PART A – DETAILED SUMMARY

1. THE DOCUMENTS

The Northern Territory Department of Health & Community Services (DHCS) recommended one main document guiding the department’s strategic directions from 2004 to 2009, called Building Healthier Communities. Building Healthier Communities describes the vision for health and community services system in the Northern Territory over the next 5 years. It was written to act as a framework for more detailed planning and implementation by the DHCS in order to build healthier communities, improve the health system, tackle old challenges in new ways, and have responsive, accountable and effective health and community services. The document outlines the NT government’s broad agenda for change and the key areas in which it will act. It describes challenges faced in ten key areas where they will concentrate their energy and outlines the scope and depth of their commitment. For each area it gives examples of what has been done, what is currently underway, and what they will do in future. Building Healthier Communities is also seen as a basis for working with the non-government sector, the Commonwealth and other states. It does not talk of broader territory planning documents but does mention other health-related Plans.

The document provides some rationale for addressing health for the wider benefits, noting in particular that the social, human and economic costs of not dealing with the poorer health of Aboriginal Territorians (their “biggest health and community services challenge”) actually “robs us all” of opportunity, growth and pride. They also see some population benefits in improving health, in that
addressing the needs of older Territorians could make the Territory an attractive retirement option for older people.

Two other departmental documents were also referred to by the researchers: The Department’s Annual Report 2004-05 (2005) and Aboriginal Health and Families - A Five Year Framework for Action. The latter document was written with two purposes: firstly, to guide significant reform to the health and family wellbeing service platform in the NT to ensure that the services offered are accessible, balanced and contribute to sustained health and welfare gains for Aboriginal people; secondly, to reform the quality and functioning of the health and family wellbeing system to provide the best mix of resources in locations where they are needed. It states that it was written specifically to map a course for the Department’s implementation of what was contained in the Building Healthier Communities document.

2. **PROCESS, DEVELOPERS, STAKEHOLDERS**

It is not clear how Building Healthier Communities was developed, but it appears to have been written as a framework for “a new team”, perhaps after the Bansemer Review of the Department. The document says that the government’s commitment to “making a difference to health and community services” is why the Department of Health & Community Services was comprehensively reviewed and why they want to change the way they do things. The document says the Review identified high levels of need in some areas that had been neglected for many years eg mental health services, disability services, health and child protection, as well as areas where needs are increasing eg renal disease, STIs and HIV/AIDS, alcohol and substance abuse.

The Aboriginal Health & Families Framework appears to be another internally developed document by the Department of Health & Community Services. The document does not say whether Aboriginal people or communities were consulted about the Framework’s development or provided any input in terms of how they would like to see services and health systems reformed, or what they would deem to be appropriate services for their needs. Rather, it is focussed on "the Government's objectives for improved health and family wellbeing for Aboriginal people”. An Office of Aboriginal Health, Family and Social Policy was created to lead the strategic reform and evaluation of the Department's efforts in relation to this framework.

3. **VALUES, DEFINITIONS & LANGUAGE**

Building Healthier Communities does not explicitly mention “health inequalities”, “health inequities”, or “vulnerable groups”. However, it implicitly talks of health inequities when it talks of the “unacceptable situation where the gap in life expectancy between Aboriginal and non-Aboriginal Territorians remains at around 20 years” and of the need to commit to a comprehensive approach of supporting Aboriginal people achieve better health and life outcomes for themselves and their communities”.

The main word the document used in this document is “disadvantage”. For example, it mentions that “working to overcome disadvantage” for children in the early years “will have positive effects not just now but for many years to come”. It also implicitly talks of the social determinants of health when saying that there are “many pathways to better health”, through schools, jobs, housing, justice, community development, and the strengthening of families and communities”. It also acknowledges that “for some Territorians links of family, kin and community are weakened by economic or social disadvantage, poor health, poverty or lack of education. Some find themselves trapped in a cycle of dysfunction and disadvantage”. In fact, social determinants of health are referred to as 'health hardware' when the document talks of the need to “contribute expertise on housing and infrastructure developments under the Government’s regional development initiatives.” There is also acknowledgement of the lifelong impact of social determinants when the document talks of the “pay off” of working to “overcome disadvantage” by investing in education, employment and family support in children’s earlier years in improving lifelong health and avoiding anti-social behaviour and crime later, and to help families and communities “break the cycle” of dysfunction and disadvantage.
The document also notes that “employment, education and opportunity are central to this Government’s commitment to family and community and that the health and community services system also has an important role to play. They also have stated aims to particularly “support the employment of people from groups disadvantaged in the workforce, to increase the number of Aboriginal people in the workforce at all levels, and to promote careers in health and community services professions to the Aboriginal community”.

