Dear Minister

In accordance with the provision of Section 28 of the Public Sector Employment and Management Act, it gives me pleasure to submit the Annual Report on the activities and operations of Territory Health Services (THS) for the year ending 30 June 2001.

I advise that, in respect of my duties as an Accountable Officer, and to the best of my knowledge and belief:

a) proper records of all transactions affecting the Agency were kept and that employees under my control observed the provisions of the Financial Management Act, the Financial Management Regulations and Treasurer’s Directions. Proper records were kept of transactions undertaken by the Department of Corporate and Information Services (DCIS) on behalf of THS

b) procedures within THS afforded proper internal control, and a current description of these procedures, which were prepared in accordance with the Financial Management Act, can be found in the accounting and property manual

c) no indication of malpractice, major breach of legislation or delegation, major error in or omission from the accounts and records existed

d) in accordance with the requirements of Section 15 of the Financial Management Act the internal audit capacity available to the Agency was adequate, and the result of internal audits were reported to the Chief Executive Officer

e) financial statements included in the annual report were prepared from proper accounts and records and were in accordance with Part 2, Section 5 of the Treasurer’s Directions where appropriate. All financial statements prepared by DCIS on behalf of THS were prepared from proper accounts and records

f) all Employment Instructions issued by the Commissioner for Public Employment were complied with.

Yours sincerely

PAUL BARTHOLOMEW
Chief Executive Officer

30 September 2001
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CEO’s Foreword

It is with great pleasure that I present this foreword to the 2000/01 Annual Report.

This was a year of some disruption in the leadership of Territory Health Services (THS) with a number of occupants in the CEO position. Despite this uncertainty, the very important work of the Department continues unabated and this annual report lists just some of the many achievements during the year.

During the period February to May, THS, with the support of a consultant Doug Stace, undertook a comprehensive review of Strategy 21 our Corporate Plan for 1999-2003. Consultations were held in Darwin, Katherine, Tennant Creek, Nhulunbuy and Alice Springs involving a total of some 300 people. This included THS staff, non government organisations, consumers, local government and other government departments.

The THS Executive reflected on the feedback received from these consultations and made some changes to Strategy 21 to ensure that the Department’s goals are appropriate and relevant to the challenges of the future. The new Strategic Plan, Strategy 21 – Directions 2005 was launched by the then Minister the Hon Stephen Dunham MLA. I encourage all staff to become familiar with this important document.

THS continues to struggle with recruitment and retention of professional staff, especially in smaller centres and remote communities. This is particularly the case with nurses where there is a national and indeed worldwide shortage of nursing staff. To meet this challenge, THS with the support of the union and nursing staff initiated two major projects – the Nursing Career Structure Review and the Nursing Recruitment and Retention Taskforce. The strategies developed as a result of these processes are now being implemented. Many of the recommendations will also be applied to assist in improving our recruitment and retention of other professional staff, such as therapists.

THS continues to actively support the Aboriginal Health Forum and the roll out of health zones under the Commonwealth’s Primary Health Care Access Program. Considerable effort was devoted during the year, in concert with our Forum partners, to prepare for the roll out of the first five zones in Central Australia. Next year it is hoped that the Commonwealth Minister will approve funding for the first two zones in the Top End to build upon the successful coordinated care trials in Katherine West and Tiwi Islands. These initiatives attract significant additional Commonwealth funding to the selected areas and greatly assist in providing remote communities with improved access to primary health care services.
Through the establishment of community controlled health boards, they also significantly advance a number of our Strategy 21 Stretch Goals.

As more and more health zones are established over the coming years and as THS continues to pursue opportunities for transfer to the non government sector of some of its community based services in our regions and districts, the role of THS and our organisational structure will undergo major change. Any proposals for restructuring will be done in full consultation with staff and unions.

THS will continue to have responsibility for the provision of public hospital services across the Territory.

There has been considerable investment in our acute care services over the year with major redevelopments of Royal Darwin Hospital and Alice Springs Hospital now in full swing and the Palmerston Health Precinct, which offers a mix of private and public health services within one complex, opening its doors in January 2001.

