AMSANT Aboriginal Corporation
ICN 8253 | ABN 26 263 401 676
Level1 Moonta House |43 Mitchell St NT 0800
Postal Address - GPO Box 1624 Darwin NT 0801

AMSANT

Commonwealth Government COVID-19 Response Inquiry

December 2023

Introduction

Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) is the peak body for Aboriginal Community Controlled Health Services (ACCHS) in the Northern Territory. ACCHSs are valued for the provision of culturally appropriate, holistic primary health care and are well positioned to address barriers to accessing health care (such as racism, transport and cultural needs).

The maintenance of public health restrictions until the availability of COVID-19 vaccines and antivirals is likely to have been an important contributing factor to the lower-than-expected mortality rates among Aboriginal and Torres Strait Islander people at the time that many restrictions were lifted in early 2022. In contrast, the national 2020 COVID-19 mortality rate for Native Americans in the United States was almost three times that for the Caucasian population - the rate being highest on "reserves", which is their equivalent of Australian Aboriginal remote communities (Leggat-Barr et al., 2021).

However, the current mortality rate from COVID-19 in Aboriginal and Torres Strait Islander people is 1.6 times that of non-Indigenous people; in remote and very remote areas, this increases to 3.7 times (data up to 31 March 2023; ABS, 2023). Higher rates of socioeconomic disadvantage (ABS, 2023) and some of the highest rates of chronic disease in the world (Hare et al, 2022) drive this disproportionate impact. However, features of the Australian Government's pandemic response could have been delivered more effectively to better protect this population. This submission outlines identified strengths and deficiencies of the pandemic response below, as well as recommendations for improving systems to avert a disproportionate impact on Aboriginal people in the NT in the next public health emergency.

Governance and Aboriginal leadership

The Aboriginal and Torres Strait Islander Advisory Group on COVID-19 (the 'Taskforce') was established in March 2020, co-chaired by the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Australian Government Department of Health. Key reasons for the effectiveness of the Taskforce include:

- Co-chairing by people with relevant expertise (e.g. in this case Dr Dawn Casey and a senior public servant with experience in the ACCHS sector).
- Aboriginal representation from the outset.
- High level input into Communicable Diseases Network Australia (CDNA).
- Adequate resourcing, including secretariat support.
- Knowledgeable membership including key affiliate representation.

The ACCHS sector also demonstrated its role of leadership, expertise, and adaptability during health emergencies. The sector delivered an immediate and effective response despite existing resource limitations in the primary care sector.

Aboriginal Medical Services Alliance – NT
Telephone (08) 8944 6666 Facsimile (08) 8981 4825
Email: reception@amsant.org.au Web: www.amsant.org.au

Recommendations:

1. Advisory and/or decision-making bodies that would direct any public health emergency response for Aboriginal and Torres Strait Islander communities must be formed early and include leadership from the ACCHS sector.

Funding and resources

ACCHSs played a significant role across all essential pandemic activities, including raising awareness of COVID-19, promoting and delivering vaccines, and supporting those who contracted COVID-19. Rapid provision of funding to ACCHSs and affiliates, to support these activities, was relatively flexible with reasonable reporting processes. Deployment of rapid and flexible funding to the ACCHS sector is essential in any future response.

However, there was a lack of Australian Government support for vulnerable Aboriginal communities during the first severe Omicron wave of COVID-19 in the NT. The NT Government was overwhelmed and avenues to obtain Federal support in a timely manner were not clear.

In early 2022, three ACCHSs s requested assistance during the Omicron outbreaks. One was being impacted by floods and internet/phone outages and another two were having severe COVID outbreaks to manage with already existing severe staffing shortages. The NT government was not able to support their COVID response in a timely manner and the avenues to request Federal assistance was not clear, despite Darwin being the base for the National Critical Care and Trauma Response Centre. By the time Federal assistance was made available, the emergencies in each of the communities had already peaked and for one remote community – the response provided ('mapping of need') was not a priority (when practical support on the ground was required). There must be clear and timely avenues for support for very remote communities in a public health emergency given the limited resources available and heightened vulnerabilities of remote communities.

There was also insufficient support for homeless people or people living in very overcrowded houses who could not safely isolate when they had COVID 19. This lack of support contributed to rapid spread of COVID 19 within Aboriginal communities.

Recommendations:

2. Rapid and flexible funding must be provided to the ACCHS sector to carry out essential public health emergency activities and to support additional costs - e.g. the cost of quarantining staff.
3. Reporting and administrative requirements of public health emergency funding must not be overly burdensome on health services.
4. Federal government support in a public health emergency must be timely and accessible in response to urgent health service and community needs particularly in remote and very remote communities or high risk urban communities – e.g. town camps.

Biosecurity zones

In February 2022, the Commonwealth Minister for Health, at the request of the NT Government and with the support of the Northern Land Council established a series of biosecurity zones to slow the movement of people, and the spread of COVID-19. It is difficult to assess the impact these

biosecurity zones had on reducing the spread of COVID-19 because there was no reported community spread in NT towns. The challenges to implement the zones included:

- Significant added stress on an already strained primary care workforce.
- Anecdotal suggestion that the biosecurity zones were "leaky", people could get around them (e.g. leaving a car at the outskirts of the zone and then walking across the border). To stop this would require massive police resourcing which is unlikely to be sustained.
- Biosecurity measures included limiting visitation access to "'essential workers' only", with governments and agencies such as the NT PHN unilaterally deciding which services were non-essential and often diverting these workers to other areas. This included nearly all allied health workforce and the mental health, alcohol and other drug, domestic and family violence and social and emotional wellbeing (SEWB) outreach workforce. The decision about what workforce is essential should be made with local ACCHSs and communities with advice from public health and the decision should be commensurate with the public health threat. Given the high rate of SEWB problems and chronic disease, the decision to cease these services for months at a time caused significant harm.
- The biosecurity measures required Aboriginal people who needed hospitalisation or to undergo other medical treatment to quarantine in locations that could be minimally supported and, in some cases, distressing and even dangerous (e.g. young Aboriginal mothers being discharged from hospital with their first baby having to isolate in a culturally unsafe and unsupported quarantine and patients discharged from psychiatric care quarantining on their own).
- Feedback from clinicians also included that some patients at quarantine facilities had difficulties accessing their regular medications.

