skin and eye infections, respiratory illness, diarrhoeal disease, hepatitis and other public health problems.

A strong public health effort can effectively prevent disease and injury through a range of public health policy measures, health surveillance and screening, preventive medicine, and programs to create supportive environments, strengthen community action and develop personal skills. Public health action relies to a significant degree on local councils, communities, and collaborative action between Government departments and non-Government organisations around programs that target risks that contribute to the causal pathways of disease and injury.

Australia is one of the healthiest countries in the world and statistics indicate that the health of Australians is continuing to improve. However, the public health status of Indigenous peoples remains substantially worse than any other group in the Australian population. Environmental living conditions are important contributors to the inequalities in health between Indigenous and non-Indigenous people. In particular, problems with water supply, waste removal and hazards in the built environment are key factors contributing to excesses in respiratory, skin, gastrointestinal, eye, ear, parasitic and other infectious health problems, often with long-term adverse health effects.