The new angiography unit opened in March 2001 at Darwin private hospital. This is a joint venture of NT Cardiac Services, Healthscope, and THS. This means that hundreds of Territorians each year will now be able to undergo coronary angiograms without having to travel interstate. This is a sign of the growing maturity of the Territory's health system.

Finally, I would like to express my very sincere personal thanks to all THS staff, and to our numerous partners in the health and community service sectors, for their dedication and commitment over the year to the very important work in which we are all engaged.

I commend this Annual Report to you.

PAUL BARTHOLOMEW
Chief Executive Officer
Health Zones

The poor health of Indigenous people in the NT relative to other Territorians prompted Commonwealth and NT Governments to work together with Indigenous organisations, under the banner of the NT Aboriginal Health Forum. The Forum adopted a strategy of regional health planning to deliver more responsive and better primary health care.

Additional resources were agreed upon recognising that many Territorians living outside metropolitan areas have limited access to the Commonwealth’s Medical and Pharmaceutical Benefits Schemes. Lack of access to Federal funding through Medicare and Pharmaceutical Benefits Scheme by remote communities has inhibited early intervention and care. This may contribute to an over representation of Indigenous people in hospital admissions. The NT is preparing to overcome its disadvantaged access to Medicare by entering into joint funding arrangements with the Commonwealth for primary health care services in a zone by zone rollout of the Commonwealth’s Primary Health Care Access Program.

The successful Indigenous Coordinated Care Trials (CCT) in Katherine West and Tiwi demonstrated that health zones with funding for more services and community control worked well to improve the health and wellbeing of Aboriginal people.
Features of zones are:
- an emphasis on primary health care and prevention
- involvement of local people in the planning, administration and delivery of health services
- increased resources.

In Central Australia five zones were approved during the past year:
- Walpiri
- Northern Barkly
- Anmatjerre
- Eastern Arrante
- Luritja-Pintubi.

Figure 2: Health Zones for Central Australian Service Network

Source: The Planning Unit, Commonwealth Department of Health and Aged Care, Darwin
More recently Federal and Northern Territory Governments agreed to fund expansion of health zones in the Top End. Proposed Top End zones are outlined in the map below.

Figure 3: Proposed Health Zones for Top End Service Network

Source: Top End Aboriginal Health Planning Study, Ben Bartlett and Pip Duncan, April 2000
Preventable Chronic Disease Strategy

The Minister for Health, Family and Children’s Services statement to the August 1999 Sittings of the Legislative Assembly outlined the Preventable Chronic Disease Strategy (PCDS). The aims are to reduce hospitalisations, minimise disease complications and lower costs arising from five preventable chronic diseases:

♦ diabetes
♦ high blood pressure
♦ obstructive airways disease
♦ heart disease
♦ kidney disease.

The proportion of deaths and hospitalisation from chronic disease is increasing. In 1996 25 percent of the hospital budget was associated with management of chronic diseases; it currently consumes about 40 percent.

Following a THS review of national and international research on preventable chronic diseases, six key result areas were identified as well as cost effective services known as the Best Buys. The following graphic displays key results for the strategy with Best Buys for achieving them arranged on the outside of the wheel.
The key result areas became the focus of THS health workers through the use of a recall system promoting better coordination of Best Buy services. A number of indicators were established to monitor the Preventable Chronic Disease Strategy that will be reported in subsequent annual reports.
Tobacco Action Project

The Tobacco Action Project (TAP) has received $500,000 funding each year since 1996. This past year TAP initiatives aligned more closely with the Preventable Chronic Disease Strategy in recognition of smoking as a contributing factor to the five targeted chronic diseases.

TAP strategies for 2000/01 were to:
- encourage cessation of smoking
- prevent uptake of smoking by young people
- support Indigenous people with culturally appropriate initiatives to prevent and stop smoking
- protect people from environmental tobacco smoke (passive smoking).