Recommendations:

5. Where public health emergency responses may have a significant social impact (e.g. biosecurity zones) there must be rapid funding of measures to provide support for those affected (e.g. appropriate quarantine facilities).
6. ACCHSs and local communities should be central to the decision making about which services should continue and how they should continue in a public health emergency with the decision being guided by the severity of the public health threat. Services that should be considered high priority include allied health and responses to, and management of, mental health, domestic and family violence, alcohol and other drug use, and social and emotional wellbeing.

Access to vaccination and treatment

COVID-19 vaccination was rolled out too slowly to the NT ACCHS sector, with vaccines being freely available to low-risk people in Darwin at the same time they were inaccessible to very remote people. It appeared that the Federal Government felt that remoteness was sufficient to protect these communities along with the biosecurity measures. However, if there had been community transmission in towns such as Alice Springs or Broome, biosecurity measures (with their deficiencies as listed above) would not have been sufficient to protect remote communities.

One factor of the slow rollout was ineffective messaging (discussed further below), which caused a lack of trust (e.g. about safety of the AstraZeneca vaccine) that could not be recovered in some communities. There should have been a more rapid pivot to Pfizer vaccine availability for all Aboriginal community members to hasten uptake of vaccines.

A positive feature of the response was the lower thresholds for Aboriginal people in very remote communities to access antivirals – this was essential in communities known to be at higher risk of poor health outcomes from COVID-19.

Recommendations:

7. Vaccinations and treatments must be prioritised and effectively distributed to high-risk groups including Aboriginal communities.

Public health messaging

Australian Government messaging for COVID-19 broadly, and COVID-19 vaccination specifically, was relatively ineffective for Aboriginal people in the NT. Local organisations produced high quality resources that were responsive to local community information needs and preferences (see Trudgen, 2020 as one example). These organisations (including ACCHSs) should be resourced to undertake public health messaging.

There remain ongoing issues with a lack of clear messaging to the public, including Aboriginal communities about the ongoing risk of COVID-19 risk, the long-term impacts of COVID-19 on chronic disease risk and Long COVID.

Aboriginal and Torres Strait Islander communities were targets for disinformation regarding the COVID-19 vaccine, which may have contributed to vaccination rates under 90% in Aboriginal communities when COVID-19 arrived in the NT (Roussos, 2021). Disinformation compounds hesitancy and distrust of government activities, stemming from the events of colonisation. Culturally sensitive public health messaging, led by local Aboriginal communities, should be initiated as early as possible in a health emergency, to combat disinformation campaigns and to promote informed choice for Aboriginal people.

Recommendations:

8. Aboriginal organisations including ACCHSs should be resourced to create and disseminate health promotional resources in a public health emergency.

Data

Stratified data, specific to Aboriginal mortality and morbidity, was slow to be collected, analysed and accessed. This data was initially restricted to Australian Government committees. Health services, including ACCHSs, needed to have accurate information about the potential risks for their communities and should have been provided with timely data. The new Australian Centre for Disease Control should prioritise improving Aboriginal and Torres strait islander communicable disease data and ensure that this data can be shared with ACCHSs and local communities.

Recommendations:

9. Public health emergency data, including mortality and morbidity data, specific to Aboriginal communities must be provided in a timely manner to ACCHSs.

Broader health system impacts

Redirection of resources to address COVID-19 led to reduced healthcare provision (e.g. routine medical or chronic diseases checks, or specialist medical services). This was exacerbated by health

workforce shortages, (in the NT, particularly fly-in-fly-out staff impacted by lockdowns), and jurisdictional border restrictions.

This pandemic highlights a need to explore what is required in ACCHSs to provide effective primary healthcare during public health emergencies.

Telehealth: Temporary Medicare Benefits Schedule (MBS) Telehealth items assisted in improving access to primary care. Telehealth for Aboriginal and Torres Strait Islander people needs to be culturally safe, well-resourced, and in addition to (not replacing) face-to-face care. Effective use of Telehealth in the ACCHS setting is resource-intensive, as a clinician usually supports the patient in-person during the consultation. Given the ongoing remote workforce crisis, Telehealth items should be expanded again in remote and very remote areas to include suitable items such as care plans and review of care plans.

Recovery phase: The recovery phase will be protracted in remote and very remote areas. Prior to the pandemic, workforce trends included very high turnover and locum use rates. This was exacerbated by the pandemic such that in 2020, one third of the vacancies in Aboriginal primary health care were in the NT (where the majority of Aboriginal people live in remote or very remote areas). This is very disproportionate relative to population share (the NT comprises only 10% of the total Aboriginal population). Most clinical indicators have declined since 2020, with little sign of recovery, revealing the strain on primary care (AIHW, 2023). This is very concerning given that the life expectancy gap in the NT is the widest of any jurisdiction.

There needs to be sustained workforce support for the recovery phase, particularly in remote and very remote areas. AMSANT is working with the Department of Health and Aged Care on an urgent response to the workforce crisis based on a policy paper with short, medium and long term actions (attached). Any identified actions must be resourced. There must also be policy action to support more equitable distribution of the health workforce.

Investment in building the resilience and capacity of the ACCHS sector is not just about service provision – it is also about investing in the employment of Aboriginal and Torres Strait Islander people. This potential area for growth has not been thoroughly considered in the pandemic response. Aboriginal and Torres Strait islander staff were invaluable in the acute phase of the pandemic with key skills including providing culturally safe communication, addressing vaccine hesitancy and supporting contact tracing. Enhanced public health training could support a larger Aboriginal workforce working across a range of communicable diseases within Aboriginal primary health care who could then easily pivot to a central role in a pandemic response or other public health emergency. There is also a need for increased Aboriginal and Torres Strait Islander participation in the government public health workforce to ensure a culturally safe and more effective response.