The Aboriginal Health & Families Framework talks extensively of primary health care provision as a key way to improve health for Aboriginal Territorians. However, it states that “the most important thing a health system can do to improve Aboriginal health and wellbeing” is to develop “a balanced set of primary health and family wellbeing services”. Aside from this focus on service provision, there is little mention of possibilities of addressing the broader social determinants of health or considering the health effects of the social, environmental and housing conditions in which Aboriginal people live. Despite commenting that “everyone's life course is a cascading combination of biological and social/environmental influences”, the document states that “how people's lives unfold over time is influenced by whether or not they are born into and live in a family and community that is capable, and whether they have access to health and family development services at the right times throughout their lives. When these positive factors are absent, and access to support and services is limited, people will accumulate a significant burden of ill health and shortened lives. Most importantly they will also deliver to their children a poor start in life”. However, having said this, the document does acknowledge the importance of employment in relation to health and states that “from the health/social justice perspective, evidence shows that there is an association between work, type of work and the security surrounding employment, and the prevalence of ill health and mortality. Further studies have shown that the impact of unemployment reaches beyond the lives of those without work to touch whole families and future generations”. Whilst not directly aiming to collaborate with other departments to improve employment opportunities for Aboriginal people, the document does have a whole section on what the Department can do to improve Aboriginal representation within the health workforce. In particular, the younger population profile of NT Aboriginal people is seen as offering a growing proportion of the Territory's population and a potential pool of Territory-based and Territory-loyal workers. The Department therefore aims to create health workplaces which affirm Aboriginal culture and values and which seek to create targeted and general employment and career opportunities for Aboriginal people.

Who is responsible for health equity in the dept – one section or whole department?

Health equity is not explicitly discussed from this perspective in the NT documents.

4. HEALTH OUTCOMES & HEALTH ACCESS

Building Healthier Communities aims to improve overall health and services, and also improve the health outcomes of those with poorer health. There is also a stated aim to not only increase social and physical access to services, but specifically to improve technological access to health promotion and prevention information, particularly for rural and remote communities.

The NT government’s vision is “Ensuring that all Territorians enjoy long and healthy lives, and have a health and community services system that is responsive, accountable and effective”. The document however acknowledges that “some individuals and families have not benefited from our system as well as they might” and that in particular “the health of Aboriginal Territorians needs concentrated effort, and distance and lack of infrastructure pose major challenges for service delivery for all people living in remote and regional areas”. They note that Aboriginal people in particular continue to have much poorer health than other Territorians” and that despite changes in the health of Aboriginal people, there have been worsening outcomes in some areas (such as renal disease and diabetes) which have offset gains in other areas (for example, in infant mortality). Addressing Aboriginal ill health and disadvantage is therefore stated as being amongst the NT Government’s highest priorities, and will focus not only on better health outcomes but also on better life outcomes. The document also states the Health Minister’s personal vision for this: “By the end of the decade I want the world’s best practice health care for Indigenous communities in the Northern Territory.”
Improving access to health services is also a stated intention, particularly for the elderly, to help them lead “independent and healthy lives in the community”. Due to the geography and population distribution of the NT, regional and remote access issues are seen as another “big challenge”, particularly in providing best quality specialist and hospital care without the need to travel to a major urban centre. There is also acknowledgement that “accessibility is not just about physical location, must also meet needs of people and be provided in manner which takes account of their lifestyle”. The document aims to provide services which are both “easier to get to” and “easier to use”, providing services in communities and specialist outreach, along with fairer and more equitable access to services for people with disability. There is also a stated intention to improve access to opportunities for employment for “people from groups disadvantaged in the workforce” and to increase the number of Aboriginal people in the workforce at all levels, including creating pathways across professional boundaries.

In relation to access to health information, the document states an intention to “boost access to health information for Aboriginal people”, providing information that is culturally and linguistically appropriate for health awareness and promotion. The NT government is looking to technological solutions to address the challenge of “servicing a small, dispersed population over a huge area where access can be seasonal”. It therefore aims to invest in a “health information network” to link health professionals with clients and community and allow interaction wherever located, and also to give the public access to health information, to enable videoconferencing to be used to maintain regular contact with family at a distant, and to provide on-line access to doctors to discuss care and treatment. There is also a stated aim to widen opportunities for particular groups, eg they intend to “introduce world best-practice systems so children in care have the same opportunities as other children”.

