

Health and Homelands: Good Value for Money?

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Acknowledgments *I am grateful to the Institute for Cultural Survival, Aboriginal Medical Services Alliance of the NT (AMSANT) and the Miwatj Health Aboriginal Corporation for funding this report and to David Cooper, Harvey Creswell and John Greatorex for helpful comments on an earlier draft.*

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Executive Summary

This paper examines the question of whether and how a study of the costs and benefits of the homelands might be conducted. It is concluded that cost benefit studies of different designs are possible.

As others previously have established beyond reasonable doubt, there are positive health benefits from homelands living. Current policy statements by governments regarding centralization of services (and inevitably populations) are a threat to this improved health and, in the current parlance surrounding Aboriginal health, risk widening the health gap rather than closing it.

Compiling this report has involved examining in some detail the evidence that exists on the benefits in particular but also the costs of homelands living. There is solid evidence on the health benefits of the homelands. The evidence on the costs of the homelands is not as solid but it does suggest that they are not large and may even involve cost savings to governments. Strangely too the extent to which equity figures as a consideration in debating the homelands is largely absent. The paper argues that it ought not to be.

Research for this report has unearthed no evidence to support those current government policies which threaten the existence of the homelands. An interim moratorium on policy action on the homelands is

proposed until findings are available from the sorts of studies suggested in this report. Only then, once good evidence in a cost benefit framework is available, ought policy decisions be made about the future of the homelands.

1. Introduction

This paper examines the question of whether and how a study of the costs and benefits of homelands living might be conducted. In making such an assessment it is necessary first to define the relevant terms, here especially cost benefit analysis and the homelands. This is done in *section 2*.

In *section 3* various possible study designs are set out. While some might want to argue that there is only one 'proper' design, that is not the view taken in this paper. Given that this is difficult territory to set up a good study - there is no prospect for example of a randomised controlled study - there is then a need to look at different possible designs and different studies and judge what is best. There are it is proposed four characteristics that are relevant in deciding on which if any study to pursue: the objective, the feasibility, the rigour and the defensibility.

On the objective of the study and how relevant this is to the overall concerns of the funders/organisers, it is assumed that the concerns relate to the threats to the health of Aboriginal people as a result of the policy pronouncements by both the Federal and NT governments. As others have previously established beyond reasonable doubt (see for example Andreasyan and Hoy 2009; Burgess et al 2005, 2007 and 2009; McDermott et al 1998; O'Dea et al 1988; Rowley et al 2008; Scrimgeour 2007 and 2009) there are positive health benefits from homeland living. Current policy statements are a threat to this improved health and in the current parlance surrounding Aboriginal health will serve to widen the health gap rather than to close it. The objective of any study is then to seek to minimize this threat, by showing that the retention of and support for the homelands is good for the health of Aboriginal people and is good value for money for governments.

Second there is the question of feasibility. Can the study be done in a reasonably or adequately satisfactory way? Thereafter there would need to be consideration, in selecting one or more study design, of a combination of the probability of 'pulling it off' with the degree of rigour likely to obtain in different studies. In all of this there is a need to recognise that whatever study is done, it would be being done with a view to making a difference to policy. As such there will be those who will be ready to criticise whatever is done. The question of 'defensibility' of the study and its results then comes into play. But under this same heading of defensibility, but in a sense on the other side, there is the question of an appeal that might lend itself to the ear of government and draw positively on the appropriate social climate and the political sensitivities that are current.

Section 4 deals with what is an extra issue, that of equity. Cost benefit analysis has both strengths and weaknesses. One of its key weaknesses is that it is not able to handle equity or at least not very well and not readily. Yet in the context of the homelands, equity is potentially a major consideration.

Section 5 considers briefly core services. In *section 6* the points raised in the TOR under 1. 'Description of the work required' are discussed while the overall conclusion is set out in the final section of the paper.