Achievements this year included:
- a 24 hour Quitline counselling service with callbacks
- health promoting schools grants to 28 schools
- distribution of Choose Yourself campaign kits containing activity plans to supplement the magazine, video and website
- public education including local materials to address Indigenous smoking and health workers supporting no smoking initiatives
- agreement to review the NT Tobacco Act to consider how legislation can underpin prevention and cessation of smoking activities.

Evidence both nationally and internationally supports a well financed, sustained approach to tobacco control with supportive legislation having the greatest likelihood of success.

There has been a decline in smoking across Australia including the NT. The rate of decline has been more pronounced elsewhere as indicated by the graphs.
Figure 5: Smoking Prevalence for Selected Years 1980-2000 Australia and Northern Territory


Figure 6: Smoking Prevalence Rates 1999/00 Northern Territory

Source: Alcohol and Other Drugs; Preliminary results NT Health and Wellbeing Survey, Epidemiology Branch, Territory Health Services 2001
Quality Improvement

The strategic intent of Territory Health Services through Strategy 21 is to create and enhance a Territory wide network of services which delivers continuing improvement in the health status and wellbeing of all Territorians. The Quality Improvement Best Practice Standing Committee was established in 1999 to achieve continuous quality across all health and community services in response to this strategic intent.

The Territory Health Services Quality Framework and Strategic Action Plan outlines the work to be undertaken over the next two years allocating $1.8 M for projects to achieve:

♦ good governance
♦ effective information systems to reflect, refocus and reform
♦ partnerships with consumers
♦ an organisation where quality is built into culturally appropriate and innovative services.

To date the major focus on quality improvement has been through the preparation of public hospitals and some community health centres for assessment against nationally accepted health care standards. Currently 51 percent of public hospital beds are accredited against these standards.

The Territory introduced the Australian Incident Monitoring System into all five public hospitals. During the year data from this system was used to manage:

♦ falls prevention
♦ patient informed consent
♦ quality use of medicines.
## Hospital Redevelopment

$70M redevelopment work began during the year to upgrade Royal Darwin and Alice Springs Hospitals. Completed work improved care and comfort for service users and were an attraction to recruit and to retain health services staff. The table outlines the redevelopment stages and timeframes for their completion.

<table>
<thead>
<tr>
<th>Royal Darwin Hospital</th>
<th>Alice Springs Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>$40M</td>
<td>$30M</td>
</tr>
</tbody>
</table>

### Stage One

<table>
<thead>
<tr>
<th>Royal Darwin Hospital</th>
<th>Alice Springs Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due for completion September 2001</td>
<td>Completed April 2001</td>
</tr>
<tr>
<td>Pharmacy completed</td>
<td>Mental Health Unit</td>
</tr>
<tr>
<td>Physiotherapy completed</td>
<td>Medical Ward (East Wing)</td>
</tr>
<tr>
<td>Kitchen completed</td>
<td>Maternity Unit</td>
</tr>
<tr>
<td>Northern car park completed</td>
<td>Birth ing Suite</td>
</tr>
<tr>
<td>Temporary Kiosk in place</td>
<td>Special Care Nursery</td>
</tr>
<tr>
<td>Bus stops and taxi rank relocated</td>
<td>Rehabilitation and Physiotherapy</td>
</tr>
<tr>
<td>Rotary shelter relocated</td>
<td>Kiosk and balconies</td>
</tr>
<tr>
<td>Helipad relocated</td>
<td>Public car park</td>
</tr>
<tr>
<td>Ambulance bridge completed</td>
<td></td>
</tr>
<tr>
<td>Temporary Patient Services completed</td>
<td></td>
</tr>
<tr>
<td>Temporary entrance completed</td>
<td></td>
</tr>
</tbody>
</table>