Along with discussion of improving health outcomes and services is implicit talk of improving the social determinants of health. For example, there is an intention to develop better understanding of the “causes of disadvantage and the ways that the design and delivery of services can reduce disadvantage.” There is also an aim to improve Aboriginal health that is based on strengthening “relationships between research bodies and services so programs are based on sound evidence”.

The Aboriginal Families & Health Framework aims to build better services and a better health system. In order to improve child health it focuses on improving antenatal care and nutrition for mothers, and improved nutritional and family care for infants, to raise birthweight and the incidence of breastfeeding. There is also an emphasis on appropriately immersing Aboriginal children in their culture and encouraging language development. For adolescents there is a focus on improving transitions from school to minimise health risks such as mental health and sexual health, for example by liaising with schools on health prevention and health promotion programs, liaising with communities to reduce anti-social behaviour, or providing community level interventions to raise self-esteem and coping skills. There is however no mention of the possibility of providing youth with appropriate training or employment opportunities, or to collaborate with other sectors outside of health to provide these as a way of reducing anti-social behaviour, risky lifestyle behaviours or low self-esteem. The document does however highlight the need to consider gender differences, including over the lifecourse, and in lifestyles and health needs, and therefore to develop men’s and women’s health strategies.

5. STRATEGIES FOR ACTION: HEALTH

There are no plans or strategies which explicitly talk of addressing health inequities. However, Building Healthier Communities has 10 core strategic areas which do address the social determinants of health (although they are not so-named). These aim to improve health for particular groups, to address particular behaviours, or address particular service issues, and most of these will also implicitly address health inequities, particularly for Aboriginal children and people in remote and rural communities.

1. Giving kids a good start in life
2. Strengthening families and communities
3. Getting serious about Aboriginal health
4. Creating better pathways to health services
5. Filling service gaps
6. Tackling substance abuse
7. Building quality health and community services
8. Creating better ways of working together
9. Valuing and supporting our workforce
10. Creating a health information network

Each area has some key priorities for action. For example, the first core strategy “Giving Kids a Good Start” has three priority areas with related objectives. The first priority is Children’s Health. This has objectives of firstly developing targeted approaches to pregnant women and to children in their first years of life to improve nutrition, promote child growth, reduce smoking and drinking in pregnancy and provide effective antenatal care; secondly of investing in children's health by increasing the child health workforce in remote communities; and thirdly of standardising the management of childhood illnesses, improving the timeliness of interventions, and strengthening child health monitoring and evaluation activities. The other two priority areas for children are Supporting Families which focuses on child protection and families in crisis, and Working Together which aims to work with schools, families and communities so that children who attend school are healthy and able to learn.

Many of the priorities specifically aim to encourage cross-sector and/or whole-of-government action on social determinants of health. For example, the document talks of using “a whole-of-government approach – including law and justice, housing, education, economic development and employment – to provide a ‘critical mass’ for change in Aboriginal health”. They also talk about getting the “right balance” between treatment and prevention” and about improving hospital services whilst also addressing the need for community level PHC services [which should preferentially benefit those with the poorest health].

A range of specific groups is identified in Building Healthier Communities: pregnant women and the early years, children, children in care, children with disabilities, children with special needs or medical conditions, Aboriginal population, working families, families & communities, rural/remote communities, itinerants with complex health needs, young people (especially those facing substance abuse and mental health issues, and violence), older people (including provision of concessions, subsidies and support services, meals, transport and help at home), and highly-at-risk families.

No specific funding mechanisms to address inequity are discussed in the document. However, they do talk of wanting to “resource the community sector and peak bodies so they can contribute their expertise to our joint work”. and to “focus the funding priorities for non-government organisations on the contemporary needs of Territorians”.