2. Defining terms

2.1 Cost benefit

A cost benefit study is a formal, structured evaluation of a policy or intervention in which the costs and benefits are calculated and compared, at least ideally both in money terms. A judgment can then be made as to whether the policy is 'efficient' – in other words good value for money. This is the case if the benefits are greater than the costs i.e. the policy is 'worthwhile'. This judgment is best made when costs and benefits are measured on a common numeraire, hence the desire to set both in money terms. The costs and benefits involved are best seen as the social costs and the social benefits and should ideally include all effects, positive and negative, no matter on whom they fall or to whom they accrue.

Most but by no means all costs are usually relatively easy to calculate, although they ought strictly to be based on what are known as 'opportunity costs'. These are defined as the benefits foregone in the best alternative use of the resources. That complicates things somewhat, especially as that concept is subjective and value laden. Which costs to include is easily answered in theory: all costs no matter on whom they fall that are a result of the implementation of the policy. Costs here might include not just those that normally have a money tag attached to them such as labour inputs but also intangibles such as patient travel time. There can also be negative costs e.g. cost savings to individuals or to government.

The main measured costs that it is envisaged will enter into this study are health service costs and cost savings. Ideally the costs to be measured will refer to any estimated change in resource use for the people, diseases and locations involved. Thus if for example there is a reduction in people suffering from diabetes in location A, the cost figures to be used will relate to the resources saved (or freed up to be used on other patients or in other clinics) in the relevant clinic in location A or used by these clients in some other location e.g. a clinic elsewhere or a hospital. Thus what is ideally required is the change in costs involved in the location involved for the patients involved.

There are three issues of data availability that arise here. First the prospects for measuring the marginal or changed cost; second the question of relating costs specifically to the management of the disease or condition involved; and third whether the costs can be related directly to the clinic or other services provided to the specific clients in the specific clinic/hospital involved.

It can in practice be difficult to estimate 'marginal' costs. Where services are labour intensive, as many of them will be in this case, it may well be that average unit costs will be good approximations to these marginal costs. That is unlikely to be too much of a problem but needs to be tested if at all possible. Second the clinics and hospitals appear to have good data on diagnoses so that attributing costs to specific conditions ought to be straightforward. Third data are available at a Territory level on the PHC costs of treatments by various diagnoses and these can be used (Zhao et al 2006). It is likely to be the case that these territory-wide data have been aggregated up from individual clinics or at least a sample of such clinics and can be disaggregated to get back to the individual clinic level. Hospital data appear adequate.

The aggregated PHC data may be used if there is no reason to believe that homelands clients' unit costs for specified conditions are likely to be different from those of non-homelands clients.

That assumption can be and should be empirically tested. If they are broadly similar, then the aggregated data can be used. If they are not then clearly the specific data will need to be obtained from clinic records which almost certainly will exist in a usable form but, if not, then a study might need to be set up to calculate these.

Other costs associated with treatment such as patient travel and time costs will ideally need to be collected and are unlikely to be available 'off the shelf'. Again a study might be needed here but the importance of these costs is difficult to judge at this time. Will they change to any great extent and sufficiently to make a possibly significant difference to the results? (There is a technique available to test this – known as 'sensitivity analysis' – which, very simply, indicates how sensitive results are to variations in the values of some parameter or other. Where rough estimates of various costs or benefits 'will do' because the results are not sensitive to these, analytical time and energy is then better spent on estimating other variables more precisely.)

Benefits include all effects not included as costs and may be positive or negative. Again all benefits that arise because of the policy are to be included. Health gains are a benefit. There can be negative benefits such as the creation of anxiety or loss of health. Benefits are perhaps best seen as anything that anyone is willing to pay for, not just with money but for example giving up time to obtain.

In this paper the costs and benefits are set in terms of health and health care costs and benefits as that is the focus of interest. Seeking to establish *all* the costs and benefits of homelands living versus non homelands living would be a truly formidable exercise and one that would in many respects be speculative, indeed so speculative that it would suffer greatly from being open to attack as a result of the problems surrounding the assumptions that would need to be brought to bear. It is feasible but the worry would be that it would be so tentative in its findings as to be not worthwhile. It might be however investigated at a later stage of this process.