### Stage Two

<table>
<thead>
<tr>
<th>Royal Darwin Hospital</th>
<th>Alice Springs Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due for completion August 2002</td>
<td>Due for completion September 2001</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Medical Ward (West Wing)</td>
</tr>
<tr>
<td>Operating Theatres</td>
<td>Radiology Department</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>Paediatric Unit</td>
</tr>
<tr>
<td>Coronary Care</td>
<td>Outpatients Department</td>
</tr>
<tr>
<td>High Dependency Unit</td>
<td>Main front entry</td>
</tr>
<tr>
<td>Imaging Unit</td>
<td>Staff amenities</td>
</tr>
<tr>
<td>Central Sterilising Department</td>
<td></td>
</tr>
<tr>
<td>Bridge link to Darwin Private Hospital</td>
<td></td>
</tr>
</tbody>
</table>

### Stage Three and Four

<table>
<thead>
<tr>
<th>Royal Darwin Hospital</th>
<th>Alice Springs Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due for completion July 2002</td>
<td></td>
</tr>
<tr>
<td>Surgical/Medical Ward</td>
<td></td>
</tr>
<tr>
<td>Medical Imaging – Emergency Dept</td>
<td></td>
</tr>
<tr>
<td>Intensive Care</td>
<td></td>
</tr>
<tr>
<td>High Dependency Unit</td>
<td></td>
</tr>
<tr>
<td>Day Surgery</td>
<td></td>
</tr>
<tr>
<td>Operating Theatres</td>
<td></td>
</tr>
<tr>
<td>Aboriginal Liaison Unit</td>
<td></td>
</tr>
</tbody>
</table>
Palmerston Health Precinct

The $7.2M Palmerston Health Precinct began delivering services in January 2001. The project continues the longstanding commitment to provide the best possible health care for all Territorians.

The Precinct provides a mix of private and public medical services within one purpose built complex including:

♦ a community care centre operated by THS
♦ a 24 hour medical centre offering private GP clinic services
♦ St John Ambulance
♦ visiting medical specialist suites.

Radiology, dental and therapy services are planned for later in 2001.

Public response to the precinct demonstrated how collaboration between private and public sectors is meeting a community need. From the middle of January until the end of May 2001 over 9,000 people attended the community care centre; 470 people received specialist medical attention; and the 24 hour Farrar Medical Centre had 70-75 contacts per day. Agreement was reached with private pharmacy services to fast track prescriptions for people using the precinct’s services.
Angiography Unit

The Territory's first angiography unit opened in March 2001 as a joint venture of NT Cardiac Services, the operators of Darwin Private Hospital and Territory Health Services. This unit is located at the private hospital with THS paying fees for public patients. The service provides long term benefits to Territorians by:

♦ forming strategic alliances with other health service providers
♦ demonstrating that private and public health sectors working together can provide expensive technology to the small NT population thus overcoming diseconomies of scale
♦ providing early detection of heart problems thereby reducing the number of Territorians needing to travel interstate for screening.

As at 30 June 2001 a total of 204 angiograms were performed with 61 privately funded. There was a reduction of 135 patients travelling interstate for coronary angiograms this year. Of the total angiograms 21 were normal, 123 required further medical treatment in the Territory and 66 travelled interstate for surgical intervention.

Figure 7: Angiograms Performed in Northern Territory
Nursing Career Structure Review

Territory Health Services employs about 1,700 nurses comprising 36 percent of the total workforce. Nurses are numerically and strategically a major employee group. Supply and retention of nurses underpin health care for Territorians in hospital and community clinics.

Against a backdrop of international wide competition to employ the best nursing staff, THS undertook two projects to consider employment and recruitment issues: the Nursing Career Structure Review and the Nursing Recruitment and Retention Taskforce.

During the past year both projects moved through Territory wide consultations and options appraisal phases. Recommendations for improving recruitment and retention were identified by the Taskforce with a project officer employed to develop an implementation plan by the end of 2001. A proposed model for a nursing career structure was developed and is depicted in the graphic.