There also needs to be consideration of a public health loading for ACCHSs particularly in Northern Australia where the rates of communicable diseases such as trachoma and rheumatic heart disease are particularly high. ACCHSs also often undertake much of the work normally done by public health staff in other populations-e.g. contact tracing. Funding could also be used to support local workforce and ensure ongoing pandemic preparedness. AMSANT suggests this loading be set at 10%.

Recommendations:

10. ACCHSs need to be adequately resourced for ongoing maintenance of primary healthcare provision during a public health emergency, in addition to supplementary emergency activities.
11. MBS rebates for Telehealth should be expanded in remote and very remote areas to improve access to primary healthcare where face-to-face care may have limited availability.
12. There must be long term resourcing and policy attention to the workforce crisis in remote and very remote areas that was exacerbated by the pandemic.
13. Invest in capacity building for the ACCHS sector with a focus on Aboriginal and Torres Strait Islander workforce including training and support for an Aboriginal and Torres Strait Islander public health workforce.
14. Leadership from the ACCHS sector must continue throughout the recovery phase.
15. ACCHS should be provided with a 10 % communicable disease loading to support clinical and public health approaches to communicable disease control.

Community supports and social determinants of health

How social determinants affected Aboriginal and Torres Strait Islander people was not adequately considered in the pandemic response. Extreme measures were undertaken (such as isolating whole communities), it was still not possible to slow the spread of COVID 19 in remote communities and in town where overcrowding in social housing existed. Funding should be increased to improve remote housing conditions in the NT, where widespread poor quality and overcrowded housing infrastructure exacerbated the spread of COVID-19 infection. Whilst overcrowding and homelessness remains at high levels, regional quarantine centres will need to be stood up quickly in the event of another public health emergency that requires Aboriginal people to quarantine and isolate.

During periods of lockdowns, biosecurity zones and quarantine, many Aboriginal people and communities became isolated with limited social supports or access to services. Resources such as additional welfare payments must be considered to offset the financial hardship associated with a public health emergency.

Recommendations:

16. Social determinants of health, community infrastructure and financial support must be addressed to ensure community preparedness for future public health emergencies.

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ICN 8253 | ABN 26 263 401 676
Level1 Moonta House |43 Mitchell St NT 0800
Postal Address - GPO Box 1624 Darwin NT 0801

AMSANT Workforce Crisis policy paper July 2023

Recommendations

Short Term Crisis Response

1. Index core funding for ACCHSs and increase the Medicare bulk billing incentive in rural and remote areas.
2. Establish an international migration campaign to recruit remote primary health care staff, including general practitioners.
3. Run a national campaign encouraging practitioners to make a long-term commitment to return regularly for some weeks/months to a particular community over a number of years.
4. Disallow MM1 and MM2 localities for international medical graduates and non-vocationally registered Australian doctors, unless working for an Aboriginal community controlled health service or if a severe shortage can be demonstrated.
5. Allocate 40 subsidised medical undergraduate places already funded to Charles Darwin University so that the Northern Territory can at last have its own medical school.
6. RACGP and ACCRM to set national stretch targets for the proportion of GP registrars 1) undertaking terms in Aboriginal PHC and 2) undertaking terms in remote Aboriginal PHC/community-controlled service providers.
7. The Commonwealth fund bonuses for GP registrars who agree to work remote with the minimum term being six months and with increasing bonuses for longer periods of training in remote and very remote areas.
8. Implement a retention payment system for remote area nurses after 12 months of service.
9. Undertake and audit of all clinics and staff housing and develop an asset upgrade and replacement plan as needed based on the findings of the audit.

Medium Term Strategies

10. The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan is implemented.
11. Establish a skills-based Aboriginal Health Worker training program and expand the Aboriginal Health Practitioner training program with community-based training whenever possible to provide a pathway for Aboriginal community members into the health professions.
12. The Centrelink system is reformed so that it encourages remote Aboriginal people to enter the workforce including part time and short-term roles.
13. Support two-year graduate nurse programs in large ACCHSs.
14. Reform undergraduate health professional training courses to make them more suitable to the needs of remote communities.

Aboriginal Medical Services Alliance – NT
Telephone (08) 8944 6666 Facsimile (08) 8981 4825
Email: reception@amsant.org.au Web: www.amsant.org.au

15. Further develop courses in the Northern Territory in nursing and midwifery and allied health professions (e.g., pharmacy, podiatry, diabetes nurse education, occupational therapy, psychology and others).
16. Establish a Centre of Excellence in GP registrar training in remote/very remote Aboriginal primary health care.
17. The Commonwealth Government to explore mechanisms to supplement GP registrar salaries in private practice so that they are comparable with equivalent hospital-based registrar salaries.

Long Term Strategies

18. Address poor education, poverty, inequality, poor housing and intergenerational trauma to unlock Aboriginal participation and contribution in the health professions.
19. Expand Aboriginal leadership and participation at all levels of the health system, including as managers, administrators and health professionals, through cadetship and scholarship programs.
20. Address maldistribution and over-specialisation of health professionals, especially of doctors and nurses

1 Introduction

The NT Aboriginal primary health care sector is experiencing a workforce crisis that is threatening to reverse some of the life expectancy gains made during the last 20 years. This paper sets out some of the issues and potential solutions. AMSANT has advocated most of the above recommendations to Minister Butler in October with three follow up meetings. No concrete action has resulted as yet, but the Minister's office has reassured us that the letter was influential and there may be some actions in the budget. Donna Ah Chee provided a paper to the NACCHO workforce summit in April which included most of the recommendations included in the paper. AMSANT has also written to NACCHO, RACGP and ACCRM about the sharp decline in GP registrar numbers and we have put forward the recommendations about GP registrars to those organisations.