That is not to deny that there may be other benefits and costs of homelands living as it has been suggested that 'country' is an important social determinant not only of health but of Indigenous wellbeing more generally. In this context it is important to think of not just social determinants but cultural determinants. As a social and cultural determinant of health there is what amounts to good evidence that 'country' is a contributor to better health.

Rose (1996, p7) suggests: "Country is multi-dimensional – it consists of people, animals, plants, Dreamings; underground, earth, soils, minerals, and waters, air ... People talk about country in the same way that they would talk about a person: they speak to country, sing to country, visit country, worry about country, feel sorry for country, and long for country".

The position here however is complicated by the fact that to a very great extent such constructs as cost benefit analysis, country, social determinants of health and health itself are western in origin and do not readily 'translate' into Aboriginal values. To take but one of these for example Shane Houston (2003) argues that health for Aboriginal people involves not just physical health but also spirituality, freedom from poverty (not strictly as a determinant of health but as an integral part of health) and the environment. Again country for Aboriginal people embraces more than it does for other Australians. As Stanner (1969 p 44) wrote: "No English words are good enough to give a

sense of the links between an Indigenous group and its homeland ... A different tradition leaves us tongueless and earless towards this other world of meaning and significance.”

Further Pat Anderson writes: “our identity as human beings remains tied to our land, to our cultural practices, our systems of authority and social control, our intellectual traditions, our concepts of spirituality, and to our systems of resource ownership and exchange. Destroy this relationship and you damage – sometimes irrevocably – individual human beings and their health” (Anderson 1996 p 15).

The concept of benefit is thus different, less tangible and by no means restricted to consequentialism (i.e. only outcomes are valued) as is the case in standard cost benefit analysis. Since however any study results are intended to influence governmental decision makers, it is argued that in the main, while noting these differences, any study should be as ‘conventional’ as possible in that that is the strategy which is more likely to carry weight.

The question of how to attach money values to benefits is similarly in part culturally based. Most cost benefit studies ideally try to use ‘willingness to pay’ as a monetary measure of benefit. The more a person is willing to pay for something the higher is its value and hence the benefit to that person. While in many situations that idea of willingness to pay can work well, a major problem is that it is dependent on ability to pay and, other things being equal, the rich have a higher ability to pay than the poor. That can lead to inequities in the valuation process. To adopt this procedure in the context of this study carries risks unless of course, as can be done and indeed is recommended, the values used are based on average national valuations and are not restricted to Aboriginal people’s values or Aboriginal people’s lives and health. (The implication of this last point is simply that the value attached to saving a life or a year of life or any unit of health gain is the same no matter whether the life involved is Aboriginal or not. This is especially important in the discussion below of the values of the Pharmaceutical Benefits Advisory Committee (PBAC).)

There is also a form of cost benefit analysis which is based on the values of the decision makers in an organisation. Here the question of willingness to pay is put to the relevant decision makers and within the organisation’s constrained budget, they are then asked to allocate that budget across various different competing projects. Their “implied values” can then be used to value benefits. (An example is the decision making of the PBAC. When decisions are made to say yes to an investment in lifesaving, this means that the benefits involved are implied to be greater than the costs. PBAC decision making reveals that the implied value of a year of life is of the order of \$50,000. Thus a life year is being valued at at least \$50,000. When the PBAC say no, the implied value of a life years is less than \$50,000. This ‘cut off point’ of \$50,000 gives the implied value of life which can then be used in other similar health sector decision processes as a monetary value of a life year (Mooney 2008).

What monetary values to use for calculating the health benefits needs to be resolved. Fortunately at least with respect to the value of life years, there is work that can be drawn upon.

1. The Department of Finance and Deregulation (2008) suggests at 2009 prices a value of life of \$3.75 million and a value of one year of life of \$161,750.

2. It can be argued that this figure needs to be subjected to a budget constraint in the relevant sector in this instance health. One option is to use the \$50,000 figure from the PBAC as outlined above.