**Figure 8:** Draft Nursing Career Pathway Model

---

EN OR RN CAREER CHOICE FOR:

- School leavers
- Mature age students
- Patient Care Assistants/Patient Service Assistants
- University Graduates
- Re-entry nurses

---
Features of the model are:

♦ the addition of a promotional position for enrolled nurses with advanced skills
♦ a graduate entry program for enrolled nurses in acute care and for registered nurses in acute and community care
♦ rewards for nurses of exemplary practice
♦ an expert level incorporating current level 2 and 3 speciality positions
♦ a Clinical Nursing Management title for those positions that are predominantly nursing management
♦ development of a work evaluation system for promotional nursing positions.

Flinders University NT Clinical School

The ongoing success of the training scheme and its impact on providing quality health services to Territorians is a performance highlight for the year. The scheme enabled Territorians to study part of their medical course in the NT. Medical students from other states also chose to train at Royal Darwin or Alice Springs Hospitals.

Fourteen students selected Territory hospitals for their third year training. Of these five were NT quota students including one Indigenous person. Seven new interns employed at RDH in 2001 were graduates of the clinical school including three Territorians. This is indicative of the influence of NT based training on the ultimate choice of doctors to return to practise here.
Seniors Card

The Northern Territory Seniors Card was introduced in April 1999. During the past year card members and business participation continued to grow as benefits of the Seniors Card were recognised by the community.

The card assists seniors to reduce their cost of living enabling them to purchase goods and services at reduced costs. Senior Territorians are also entitled to hold a Pensioner Concession Card which provides concessions on daily living expenses. $6.7M was spent on these two schemes in 2000/01.

Reduced living costs mean that Senior Territorians were supported to remain actively involved in the community and to lead the lifestyle of their choice. 67.3 percent of the Northern Territory population 60 years and older are Seniors Card holders.

**Figure 9: Senior’s Card Scheme Number of Participants by Region**

*Note: Percentages are based on NT population 60 years and older, and include Indigenous people*

**Table 1: Number of Senior Card Members and Business Participants**

<table>
<thead>
<tr>
<th></th>
<th>1998/99</th>
<th>1999/00</th>
<th>2000/01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Card Members</td>
<td>4029</td>
<td>5829</td>
<td>7502</td>
</tr>
<tr>
<td>Business Participants</td>
<td>187</td>
<td>225</td>
<td>298</td>
</tr>
</tbody>
</table>
The strategic intent of Territory Health Services (THS) is to provide a Territory wide network of services that delivers continuing improvement in the health status and wellbeing for all Territorians. How this is to be accomplished is outlined in our Corporate Plan, Strategy Twenty First Century, covering the period from March 1999 to the year 2003.

**Figure 10: Territory Health Services Strategy Twenty First Century**

*To create and enhance a Territory wide network of services which delivers continuing improvements in the health status and wellbeing of all Territorians.*
Working for Outcomes

Treasury's financial and performance management framework, known as Working for Outcomes, links financial information to the quantity and where possible the quality of particular services being provided. The matrix presented on this page illustrates the connection between Territory Health Services Corporate Plan (Strategy 21) and the translation of these plans into government provided and/or funded services to deliver the desired outcomes.

**Strategy 21 (S)**

1. Strengthening community capacity
2. Increasing the Indigenous workforce
3. Achieving a quantum shift to service delivery by others
4. Developing total health solutions through collaboration

<table>
<thead>
<tr>
<th>Links</th>
<th>Services Delivered</th>
<th>Performance Indicators</th>
</tr>
</thead>
</table>
| Health Development
4  
4  
4  
2  | Environmental Health  
Centre for Disease Control  
Alcohol & Other Drugs  
NT Clinical School | implement Foodsafe program  
increase in immunisation rates  
decline in alcohol related road accidents  
increase number of health professionals |
| Community Health
2  
1  
3  | Growth Assessment and Action  
Strong Women, Strong Babies, Strong Culture  
Health Zones | monitor children’s development  
reduce rates of infant morbidity and mortality  
increase community participation in planning and delivering services |
| Hospital Services
1  
4  
4  | Hospitals / Rural Health Clinics  
Specialist Clinics  
Patient Travel | upgrade clinics and redevelop hospitals  
reduce waiting times for specialist care  
shorten length of stay |
| Community Services
3  
3  
3  | Aged and Disability Services  
Family and Children’s Services  
Mental Health | improve services measured against standards  
prevent harm to children  
reduce youth suicide numbers |
Service Outlets

The table below shows the main services within Territory Health Services and their location.