2 Extent of health need in the NT

The life expectancy gap in the NT is the widest of any jurisdiction at 15 years but there has been substantial improvement in life expectancy over the last fifteen years (9 year improvement for men and 4.9 improvement for women) (Zhao et al, 2022). These gains have been primarily attributed to health system improvements, especially primary health care as in this period, other key social determinants of health have not improved. Clearly there is a long way to go with progress needing to accelerate if we are to close the life expectancy gap by 2031 in accordance with Close the Gap Goals.

The disease burden is growing with a major study showing that rates of diabetes in Central Australia were the highest in the world with rates increasing substantially in both the Top End and Central Australia(Hare M et al 2022,) Rates of diabetes in pregnancy are also estimated to be the highest in the world in Central Australia whilst type two diabetes in children in Northern Australia is amongst the highest rates globally and is growing (Hare M et al 2020, Titmuss A 2022)). . Of the four jurisdictions with RHD registers (Queensland , Western Australia South Australia and the NT) ,the NT has 42% of the cases of rheumatic heart disease on the RHD register, and the rates of

people with ARF are increasing at a faster rate than other jurisdictions (AIHW 2021 , AIHW 2020), ACCHS data demonstrates a 12% increase in people requiring monthly penicillin needles in just one year The failure to address social determinants adequately has led the health system to deal with an ever growing burden of chronic and communicable disease fuelled by social and cultural determinants such as poverty, expensive food, overcrowded housing , intergenerational trauma and racism.

3 Workforce crisis

3.1 Turnover and retention

The levels of staff turnover and vacancies were high prior to COVID as evidenced by a workforce turnover study conducted in the NT government primary health care sector demonstrating that only 20% of nurses/AHPs were still working at the same remote clinic 12 months after commencement and half had left four months (Russell D et al, 2017). The most recent OSR report (2020 -2021 CY). demonstrates that 34% of vacancies were in the NT despite the NT Aboriginal population comprising only 9% of the total Aboriginal population (AIHW, 2023). The total number of vacancies were much higher than in states with significantly higher Aboriginal populations such as Queensland (AIHW, 2023).

3.2 Impact of crisis on access to health professionals

3.2.1 Aboriginal staff

Aboriginal and Torres Strait Islander people make up 53% of employees in Aboriginal PHC, of which 89% are employed in the ACCHS sector (AIHW, 2023). There are multiple benefits to service delivery outcomes when teams include Aboriginal staff including better connection, rapport and trust with patients, improved communication, improved attendance at appointments higher compliance with treatment, better follow up and reduced discharge against medical advice in hospital (AIHW 2022a). The proportion of Aboriginal staff in ACCHSs has slowly been declining since 2013 when the proportion of Indigenous staff was 58%. The NT has the lowest rate of Indigenous health professionals employed per 100, 000 population of any jurisdiction despite having the highest proportion of Aboriginal people and a particularly high health need compared to other jurisdictions (AIHW 2022a).

3.2.1.1 Aboriginal Health Practitioners and Aboriginal Health workers.

Aboriginal health practitioners/workers are critical to a culturally safe effective workforce delivery yet their numbers have been slowly declining for many years (number declined in the NT from 228 in 2013/2014 to 205 in 2021(AIHW 2022a) . Retention of these critical staff is made more difficult by high turnover of non-local staff with AHPs and other Aboriginal staff continually needing to orientate and support new staff. The funding of an additional 500 places nationally for local entry level Aboriginal workforce in Aboriginal community-controlled health services across Australia is very welcome and needs to be built on through ongoing investment in recruitment training and support of this critical workforce.

3.2.1.2 Other identified roles for Aboriginal staff.

There are a number of career choices in health and related fields beside clinical roles. These include roles in administrations, community health /health promotion and public health, SEWB/mental health/AOD and family support. There are also emerging areas in health coaching and opportunities in disability and aged care as more services expand activity in these key service areas. However, there are not always clear pathways into these diverse career options. An NT Human Services

Industry plan has been developed to guide development of a range of roles in health and social services. AMSANT is also undertaking research into mapping these diverse career pathways to facilitate clearer career pathways through Central Australian Academic Health Science Centre funded research.

3.2.1.3 Aboriginal representation in all administrative and health professional roles

The proportion of Aboriginal registered doctors, nurses, allied health staff and other registered health professionals is much less than population share and has been only slowly increasing with an approximate doubling nationally from 1996 to 2016(AIHW 2022b). The professions with the biggest gap between Indigenous and non-indigenous rates are medicine, nursing and allied health (AIHW 2022b).

Aboriginal staff are critical to non-clinical areas including policy and advocacy, research, strategy and planning and management/administration. This includes senior roles up to and including the CEO of services. Strong Aboriginal leadership is crucial to the effective functioning of the ACCHS sector.

3.2.1.4 Doctors

Most NT ACCHSs have very significant shortage of general practitioners and this has worsened during the pandemic Telehealth Medicare rebates have helped somewhat with services using general practitioners living in non-remote areas to provide this service. However, this has limits and resident GPs are still required to review and physically examine patients as well as to support other staff (particularly nurses and AHPs) and have input into clinical governance. Given the high burden of chronic complex disease, it is unacceptable for very remote areas to have half the ratio of doctors to patients as urban and regional areas (AIHW 2022a).

The recently announced changes to overseas doctors' requirements to work in an area of workforce shortage will actually worsen shortages in rural and remote areas at this time of crisis. Prior to 2022, overseas trained doctors were required to work in a remote for five years or a rural area for 10 years before they could access GP MBS items in urban and regional areas. This policy resulted in significant numbers of overseas doctors practising in the NT. Overseas trained doctors can now access GP Medicare rebates in some outer metropolitan (M1) areas as well as all MM2 areas. These changes have caused an immediate shift of doctors away from remote areas. The decision and the failure to consult with the rural and remote health sector prior to the decision being made is very disappointing given the extremely high health need in remote areas.