Health gains outside of lives saved or life years saved can be tackled in a proportionate way. There is substantial literature on measuring health and health gains including the most common in the health economics literature of QALYs – quality adjusted life years. The ‘quality adjustment’ is about ill-health, adjusting lives saved for example to take account of changes in morbidity or pain or other effects of illness. Two specific problems arise here. First the relative values of quality of life versus quantity of life may well vary between Aboriginal and non-Aboriginal people, especially given different constructs of health. (Aboriginal people might for example value mental health impairment higher than non-Aboriginal people but the reverse might be true for physical health.) Second to make QALYs or any other health status measure work in practice requires that various health states have been or are able to be converted to QALYs. The prospects of trying to do this are daunting and it is not recommended for three reasons. First it is a big task. Second few decision makers would place much value on the results. And third it may well not be necessary to make the arguments.

2.2 Homelands

With respect to the focus of this study what is sought is to examine the costs and benefits of people living in the homelands or what are sometimes called ‘outstations’. The latter expression has some negative connotations culturally for some Aboriginal people and hence is avoided where possible in this paper.

There are various definitions and descriptions of the ‘homelands’ but the essence is summed up as follows by Robyn McDermott and colleagues (1998): “Changes in government policy in the 1970s, notably the replacement of an assimilationist policy with one of self-determination, gave Aboriginal people the opportunity to regain a degree of control over where they lived. Many small family groups began to move back to traditional homelands from settlements, towns and missions.”

Or as Jon Altman and colleagues (2008) more recently write: “Outstations/homelands are at the centre of Aboriginal economic, cultural and spiritual life across much of Australia. Outstations/homelands represent a strong Indigenous priority ... They are the result of Indigenous initiatives to improve wellbeing by providing a social setting within which Indigenous languages, ecological knowledge, culture and law can remain strong and relevant, and so underpin community development, economic initiatives and sustainable land and sea management.”

They continue: “The importance of outstations/homelands to Aboriginal people is clear from the number of outstations/homelands and the number of people who live in or utilise them. There are an estimated 500 outstations/homelands, with approximately 10,000 people associated with them and another 40,000 people linked to outstations/homelands and country but often residing primarily in larger ‘township’ communities in the region.”

3. Possible study designs and studies

What is ideally required is a study that looks at the world with and without homelands and tries to gauge which is a better world. Such an ideal design is not possible. It is then necessary to look for proxies to that ideal.

3.1 Homelands versus non-homelands

For people living in the homelands, are they in relevant ways 'better off' than people living elsewhere? Here we need to try to ensure that the two lots of people are the same except that one lives in the homelands and the other does not. This 'matching' is tricky but has to be as good as possible if the study results are to hold water in the sense that any differences can be attributed to homelands/non-homelands. One major difficulty here is that there are so many different social determinants of Aboriginal health and all too little knowledge or evidence on what the influence of any are individually or in combination. Good matching is thus crucial but the opinions of those who have read a draft of this report are that it can be done in certain well chosen locations. It would require good local knowledge but that is available in at least some regions.

Another issue to be addressed in this design is self-selection. Are the people who live in the homelands there because they choose to be there and those who are not there, do they choose not to be there? If people 'self-select', differences that arise may be because they want a different location or life style or culture or whatever it is that made them choose.

On the objective, this study scores quite well. On feasibility a study based on this study design ranks highly as there are both homelands and non homelands communities to allow the study to be done. On rigor the question revolves around the issue of matching. There is no way that this can be perfect but to do a series of pair wise comparisons of homelands versus non homelands communities rather than a single comparison of one community versus another will add to the rigor of the results. On defensibility, this study design, while not ideal, is a common one in research and an 'obvious' way to go about such a study. These two features of feasibility and rigor make it quite defensible.

3.2 Added/loss of benefit from moving to/from homelands

The question of the movement of people either to or from the homelands can lead to another study design. In moving, do people get more or less benefit? The fact that they moved (if an informed choice) can in itself be taken as an indication of preference i.e. a presumption of higher anticipated benefit in the new location. A study design can be built around the assessment of benefits to movers. This design assumes that matching can be done or that movers can be assessed for why they moved and what benefits they got. That may be difficult to achieve.