<table>
<thead>
<tr>
<th>Service</th>
<th>Location</th>
<th>Alice Springs</th>
<th>Darwin &amp; Suburbs</th>
<th>Katherine</th>
<th>Nhulunbuy (Gove)</th>
<th>Palmerston</th>
<th>Tennant Creek</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care Centre / Public Health Unit / Health Promotion Unit</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Centre</td>
<td>Refer to Service Outlet Map</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Clinic</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease Control</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Centre</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Unit</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Hospital</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal Unit</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Assault Referral Centre</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STD Clinic (Clinic 34)</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td>✔ ✔ ✔ ✔ ✔ ✔</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

* service under negotiation

The service outlet map (page 24) shows communities with an onsite health service. For a full list of services, including THS and Commonwealth funded services and contact details refer to Top End Service Network (page 64) and Central Australian Service Network (page 70).
Service Outlets Map
THS Organisational Structure

The organisational chart (page 27) indicates a reduced span of control from the previous year streamlining decision making and supporting the integration of services. This chart displays THS service delivery by programs/output groups and their services. Expenditure by Activity is provided in Financial Table 1 (page 165).

Note: Oral/Dental ($5.7 M) and Public Health ($6.2 M) are not defined as output groups.
NORTHERN TERRITORY GOVERNMENT
Minister for Health, Family and Children’s Services

Territory Health Services Executive

STANDING COMMITTEES

- **Information Management**
  Chair: Assistant Secretary, Business and Operational Support

- **Quality Improvement**
  Chair: Deputy Secretary, Service Provision

- **Program Development**
  Chair: Assistant Secretary, Community Health, Aboriginal Health and Hospital Services

- **Finance**
  Chair: Chief Executive Officer

- **Workforce Advisory**
  Chair: Assistant Secretary, Business and Operational Support

- **Internal Audit**
  Chair: Chief Executive Officer

♦ Propose: Annual Health Budget Strategy (identifying major policy initiatives, program outcomes and outputs for approval by Legislative Assembly)
♦ Monitor Performance: Corporate Strategy 21, Output/Outcome Indicators, Client Feedback, Program Evaluations, Audits, Agreements, Expenditure
♦ Analyse: Demand, Emerging Service Pressures, Program Cost/Effectiveness, Community Capacity, Potential Risk and Critical Success Factors
♦ Develop: Strategies to Improve Health Status, Wellbeing and Community Capacity, Strategies to Improve Cost Effectiveness, Resource Allocation
♦ Report Annually: Outcome Indicators, Program Effectiveness/Efficiency, Financial Statements, and Compliance with Government Policy
Legislative Responsibilities

The Minister for Health, Family and Children’s Services and Territory Health Services is responsible for administering the areas of government relating to: social welfare, community grants for health related organisations, health including hospitals and medical services, human quarantine, food standards, alcohol and other drug dependence, aged and disability services, and mental health services.

The Minister is also responsible for Senior Territorians. Territory Health Services provides administrative support to this Ministerial portfolio in the absence of a specifically nominated agency.

The Minister administers the following Acts:

- Adoption of Children Act
- Adult Guardianship Act
- Cancer Registration Act
- Community Welfare Act
- Dental Act
- Disability Services Act
- Emergency Medical Operations Act
- Food Act
- Guardianship of Infants Act
- Health Practitioners and Allied Professionals Registration Act
- Hospital Management Boards Act
- Human Tissue Transplant Act
- Medical Act
- Medical Services Act
- Mental Health and Related Services Act
- Natural Death Act
- Notifiable Diseases Act
- Nursing Act
- Optometrists Act
- Pharmacy Act
- Poisons and Dangerous Drugs Act
- Private Hospitals and Nursing Homes Act
- Public Health Act
- Radiation (Safety Control) Act
- Radiographers Act
- Silicosis and Tuberculosis (Mine Workers and Prospectors) Act
- Therapeutic Goods and Cosmetics Act
- Tobacco Act
- Transfer of Powers (Health) Act.