In addition to Building Healthier Communities, the NT government has several health Plans which specifically target improved health outcomes and health access for disadvantaged groups. For example, the Aboriginal Public Health Strategy and the Northern Territory Food & Nutrition Action Plan 2001-2006. The latter targets special groups – women of childbearing age (pregnancy, lactation and support for breastfeeding), children 0-5 years, school –age children, and Aboriginal people) - as well as targeting issues such as healthy lifestyle and food supply. The Aboriginal Health & Families Framework focuses mainly on providing improved core services to achieve improved health outcomes. For example, in terms of improving life in the Family Years, it aims to provide sexual and family planning support, to provide regular home visits to Aboriginal mothers from Aboriginal Health Workers or nurses, and to improve interventions for nutrition, smoking, alcohol and substance abuse. The targeted outcomes in the 5-year objectives related to such service provision include: reduced number and proportion of over-15s with a body-mass index in the overweight and obese range; increased proportion of female clients having a Pap smear in the previous 24 months.

TARGETING CHILDREN AND REFUGEES

CHILDREN
The first core strategy in Building Healthier Communities focuses on children in the early years. Children should also benefit from the second strategy to build stronger families and communities. The lifecourse perspective is emphasised, providing support from pre-birth through the early years, then later...
for youth, young people, adults, and the elderly. A range of special needs groups are also identified, e.g., pregnant women and the early years, children in care, children with disabilities, children with special needs or medical conditions, and children in high-risk families. The document also mentions the NT Parenting Strategy. Also talks of a "whole of life" approach to health and well-being, focusing on key transitions.

The *Aboriginal Health & Families Framework* highlights the need to take a lifecourse approach to health and as part of this foregrounds the need to focus on the early years of life. There is acknowledgement that poor socio-economic status is a "marker of elevated risk" for child health outcomes and that diet, nutrition, and the physical environment of children are affected by socio-economic status. Nevertheless, there is no mention of the possibility that the Department of Health & Communities might, on the basis of reducing major health inequities, advocate for a whole-of-government approach to improving the socioeconomic status of Aboriginal people. Furthermore, the focus on improving child health is on "three major elements of child development, namely physical health, cognitive development and socio-emotional behaviour”, rather than on social determinants or healthy settings.

**REFUGEES**

Refugees are not mentioned in the NT documents. However, it is perhaps not surprising that refugees are not given strategic mention, considering that the NT takes only 5% of the refugee numbers going to NSW and Victoria (approximately 100 per annum, compared with 2,000 - 2,5000 pa).

6. **STRATEGIES FOR ACTION: OTHERS INVOLVED**

*Building Healthier Communities* talks of "working together", taking responsibility together across the whole of government, and helping individuals and communities to take responsibility for their own health. One of the 10 priority areas for action is specifically "Creating better ways of working together". The department says that its services will play a major role in the whole-of-government commitment to meet the needs of families and communities and support them in realising their aspirations. *Building Healthier Communities* also shows recognition of the need for broad action to address the social determinants for health when they say that “many improvements in the health of our community need action across Government. The health and community services system will play a key role in our coordinated Government response. We will act across the system. Evidence of this is provided in relation to several issues. For example, there is mention of a whole-of-government 5 point plan” to address community concern over substance abuse and a major overhaul of the Liquor Act and work to provide a new Alcohol Framework for the NT to tackle associated anti-social behaviour. Under the core area “Strengthening Families & Communities” they also intend to “initiate a new approach to supporting highly-at-risk families so that all Government agencies work together and families make decisions with one care manager. In relation to improving Aboriginal health they also identify the need to work with other areas of Government to open the many pathways to better health, through schools, jobs, housing and the strength of families and communities. They say that the renewed focus on Aboriginal health will affect every part of the health and community services system.

*Building Healthier Communities* also acknowledges the need to work beyond government and that the responsibility and accountability needs to be shared if they are to "ensure all Territorians enjoy the benefits of our health and community services system". The department expresses a desire to “take responsibility together”, particularly in planning regional services that recognise community priorities alongside departmental priorities. They also recognise and commit to work with the expertise and commitment of the community and non-government organisations. They identify the need to recognise regional and local differences and to work to develop responses that fit the needs of local people and can be managed by people in the community. Within the 10 priority areas they say they will work with Aboriginal community partners… for local community decision-making, participation and control. The document also talks of the Primary Health Care being the key mechanism to improve Aboriginal health, which will require doctors, nurses, health workers and other professionals working together at the community level, and clinics and care centres to manage ill health and provide a 'gateway' to other services such as hospitals and specialists. The document also makes some mention of involving people in responsibility for their own health, by encouraging healthy lifestyles and regular health checks.
Compared with Building Healthier Communities, the **Aboriginal Families & Health Framework** focuses mainly on what the Department of Health & Community Services can do to improve health outcomes through improving the provision of “core services”. It gives passing mention to the need to encourage Aboriginal people to take responsibility for their own health. There are objectives of working with communities and schools to develop health programs and plans, and of encouraging community engagement in developing culturally secure services. Under a “Partnerships” section the document talks explicitly of an intention to “support pathways to community control” by engaging Aboriginal communities in the setting of strategic priorities, ‘agreeing non-core services”, and monitoring the performance of all community health care centres. The document also acknowledges that “a variety of the outcomes sought by this Framework for Action require reform in a number of domains including the workplace, education and training, and the business of government”. It states that the framework will seek to involve other stakeholders that have a significant role in building the successful implementation, including unions and professional groups, but does not mention any need for cross-agency partnerships to address health issues.