Another possibility here is to examine the health of people and their use of services in locations where homelands were either established or abandoned. A before and after study can then be conducted. That design is possible provided such circumstances exist. It has the advantage that the people concerned before and after are the same people and there is then no need to match

locations as in 3.1. The downside is that there is a need to control for other factors which may have changed over time and it may be these rather than the existence or abandonment of the homelands which have led to the better / worse outcomes. While in such a situation clearly it is not possible to exercise complete control over these other potentially confounding factors, often trends over time in some related population or the total population from which the sample population is drawn will give a good enough picture of what might have happened otherwise.

This design is particularly attractive in terms of the objective. It also scores well on feasibility, rigor and defensibility. The only real issue over feasibility is whether such movements can be identified but the evidence suggests that they can. Most important is to identify where people have moved off homelands and what has happened to their health and their use of health care. (This is important as that is what will happen if the homelands are now to be 'closed'.)

If the data can be obtained to follow the relevant cohorts, then the study can be made rigorous. It is particularly defensible as it is the one study design of those listed in this paper that can incorporate the (potentially traumatic) effects of movement. The other designs are static in this context.

It may be that such a study is best done prospectively. Then the health and health care use of movers can be monitored and measured before the move, immediately after and then some time after, the hypothesis being not just that the homelands are more protective of health. It is further hypothesised that the act of moving away from them is deleterious to health but after a period of time health may settle down, even if not recover to the original homelands-based level.

Health care consumption is measurable in the homelands and in the new locations both short run and longer term, especially if the study is done prospectively (Campbell et al 2009).

3.3 Is investing in homelands a good buy?

Another study design arises from the essentially economic question: if governments want to invest more in Aboriginal health where and/or in what is it best to invest? This is a question that is central to for example closing the gap and yet it is seldom posed in that context.

This is in economic terms the 'marginal question': if there is an extra (or marginal) \$1 million to spend on improving Aboriginal health (or closing the gap?) where best to spend it? Where will that \$1 million do most good? Given the evidence that already exists about the benefits of homelands living, the question of these marginal benefits seems particularly pertinent.

This study design would thus consider questions around the benefits of various extensions of existing services / interventions. Is it better to invest an extra \$1 million in the homelands or in more centralised communities? But the question of where to spend any extra can be extended well beyond that. Might it be better spent in AMSs? In housing? In training more Aboriginal Health Workers? In child immunization?

What is needed here is to be able to compare different investments in Aboriginal health and to see how efficient these are as compared with investing in the homelands or at least continuing to provide

services to the homelands. There is some evidence around on cost-effective recommendations in Indigenous health (for example from Russell and Leeder 2008; and also Beaver and Zhao 2004).

This can be extended but this approach might allow a relative cost-effectiveness 'league table' for Aboriginal health to be assembled. Where homelands would sit is anyone's guess but the approach is appealing. The data can be assembled at the level of arguing for the homelands. The design does not require to show that the benefits of the homelands are greater than the costs; only that the relative cost effectiveness of investing more in the homelands is higher than investing more in at least some other programs and interventions in Aboriginal health that have government backing. The argument is a simple one: 'Why, when you are funding X where the cost effectiveness is Y, are you not prepared to continue to fund the homelands where the cost effectiveness is Z [assuming Z better than Y]?'

There is a possible down side to this and that is that the governments involved might use such a study not as a basis for deciding where to spend more on improving Aboriginal health but as a mechanism for redeploying monies – in other words to stop or reduce funding on the 'bad buys' so that these monies can be put to better use on other 'better buys'. If that happened any reprieve for the homelands might be at the expense of other programs. How governments might respond – spend more because of better evidence of marginal cost effectiveness; the same but reallocating from poorer to better buys; or less because as much can be achieved but at lower cost – is open to speculation.

3.4 What is it about homelands that provides benefit? For example, caring for country?

This study design would examine the question: is it homelands per se that make the difference or something within certain homelands? This design would thus seek to explain what it is about certain homelands that result in higher health status. One option for example would be to examine activities that fall under the heading of 'caring for country' to see how these might emerge in a cost benefit framework. The evidence on health improvement from caring for country does look good.