3.2.1.5 GP registrar training

GP registrar training at its peak in 2016 had 64 new registrars commencing training, reducing to 20 in 2020 and to less than 10 in 2023. The GP registrar training program has been a crucial way that doctors enter our sector with many senior doctors training in the NT. The dramatic reduction from 2022 to 2023 in registrar numbers has occurred at the same time as the Colleges have taken over GP training from the NTGPE. Previous requirements to 1) undertake a term of training outside Darwin and 2) undertake a term in Aboriginal health have been dropped this year as NTGPE said this was too difficult to maintain when training was transitioning to the Colleges. Even if this was reinstated, it would make little difference to the number of doctor training in the community controlled sector when training numbers are so low. The dramatic slump in numbers of doctors entering GP registrar training is highly concerning for the future of the GP workforce in the NT.

3.2.1.6 Rural Generalist Training

The NTG (along with other State Governments) was funded to develop a rural generalist unit with the aim of training doctors specifically for a rural and remote career. In other jurisdictions such as Queensland, this scheme has had a strong focus on training doctors to work in small rural hospitals. This is not the key need in the NT where small rural hospitals such as Tennant Creek are well supplied with doctors (on generous packages) whilst remote Aboriginal PHC remains very short of doctors. Hospital salaries are difficult for our sector to compete with and there is risk that doctors will be drawn away from Aboriginal PHC to hospital medicine. The evidence strongly suggests that well trained GPs will provide greater health benefit working in Aboriginal primary health care than in Emergency Departments (Levine et al, 2019).

3.2.1.7 Junior doctors

A scheme to provide junior doctors exposure to primary health care in rural, remote and very remote areas (prior to these doctors deciding which speciality to pursue) commenced in 2022. A previous iteration of this scheme was very successful with many NT ACCHSs participating. The first allocation of junior doctors in 2023 in the current scheme was weighted towards government PHC and the hospital system outside of Darwin and Alice Springs with only two (out of 9) being allocated to the community-controlled sector. Further allocation to our sector is being hampered because hospitals are still the employer and need to release these doctors for a term. The Royal Darwin Hospital has only released a limited number and Alice Springs Hospital has refused to release any junior doctors for this scheme. The NT has aimed to source junior doctors from interstate with limited success. This is likely to improve only slowly with overseas trained doctors now returning to the system but with intense competition for health professionals including doctors from other developed countries.

3.2.1.8 Nurses

Nurses and midwives are the most common health professional worldwide at around 27 million (WHO 2020). There is a global shortage of nurses (estimated to be between 6-13 million by 2030) which has been worsened by COVID 19 and is causing intense international competition for nurses (Health Workforce Australia 2014). The last national study by Health Workforce Australia in 2014, shortly before it was decommissioned predicted that there would be an Australian shortfall of 85,000 nurses by 2025 and 123,000 by 2030 (Health Workforce Australia, 2014). The number of nurses being trained has continued to increase but retention is also a key issue as is ageing of the workforce. There has been a steady increase in the number of nurses registered but not practising, The Commonwealth Health Department is undertaking a nursing workforce strategy but there seems little other policy to address these severe and potentially worsening shortages.

Very remote areas have a higher ratio of nurses to population than less remote areas, but this is largely because nurses are doing work undertaken by general practitioners in regional and urban settings and also because there is a very high health need. In 2020, there were 1,202 FTE clinical nurses and midwives per 100,000 people in Very remote areas compared with 1,069 in Major cities. (AIHW, 2022b). Anecdotally, the nursing shortage has greatly increased over the last two years.

Nursing shortages have been acute over the pandemic and have caused NTG government clinics to cease providing a 24/7 resident service in several remote communities in Central Australia.

3.2.1.9 Allied health

Allied health is a key part of comprehensive PHC and there are widespread shortages exacerbated by COVID but also competing demands from NDIS and to a lesser extent- aged care. Key health professionals such s clinical psychologists are also in very short supply in very remote areas with a severe maldistribution. However, a detailed outline about allied health is beyond the scope of this paper.

3.3 Impact of workforce crisis on health service performance

Review of the national key performance indicators (last results from June 2022) showed a decline over time with the NT having lower performance than most other jurisdictions in some important indicators including health checks (2nd lowest for 0-14 age group and 3rd lowest for adults), recording of alcohol consumption(lowest),recording of BP in people with diabetes (2nd lowest), and good BP control (lowest of any jurisdiction)(AIHW, 2023). Review of the NTAH key performance indicators for the calendar year ending December 2022 demonstrates ongoing worsening performance in 15 indicators with two stable and none improving. There were sharp declines in very important indicators such as completeness and timeliness of immunisation, screening for sexually transmitted infections, rates of adult health checks and the proportion of people who require monthly penicillin needles for rheumatic heart disease prophylaxis receiving at least 80% of their needles. Given the COVID pandemic has improved over the last six months, some recovery could have been expected by now, without a workforce crisis. However, it is clear that this recovery will be uncertain, long and slow without decisive action on the workforce crisis.

3.3.1 Reasons for the decline in performance

Continuity of care is critical particularly in chronic disease care and this is compromised by a high proportion of short-term staff who often focus mainly on acute rather than preventative care. Staff shortages result in staff working long hours which then leads to staff requiring fatigue level during business hours- this then can cause a vicious cycle of routine primary health care being neglected, leading to more acute presentations and thus more fatigue leave. Staff get burnt out and dissatisfied in this environment as they know they are not providing high quality care whist still working very hard. There are also OH and S issues with fatigue potentially causing more accidents and staff mental health issues. In addition, the low numbers of Aboriginal health professionals particularly in remote teams and under representation in senior professionals roles will reduce the performance of the service as a whole.

A recent paper published in the MJA online (Larkins et al 2022) showed that in NT government clinics more than 70% of chronic disease patients have not seen a doctor for more than 12 months. In addition to this, it has been reported that in Central Australia, 90% of remote patients which chronic conditions in NT government clinics are not collecting their medications and there has been an increase in End Stage Renal Failure by 20% in the last 12 months (personal communication Dr Paul Burgess).