7. IMPLEMENTATION & FUNDING

Each priority area of **Building Healthier Communities** has a page outlining “What we have done”, “What we are doing” “Where we are going”. These are all relatively general goals, although some are targeted to disadvantaged groups or may in particular benefit these groups. As an example under priority core area 1 on Children:

“**What we have done**” – Developed Child Protection Framework; injected $54m over 5 years for Child Protection Framework; established Office of Children & Families to support parents in raising children; introduced “Child Health Initiative” to dramatically increase number of child health workers across NT.

“**What we’re doing**” – Reviewing situation of all children in foster care; increasing child care subsidy to working families; introducing a school breakfast program for 500 remote area children; offering immunisation to school children, responding to report on Children’s Dental Services.

“**Where we’re going**” – Introduce universal child health screening and monitoring to ensure health problems picked up, treated and referred as early as possible.; increasing employment of child health specialists; introducing new “Community Welfare Act” to employ more child protection and family support workers…

Other examples are given of programs already in places, such as dedicated youth programs like “Youth Bear” and “E-Cruz”, a youth development program at Borroloola, flexible aged care facilities in regional areas, and a Safe Families Project in Alice Springs using coordinated case management for youth at risk. In relation to remote access to health, the department has opened a new kidney dialysis unit in Tennant Creek and intends to expand these elsewhere; while new public dental clinics have been opened in other areas.

For Aboriginal health the document mentions the Building Stronger Regions Strategy and the Community Harmony Strategy. Under these they provide examples of specific initiatives that have been implemented to improve Aboriginal health eg they have worked with the Jawoyn community and Commonwealth Government to expand primary health care services in Katherine East through the Sunrise Health Service, have extended specialist outreach services to remote areas, are currently developing an Aboriginal Health Action Plan, and Aboriginal Employment and Career Development Reform package, and are working with specialist colleges to mentor Aboriginal medical students.

In relation to access the document says that a whole-of-government remote telecommunications strategic plan is being developed and videoconferencing “Telehealth” services are being established in public hospitals.
FUNDING: Very little funding is mentioned in Building Healthier Communities, but a lot is mentioned in the Annual Report which reports on the progress of plans in Building Healthier Communities. In the 2004-05 report under “Giving kids a better start”, for example, they report they have

- Created 25 new child health positions with $2.2m funding to support universal child health programs in remote communities;
- Increased funding for Child Protection Services by $2.8m as part of a $53.8m package over five years for intensive family support services aimed at respite care, parent skills training and counselling;
- Allocated $500,000 for intensive family preservation services known as Homestrength to help families in need and at-risk youth. Homestrength began in Darwin in June 2005.

Building Healthier Communities says that lasting change will require well thought-out resource allocation, sound management, and accountability systems. The DHCS is changing its financial management to commit to minimum funding on a rolling 3-year basis. They also want to resource “working together” – “resource the community sector and peak bodies so they can contribute their expertise to our joint work”. They also want to “focus the funding priorities for non-government organisations on the contemporary needs of Territorians”. [This would be a prime area in which the DHCS could advocate for equity in the wider arena].

The Aboriginal Health & Families Framework sets out a list of 5-year objectives under each health issue, along with a list of “Core Services – What We Will Do”. These are general objectives related to improving health services and outcomes rather than benchmarks or measurable targets in relation to health indicators. For example, in relation to adolescent health the objectives include increasing the rate of physical activity in general (rather than by any proportion), reducing the uptake of risk behaviours, increasing the age at which women have their first child and increasing the proportion of residents who are screened for chronic diseases. In relation to these, the aims for core services are to work with schools to develop health and wellbeing prevention and promotion programs, support community leadership and contribute to the development of alcohol, inhalant and drug abuse action in communities, support local initiatives which aim to build positive self-image and coping skills for Aboriginal people, and to develop sexual health programs and the provision of sensitive contraceptive services.