This study design is tricky on two counts as now there is a need to have matching communities which are the same except that, while both are homelands communities, the *nature* of the homelands differs and hence any differences in health status in the two communities can be attributed to the different types of homelands.

The objective here is different from the other studies proposed and seeks to address the question of what is it about homelands that makes for better health. That in a sense is a sub-objective, an important one but a lesser one.

This is also perhaps the least feasible study as there is a need to work out what it is that makes one homeland 'better' than another, otherwise the study goes on a fishing trip. There are two complications here. The evidence to date on what it is about homelands that makes for better

health is still being debated even if some attributes seem clear such as 'caring for country' and 'country' per se. Second finding homelands to study which exhibit such differences is likely to prove difficult.

The rigor is likely to be high if the relevant hypotheses can be well articulated and if appropriate homelands found. It is the 'ifs' that are the potential problem, which takes the issue back to feasibility.

The defensibility question here would almost certainly turn out to be murky largely because of the amount of 'noise' or confounders involved. In other words the pinning down of attribution and the issue of interpretation of the results would likely prove difficult.

This is not to argue that 'caring for country', 'country' or any other attribute of homelands is not capable of being identified as being good value in cost benefit terms. It just looks harder to prove it as compared with the other studies discussed in this paper.

4. Equity

A senior adviser to Minister Macklin has stated: “Under *A Working Future* there is no intention to abandon homelands or to relocate residents. The Northern Territory Government has committed to maintaining current levels of funding for the maintenance of occupied outstations and will also ensure that outstations residents continue to have access to health, education and other key government services. The Australian and Northern Territory Governments have agreed that the *A Working Future* (2009) approach must align closely with the principles set out in the *National Partnership on Remote Service Delivery* (2009) including the agreement that Indigenous Australians living on outstations receive services comparable to those received by other Australians living in a community of similar size, location and need.”

This is a strong equity statement and one that is seemingly based on rights rather than strictly costs and benefits. Indeed it is significant that the statement makes no mention of costs. It is further significant that the statement makes no mention of the meeting of the implied goals being in any way constrained by costs.

Turning to *A Working Future* however, there appears to be a disjuncture between the above statement and what the NT Government’s document states: “Territory Growth Towns will provide services to all people living in that region, including people living on outstations and homelands. Where outstations and homelands do not have a Territory Growth Town nearby we will continue to provide services.”

The clear implication of that statement is that where outstations and homelands do have a Territory Growth Town nearby, the government will not continue to provide services to the outstations and homelands.

The statement in *A Working Future* goes on: “We are going to develop a Statement of Expectation of Service Delivery to outstation and homelands residents that will say how much help residents can expect from governments.”

This is crucial. The implication is that resources are to be centralized in the Territory Growth Towns and that, even if more money were to be made available in these locations, there will be less for outstations and homelands.

The worry has to be that despite the statement from Macklin’s Office that “Indigenous Australians living on outstations receive services comparable to those received by other Australians living in a community of similar size, location and need”, because the responsibility for policy now rests with the NT Government, it will be *A Working Future* that will overrule any concerns for equity as expressed federally. In any assessment of costs and benefits allied to equity there is a need to keep a very close eye on what is proposed in the NT Government’s Statement of Expectation of Service Delivery to outstation and homelands residents.

5. Core services

This issue (raised in the TOR) is rather different from an economics perspective than the others covered in this paper. The question posed there is to examine: "The extent to which differentials in health status between Aboriginal people living in homelands/outstations in the NT and other Aboriginal people in the NT imply differentials in the cost of providing a core level of primary health care services to those two groups."

The concept lying behind core services is such that this author's interpretation is that while a useful idea in principle, there are two worries about it in practice: first that whatever is defined as core in principle ends up as some target in practice; and second that when resources are inadequate to provide all core services what gives is not necessarily certain specific services but some reduction in quantity or quality of many services.