The Walker coronial inquest has heard disturbing further evidence of nursing vacancies with the NT government reporting a 25 % remote nurse vacancy rate at the Central Australian Aboriginal Congress 20%. These are unfilled nursing positions which are not able to be covered by locum nursing staff. If locum nursing staff were not counted, then the vacancy rate would be substantially higher and we know that short term staff cannot do all that is needed.

3.3.2 Impact of COVID

COVID 19 has exacerbated the adverse workforce trends in the NT so that the situation is now quite dire. The NT Aboriginal PHC sector has a heavy reliance on interstate and international nurses and doctors with New Zealand being the most important source of international health staff. Our sector immediately struggled as borders closed. Border closures were necessary, but the workforce was quickly depleted and has not recovered yet. The sector struggled with Omicron outbreaks during periods of critical workforce shortages and this led to higher than normal levels of burnout and fatigue as well as staff absenteeism and early retirements. At the same time, COVID 19 vaccination and quarantine positions were plentiful and were offering wages that were often higher than standard remote area nursing remuneration despite the work being less complex and stressful. Unsurprisingly, our services lost many staff to vaccination and quarantine positions and many of these staff have not returned. There are major workforce shortages now even in capital cities, so competition remains intense. Although international migration has recommenced, global competition for health workforce is also increasing. The end result is unsustainable rates of vacant positions with two large remote /very remote ACCHS having one third of doctor positions vacant and from one third to two thirds of nursing positions vacant.

4 Strategies to address the crisis.

There has been a failure to invest in long term workforce initiatives over many years which has now culminated in the current unsustainable workforce structure in NT Aboriginal primary health care. We need ways to attract and retain new staff into the sector who are willing to give longer term commitment to Aboriginal PHC whilst also providing stronger support for the local Aboriginal workforce who are critical to effective culturally safe Aboriginal PHC. The Commonwealth Health Department needs a greater degree of engagement in these issues particularly noting the recent decision about overseas doctors detailed above, which will exacerbate rather than assist with the current crisis. There appears to be a reliance on current mechanisms such as Government funded locum agencies (e.g., Remote Area Health Corps- RAHC) to deal with workforce issues. RAHC has been very useful and has developed a strong orientation and support program for staff new to remote. However, our services find that RAHC and the Rural Workforce Agency (the two key government funded locum and recruitment agencies) can only provide a small proportion of their total locum and recruitment needs. When RAHC expanded their remit to cover all of remote Australia, the assistance they were able to provide to NT ACCHSs actually declined. Furthermore, RAHC does not recruit to permanent roles, and this is a key need whilst the Rural Workforce Agency is not funded to a level to cope with the high and growing workforce shortages. Services are forced to use commercial locum agencies who charge high fees and also require a substantial payment if a locum staff member from that agency transitions to permanent employment from locum roles.

The paper sets out some initiatives that need to be urgently considered by government, from a crisis response to more long term approaches. Some are specific to categories of health professionals whilst others are more general.

4.1 Short term crisis response

Recommendation 1: Index core funding for ACCHSs and increase the Medicare bulk billing incentive in rural and remote areas.

Due to high vacancy rates, locums are increasingly being used to cover these vacancies and services are being charged very high rates as locum agencies take advantage of shortages to increase fees

and with also competition from interstate providers. Inflation is now running at 7-8% whilst CPI is only 2.5%. Thus, ACCHSs funding is effectively being significantly cut at a time of increased expenditure.

Medicare has also been frozen for several years and although this has now changed, the Medicare rebate has been significantly reduced due to this unfortunate decision by the previous Commonwealth Government. Bulk billing rates have fallen significantly and Medicare revenue for ACCHSs is also falling in real terms.

Recommendation 2: Establish an international migration campaign to recruit remote primary health care staff, including general practitioners.

An international migration campaign specifically for remote primary health care (MM6 and MM7) including general practitioners, should be undertaken. This should be focused on Europe, the United Kingdom, New Zealand, Canada and the USA. A targeted scheme with a strong focus on Aboriginal health care could at least partly counteract the negative impact of the decision on overseas-trained doctors and reduce nursing and other shortages. The focus should be on first world countries given the ethical challenges of recruiting from countries with less well-developed health systems. Generous relocation packages will be required given intense global competition for health professionals. AMSANT has already asked the Commonwealth to run such a campaign. This was considered but declined. The Department of Home Affairs is promoting migration for priority occupations, and AMSANT was asked to contribute information to fact sheets developed for nurses and doctors. However, the material that AMSANT provided was not included in the fact sheets, which were brief, covered hospitals and primary health care and made no mention of either remote health or Aboriginal health. AMSANT has raised this issue with Minister Butlers office.

Recommendation 3: Run a national campaign encouraging practitioners to make a long term commitment to return regularly for some weeks/months to a particular community over a number of years.

A national advertising campaign could be considered asking practitioners to consider a long term commitment even if that commitment was to return regularly to the same community on a yearly basis for some weeks/months. This could be from the point of view of community members who could talk about the difference between interacting with staff that they know and like as opposed to short term staff. The advertising campaign could also counter negative publicity about remote towns which may have impacted om recruitment outcomes in recent months.

Recommendation 4: Disallow MM 1 and MM2 localities for international medical graduates and non-vocationally registered Australian doctors, unless working for an Aboriginal community-controlled health service or if a severe shortage can be demonstrated.

The Commonwealth government should urgently change the decision to allow overseas trained doctors to access Medicare in some urban areas (MM1) that are categorised as areas of GP shortages. IMGs (International Medical Graduates) working in inner regional areas (MM2) should only be able to access Medicare if the suburb is categorised as having a severe GP shortage- currently IMGs in all MM2 areas can access Medicare within the first ten years. IMGs should also not be able to work in MM3 and MM4 areas that are well supplied (e.g. Byron Bay). Non vocationally registered doctors can also access the higher vocationally registered Medicare rebate in

some MM1 and all MM2 locations. The GP shortages are not nearly as acute as they are in remote and very remote areas. Furthermore, urban patients are able to access GPs in nearby suburbs and people in MM1 and MM2 areas have good access to hospitals unlike people in very remote areas. ACCHS in urban and regional areas should be exempt from this requirement given the critical need to improve Aboriginal health outcomes. GPs that work in very remote areas should be able to access Medicare in urban areas after five years of working in very remote areas.