8. MONITORING & EVALUATION

Each priority area within Building Healthier Communities has a list of services or programs that have been initiated or will be developed. However, there are no clearly measurable targets set in this document which directly address health-related indicators for reducing health inequities. Targets are more generally worded in terms of the services or initiatives that will be introduced.

The DHCS Annual Report is the vehicle through which Building Healthier Communities progress is reported on and measured. Many targets are general and either not measuring change (except for number/type of service introduced) or change is only measured retrospectively. The Annual Report “summarises activities and outcomes during the year against the government’s framework for action, Building Healthier Communities, to inform our stakeholders of progress and future challenges in improving the health of Territorians”. The Annual Report provides information for each of the 10 priority core areas.

As an example of the mismatch between targets and achievements, the 2004-05 report provides data on life expectancy at birth for males and females in the NT over five year periods and shows that the gap between Aboriginal and non-Aboriginal population has widened. However, within the Building Healthier Communities core area “Getting serious about Aboriginal Health” there is no stated target “to improve life expectancy for Aboriginal people in the NT” [by x % over x years]. Furthermore, seeking reductions in such health inequities is only implied in the emphasis in Building Healthier Communities on Aboriginal health.
By comparison, the Aboriginal Health Action Framework makes very clear links between issue of concern, and objective and measurable outcomes. For example:

**Issue:** Between 1991 and 1995 as few as 33% of Aboriginal women in Central Australia received appropriate antenatal care.
**Objective/action:** Ensure all pregnant Aboriginal women receive technically sound and culturally sensitive antenatal care
**Target measure:** Improved proportion of pregnant Aboriginal women attending their first antenatal visit at or before 13 weeks and before 20 weeks gestation

**Issue:** Smoking - 64% males and 38% females in the Aboriginal Territorian population over 15 are current smokers
**Objective/action:** Work with schools on health and wellbeing prevention and promotion programs to Aboriginal children; develop positive self image and skills; encourage other community action on smoking etc,
**Target measure:** Reduced uptake of risk behaviours (smoking, drinking, inhalant abuse..) by youth and young people.

The Framework also has a section on Measuring Actions and Outcomes so that the Department can see “how close we have come to the objectives we set ourselves”, can make value based judgements about whether the gains made are sufficient given the time, effort and money spent on them, and can make progress transparent to the Government, to Aboriginal people, to Territorians in general that the Departments’ efforts are “on track.” The stated preference of the Department is to choose a small number of sensitive indicators that are broadly indicative of change and that can be useful in “helping us do still better”. Another stated intention was for the Office of Aboriginal Health, Family and Social Policy to also work with other parts of the Department and research partners at the Cooperative Research Centre for Aboriginal Health (Menzies School of Health Research and Charles Darwin University) to develop an effective process that leads to improvements in “effectiveness, efficiency, equity and quality of out actions and outcomes”. The 5-year objectives under this area include establishing a framework of performance measurement, and collecting and analyzing data on performance to provide regular reports. It is hoped that these will foreground improvements in the equity of health outcomes for Aboriginal people as compared with the general NT population.

The DHCS Annual Report provides more specific information on funding than does Building Healthier Communities.

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**NOTE:** in relation to the prominence given in the NT documents to improving Aboriginal health – ABS 2001 Census data shows that in terms of concentration, 29% of all Territorians are estimated to be of Indigenous origin, while other states are around 4%, and Victoria is as low as 0.6%. In terms of actual numbers there are 57,000 people of Aboriginal origin in the NT, 135,000 in New South Wales and 126,000 in Queensland. The Aboriginal Health & Families Framework also notes that Aboriginal and Torres Strait Islander people “make up the lion’s share of people who use health and community services provided by the NT government”.

**PART B - Key documents used for this analysis:**

Recommended by Dr. Mridula Bandyopadhyay, Senior Policy Officer, Health Services Policy, Department of Health & Community Services, Northern Territory Government.

NT Department of Health & Community Services

*Building Healthier Communities: A Framework for Health and Community Services 2004-2009*

Newman, Baum & Harris (2006)
Also referred to by the researchers:

NT Department of Health & Community Services


(n.d.) Aboriginal Health and Families - A Five Year Framework for Action