This issue in economic terms revolves around questions of marginal benefits and marginal costs. This is a different philosophical approach to the one which seems to be prevalent in core services thinking which is that, faced with too low a budget to provide all services within the designated core, it is services that fall off the edge.

Acknowledging that the author's thinking may be out of tune with the way in which core services are to be assessed, let us return to the issue raised in the TOR regarding the impact on the costs of providing core services when health status levels are different. Two responses seem possible. The first is that core services are core services whatever the level of health status. The second is that to imply that different population health levels in different communities will and indeed should result in different core services seems to take away the basic meaning of core as in core services.

What might be a useful avenue to explore is the extent to which any resource allocation formula for allocating monies across different geographical areas ought to take account of differential need in the different areas and if so on what basis and with what weightings or values being attached to which parameters. This brings the discussion back to the NT Government's Statement of Expectation of Service Delivery as raised in section 4 above. On what basis will this statement determine resource allocation? While not strictly within the TOR the basis of the calculations that will lead to decisions on how resources get allocated to growth towns, homelands and other areas ie the basis of the Statement of Expectations of Service Delivery is a matter that is of great import in this whole debate about the resourcing of the homelands.

6. Returning to the TOR

The Terms of Reference for this exercise asked that there be undertaken “an assessment of available research, data, case studies and other existing writing with a view to their relevance to:

- (i) weighing up the costs and benefits of homelands /outstation living and ‘caring for country’ activity in the NT as strategies for improving population health outcomes for Aboriginal people.”

This issue is the main one addressed in this paper and detailed discussion has been set out above with respect to the homelands. The question of ‘caring for country’ has also been addressed but briefly as the evidence on this is more limited and a study design to deal with the costs and benefits of this suggests that to establish such an appraisal in cost benefit terms would be difficult. This in no sense is to argue that there are not health benefits from ‘caring for country’. What evidence there is suggests that there are. It is designing a study to show this in cost benefit terms that would encounter certain problems. It is also not central to the objectives of this paper.

- “(ii) In particular, where possible consider point (i) in regard to chronic illness, child and maternal health and mental health issues.”

The data appear to be sufficiently good to allow this to be done for homelands but of course any disaggregation would likely lead to less robust results. The reservations in (i) regarding ‘caring for country’ are yet stronger if such disaggregation were to be attempted for that.

- “(iii) The extent to which differentials in health status between Aboriginal people living in homelands/outstations in the NT and other Aboriginal people in the NT imply differentials in the cost of providing a core level of primary health care services to those two groups.”

This is discussed in section 5 above. It is argued that it may be better seen in terms of how the NT Government’s Statement of Expectation of Service Delivery is derived. This may well be a focus for more work on the issue of resourcing the homelands.

- “(iv) The extent to which land ownership, and/or residing on and caring for traditional land can, on the evidence, be regarded as a social determinant of population health outcomes for Aboriginal people in the NT.”

The evidence for residing on traditional land being a social determinant of health seems strong. On land ownership and caring for traditional land the evidence is not there on the former but it is on the latter, in epidemiological terms. These are questions however that are better put to an epidemiologist rather than an economist.

- “(v) Any implications which can be drawn in regard to the health care costs, and overall impact in health benefit/cost terms, of recent policies of the NT and Commonwealth Governments which purport to focus government resources on so-called ‘growth towns’ (NT Government) or ‘priority communities’ (Commonwealth Government).”

To answer this really requires the results of studies discussed in this paper to be available. The evidence on the health benefits of homelands is quite strong. How the cost benefit calculations would work out in practice is difficult to predict. So much depends on how the policies are implemented in practice. However it does seem to have been at best premature to have made these policy announcements without having first carried out the sorts of studies discussed earlier in this paper. The question that really needs to be addressed to examine this issue is: whatever the budget for PHC in remote areas of the NT, what is the optimal split between centralised communities and homelands?