Recommendation 5: Allocate 40 subsidised medical undergraduate places already funded to Charles Darwin University so that the Northern Territory can at last have its own medical school.

AMSANT is fully behind the establishment of an NT Medical School at CDU, with 40 new places in addition to the 22 or so places that the Flinders Medical program currently has in the NT. The NT required 63 interns per year to meet its own hospital requirements and so would be able to offer all graduates internships. The evidence strongly backs the assertion that more doctors would stay in the NT if they trained locally.

Recommendation 6: RACGP and ACCRM to set national stretch targets for the proportion of GP registrars 1) undertaking terms in Aboriginal PHC and 2) undertaking terms in remote Aboriginal PHC/community controlled service providers.

The Colleges have now taken over the training program and it should be easier for registrars to do a remote term even whilst based in an interstate urban region. AMSANT has written to both Colleges requesting that a national target be set for GP registrars undertaking a term in Aboriginal Health with a specific target for training in remote Aboriginal PHC. This should be set so it is a stretch target – significantly higher than what is currently achieved.

Recommendation 7: The Commonwealth fund bonuses for GP registrars who agree to work remote with the minimum term being six months and with increasing bonuses for longer periods of training in remote and very remote areas.

In terms of the crisis in the GP training program, it is vital that financial and other incentives are used to attract GP registrars into the rural pathway. In a situation where so few doctors are choosing general practice, it is hard to maintain the previous quotas that were used to get doctors into the rural pathway, but this system had previously worked well.

A financial bonus should be paid for registrars in increasing amounts depending on the time spent in remote and very remote areas. Bonuses for very remote areas should be set at a higher level than remote levels.

Recommendation 8: Implement a retention payment system for remote area nurses after 12 months of service.

Nurses are a central part of the Aboriginal PHC workforce and currently, nursing workforce shortages are acute. Nursing shortages are the key reason that several government primary health care clinics in remote CA have ceased 24/7 service and are now just provided without reach services 2- 3 days a week in office hours only.

There needs to be a system of retention payment implemented for remote area nurses that commences after 12 months service just as there is for doctors. The payments should increase

between MM6 and MM7 locations. These payments should come from the Commonwealth government just as the GP retention payments do. This should be an urgent but also an ongoing commitment given the severe shortages.

Recommendation 9: Undertake and audit of all clinics and staff housing and develop an asset upgrade and replacement plan as needed based on the findings of the audit.

One of the most significant barriers to the recruitment and retention of health professionals in remote communities is both the quality of staff housing and the lack of adequate staff housing. It is now especially important that all housing is secure and safe and this now requires "Crimsafe" and other mechanisms to ensure adequate security. There is also need to consider more innovative ways to further develop staff housing so that options are available for shared facilities when this is preferred, as this creates a greater capacity for supportive relationships and a sense of security.

As climate change progresses it will become more and more important that clinics and houses are well air conditioned, have access to cold water and that there is planning for adequate shade around clinics, in staff housing and in the community.

It is also essential that clinics themselves are modern and safe working environments with all of the appropriate security and safety features that are needed. Clinics need to be able to be quickly locked down in the event of an outbreak of violence directed towards clinics staff, especially when clinics are often the only place that women escaping domestic violence can take refuge in remote communities.

4.2 Medium Term Strategies

Recommendation 10: The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan is implemented.

A key priority is to expand Aboriginal and Torres Strait Islander participation at all levels of the health service. This will require long term funding for cadetship programs, traineeships and scholarships so that ACCHS can support young students who are studying to become health professionals. As part of this, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 must be funded and implemented with a clear governance mechanism led by NACCHO oversighting the implementation.

Recommendation 11: Establish a skills-based Aboriginal Health Worker training program and expand the Aboriginal Health Practitioner training program with community-based training whenever possible to provide a pathway for Aboriginal community members into the health professions.

There needs to be a renewed emphasis on basic training at the Certificate two level (in primary health care) with positions available in our services at that level. Some people may be happy to stay at that level, whilst others will pursue further training up until a Certificate four. These staff bring invaluable cultural, community and language skills to our services in addition to primary health care knowledge.

There also needs to be a strong focus on community-based training in local clinics wherever this is possible with training that can only be delivered outside the local community to be provided in a network of remote training centres within the larger remote communities. This will require training

infrastructure to be developed in the larger remote communities, but it is vital to reduce the requirement for travel as much as possible. This will greatly enhance the capacity and capability of local community members to undertake both AHW and AHP training.

There also needs to be a greater emphasis on recruiting Aboriginal and Torres Strait Islander people to senior positions in the health system so they can influence the system for the better. Mentorship of those in middle management positions to enable more rapid career progression should be funded.

Recommendation 12: The Centrelink system is reformed so that it encourages remote Aboriginal people to enter the workforce including part time and short-term roles.

There needs to be major reform to the current Centrelink system which is punitive and discourages people particularly in very remote areas from engaging in part time work.

Recommendation 13: Support two-year graduate nurse programs in large ACCHSs.

A two-year graduate nurse program at Central Australian Aboriginal Congress (CAAC) has been very successful. It is a well supported program where graduate nurses are based at CAAC but also gain hospital experience. The program is very popular and had to turn away many suitable applicants. The program has attracted Aboriginal nurse graduates who are clearly keen to start their nursing career in Aboriginal health. The two-year program gives nurses the skills to commence a remote area nursing program career with limited further support. Building on the successful outcomes of the program, AMSANT is asking that there is an urgent funding decision to expand the program to all of the larger ACCHSs who wish to participate. The NT PHN is refunding the Central Australian program with underspends but there is not a commitment to ongoing funding of this program for all ACCHS that can support it.

Recommendation 14: Reform undergraduate health professional training courses to make them more suitable to the needs of remote communities.