7. Conclusion

Compiling this report has involved the author in examining in some detail the evidence that exists on the benefits in particular but also the costs of homelands living. Having done so, two things emerge. First the evidence on the health benefits of the homelands is pretty solid. The evidence on costs is not as solid but what there is ought to give little cause for concern to finance officers in the relevant government departments. It would be wrong to speculate on what the costs might be but it can be said that they are not great and are conceivably negative i.e. the continuance of the homelands may save governments money. Certainly I can find no evidence to support current policies which threaten the homelands. What might be the best in the meantime is to have some sort of moratorium on policy action on the homelands until findings are available from the sorts of studies suggested in this report.

Secondly there are good grounds for suggesting that one or more studies as listed can be fruitfully undertaken to appraise the health costs and benefits of homeland living. It is also argued that the issue of equity ought to figure in any evaluation of the homelands. There is additionally a strong argument for assessing whatever developments there are or have been on the NT Government's Statement of Expectation of Service Delivery and seeking to influence these as they will have a major impact on the resourcing of the homelands.

Answering the question as to which studies are most appropriate to conduct is partly a subjective judgment and is best made by those who might fund them. The paper has laid out the pros and cons of the different possible studies.

The best bet however is probably study 3.2 *Added/loss of benefit from moving to/from homelands* or 3.3 *Is investing in homelands a good buy?* (but 3.1 *Homelands versus non-homelands* is also a runner). Both 3.2 and 3.3 are feasible, both can be done quite rigorously and both can come up with defensible results. The latter is possibly more difficult to do. The objectives are somewhat different and it may be that that determines which is the better buy.

One of the main gaps is in assessing why homelands seem to result in better health. The evidence to date suggests that being on country may well matter and that caring for country may well also be health protecting. But before going firm on these ideas more research is needed. Yet, having said that, does it matter? If the homelands are health enhancing or protective does it really matter why?

The cost data may need to be improved in some contexts but generally look, overall, quite acceptable to be used. Some special surveys to improve cost data may be needed in some instances.

With respect to 3.3 *Is investing in homelands a good buy?* more cost effectiveness evaluations of interventions in Aboriginal health to help to build the league table would be useful but as this is again a big task and there is probably enough material around to allow this form of analysis to be conducted, such additional evaluations can probably be left.

It might also be argued that there is a need to devise Aboriginal health status measures but that is again such a massive task that it is not worthy of more discussion here.

Finally conducting a cost benefit study along the lines of the three main runners identified - *Homelands versus non-homelands*; *Added/loss of benefit from moving to/from homelands*; and *Is investing in homelands a good buy?* is feasible can be done with adequate rigor and can be made defensible.

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Report on the Feasibility of a Cost Benefit Study of the Health and Homelands

Description of work required (TOR)

1. Undertake an assessment of available research, data, case studies and other existing writing with a view to their relevance to:

- (i) Weighing up the costs and benefits of the homelands/outstation movement and 'caring for country' activity in the NT as strategies for improving population health outcomes for Aboriginal people.
- (ii) In particular, where possible consider point (i) in regard to chronic illness, child and maternal health, and mental health issues.
- (iii) The extent to which differentials in health status between Aboriginal people living at homelands / outstations in the NT and other Aboriginal people in the NT imply differentials in the cost of providing a core level of primary health care services to those two groups.
- (iv) The extent to which land ownership, and/or residing on and caring for traditional land can, on the evidence, be regarded as a social determinant of population health outcomes for Aboriginal people in the NT.
- (v) Any implications which can be drawn in regard to the health care costs, and overall impact in health benefit / cost terms, of recent policies of the NT and Commonwealth Governments which purport to focus government resources on so-called 'growth towns' (NT Government) or 'priority communities' (Commonwealth Government).

2. Provide a written report which at the minimum:

- (i) identifies those conclusions which can reasonably be drawn on the basis of the available writing and data;
- (ii) identifies the most important gaps in writing, data and research which need to be filled or supplemented in order for further conclusions to be drawn;
- (iii) outlines the broad features of a strategy for future research or data-gathering on the issue of the costs and benefits of the homeland / outstation / caring for country movement as population health strategies relevant to the goals of government health policy for Aboriginal people in the NT.

The consultant is encouraged to include information, analysis and discussion which is additional to the three points outlined above, if he feels it is relevant.