There needs to be significant reform of undergraduate training programs to make them more suitable to the needs of remote communities.

Recommendation 15: Further develop courses in the Northern Territory in nursing and midwifery and allied health professions (e.g., pharmacy, podiatry, diabetes nurse education, occupational therapy, psychology and others).

There needs to be greater investment into training in outer regional remote and very remote areas with an emphasis on nursing, midwifery and allied health. As regional and remote universities and Centres of Rural and Remote Health have become competitors for students in Australia and overseas, they have reduced focus on their core obligations to rural and remote communities with a subsequent decline in training in remote and rural areas. This needs to change. The NDIS scheme is not meeting the needs of remote and very remote participants partly because of a lack of allied health – this situation is getting worse as demand increases.

The University Department of Rural Health in Alice Springs needs to be transferred to Charles Darwin University as it has not been able to apply its resource to the very aim for which it was established – the recruitment and retention of health professional across Central Australia. It is now time to invest

in our own NT university as this institution has built the relationships with our sector which are key to success in addressing our workforce needs.

Recommendation 16: Establish a Centre of Excellence in GP registrar training in remote/very remote Aboriginal primary health care.

The AMSANT Board has supported a CAAC developed proposal for a centre of excellence in GP training in remote Aboriginal primary health care to be funded in a remote town such as Alice Springs or Broome**.** As set out in the proposal, this center would provide a national focus for GP training in Aboriginal health with specific aims including:

- Increasing the number of well supported registrar training positions in ACCHSs in rural and remote settings;
- Encouraging GP registrars to undertake training in Aboriginal health in all settings;
- Supporting GP Supervisors in collaboration with local training providers, GPSA (General Practice Supervisor's Australia- the national supervisor support organization), and government Aboriginal primary health services;
- Provide access to remote support for registrars and supervisors working in ACCHSs;
- Support partner organisations by providing access to experienced supervisors, Aboriginal cultural expertise, added information, technical support and specialised training initiatives;
- Ensure that the training and placement experience is professionally and personally rewarding for GP registrars; and
- Ensure GP registrars are provided with the support and training to prepare them to work effectively in the diverse context of Aboriginal Australia.

Key partners would include NACCHO and affiliates, RACGP and ACCRM, Rural Training Hubs and Universities, GP Supervisors Australia (GPSA) and the Commonwealth Department of Health.

Recommendation 17: The Commonwealth Government to explore mechanism to supplement GP registrar salaries in private practice so that they are comparable with equivalent hospital-based registrar salaries.

Doctors often take a substantial pay cut when they start private practice GP registrar terms, and they also lose sick leave and maternity leave entitlements that they have built up in the hospital system. Junior doctors may choose non-GP speciality career paths partly based on finances and security. This has led Tasmania to institute a single employer model for GP training. This might not suit the NT given that salary support is available for GP registrar posts in ACCHSs. However, the Federal government could provide funding to top up GP registrar salaries in private practice as these are often substantially lower than what is earned by hospital colleagues at a similar stage of training, particularly for GP registrars doing their first GP registrar post in private practice.

4.3 Long Term Strategies

Recommendation 18: Address poor education, poverty, inequality, poor housing and intergenerational trauma to unlock Aboriginal participation and contribution in the health professions.

In order to increase Aboriginal and Torres Strait Islander participation in the health workforce to a level commensurate with population share and health need, and also to increase participation at all levels of the health system including leadership roles, there must be concerted action on social determinants of health. This includes reducing overcrowding, increasing employment opportunities for Aboriginal people including in remote communities and increasing welfare benefits so they are above the poverty line. Systemic racism and intergenerational trauma must be addressed comprehensively. Evidence based culturally safe early childhood programs also have a track record of improving educational and social outcomes for populations with high levels of poverty and need to be implemented at scale. For adults who have been failed by the education system, evidence based adult literacy programs need to be implemented at a scale commensurate with the need.

Recommendation 19: Expand Aboriginal leadership and participation at all levels of the health system, including as managers, administrators, and health professionals, through cadetship and scholarship programs.

The Aboriginal primary health care sector requires strong leadership at all levels. Currently in very remote areas, the majority of managers and senior clinicians are non-Aboriginal people. This leads to a system which may not centre Aboriginal values, and which is not improving social determinants as well as it might. There needs to be a concerted effort to increase participation at all levels through funding of cadetships, scholarships, mentoring and other support (e.g. child care, transport or access to subsidised housing which is often provided to non-Aboriginal staff but not to Aboriginal staff).

Recommendation 20: Address maldistribution and over-specialisation of health professionals, especially of doctors and nurses.

In the longer term, there needs to be a review and strengthening of policies to improve maldistribution of health professionals and to increase capacity for training of health professionals in rural and remote areas. If the status quo of ongoing severe maldistribution continues, inequities in health access and outcomes are at risk of increasing for Aboriginal people in remote areas. This is clearly unacceptable given the current life expectancy gap. These long-term strategies need to be developed and implemented now otherwise the situation will be even worse in ten years' time.

AMSANT has previously advocated for Medicare Benefits to be restricted so that new practitioners could not access Medicare from locations which were already well supplied with doctors. This would be politically difficult to achieve but may be the most effective long-term strategy to reduce maldistribution of doctors.

There also needs to be a narrowing of the gap between what general practitioners and other specialists earn in order to turn around the decrease in doctors entering general practice training. If governments are not prepared to progressively tax incomes greater than $200K much more than present or put of ceiling on what medical specialists can earn, then the only option is to increase the remuneration that GPs receive. This would be best done as part of a large-scale reform process that move the system towards salaried GP positions in all localities based on population numbers much like the NHS achieves in England. This need to be part of a funding reform process for General Practice which includes patient enrolment and a mixed mode funding model such as exists with ACCHS and the former Health Care Home funding model. These types of reform are needed urgently.

There is also severe maldistribution of nurses and allied health professionals. Increased regional training, tax concessions or even tax exemptions for health employees in very remote areas, and scholarships that bond students to remote areas for several years post-graduation are all potential solutions.

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