The portfolio of Minister for Health, Family and Children’s Services is through supporting agencies responsible for the following Acts;

- Health and Community Services Complaints Act
- Menzies School of Health Research Act.
Expenditure

Expenditure for health and community services has increased each year to meet the needs of a growing and ageing NT population. Government has strategies that will attract people to the Territory and preserve our unique lifestyle. High quality and accessible health and community services are necessary to achieve this end.

New medical technologies and specialist staff added to increasing hospital expenditure. Maintenance of hospitals in small communities, necessary for their residents and the many visitors to the NT, absorbed high costs due to diseconomies of scale. The ageing population and emerging needs of families caring for disabled members resulted in more funding to develop and operate community based services. Mental illness was recognised as needing additional resources for community support services, therefore spending increased during the past three years.

Figure 11: Territory Health Services Expenditure by Activity
Figure 12: Breakdown of Expenditure for all Hospitals, Mental Health, Family and Aged Services

Figure 13: Territory Health Services Expenditure as a Percentage of Total Northern Territory Public Sector

Note: The 2000/01 NTPS figure is preliminary
Figure 14: Territory Health Services Expenditure by Source of Funding

Financial Year


Expenditure $M

$0 $50 $100 $150 $200 $250 $300 $350 $400 $450 $500

THS Revenue
Commonwealth Tied Funds
NT Government

Figure 15: Territory Health Services Expenditure by Activity and Source of Funding

Activity

Organisational Support
Health Development (Public Health)
Community Services
Community Health (Primary Health Care)
Hospital Services (Acute Care)

Expenditure $M

$0 $20 $40 $60 $80 $100 $120 $140 $160 $180 $200 $220

THS Revenue
Commonwealth Tied Funds
NT Government

Funding
Staffing

The decline in nursing numbers relates to a national and international shortage of nurses particularly in specialist areas. The maintenance of medical officer numbers is attributed to recent improved recruitment and retention strategies.

Aboriginal Health Worker numbers declined slightly. This can be attributed to the continued rollout of Coordinated Care Trials with AHWs moving across to the non government sector.

The creation of the Purchasing Division to manage performance contracts for services purchased from THS and external agencies involved changing Professional and Administration positions into Executive positions. Existing financial resources were used to implement the new Division.

Figure 16: Staffing Trends by Classification and Gender

Note: The figures reported last year reflected actual number of employees; the above figures are FTE taken as at June 30 for each year and are not averages over the period.
Figure 17: Staffing as a Percentage of Total Northern Territory Public Services

Source: Office of the Commissioner for Public Employment (OCPE)
Major Budget Outcomes 2000/01

NT Government Budget Paper 2 provides detailed financial information for each government agency with outputs/outcomes to be realised. THS performance in meeting the major budget outcomes is reported in this section. More detailed information is contained in Activity reports.

**Implement a collaborative funder/purchaser/provider framework for better accountability, transparency of funding allocation and clarity of roles within the agency**

This has been implemented and detailed in the Purchase of Services Section. Agreements were signed to purchase services from over 200 non government organisations including 45 child care centres.

**Continue the coordinated care trials within the Territory**

Two pilot coordinated care projects became the model for establishment of health zones across the Territory. A map of the proposed zones is on page 9.

**Provide additional services under remote communities incentive funding**

Funds were obtained through the Remote Communities Initiative (RCI) and directed to Milyakburra ($241,747), Angurugu ($27,555) and Robinson River ($347,486). Growth and reform allocations totalled $1M with the largest amount for alcohol and other drugs initiatives.

**Address the issue of increased demand on services for non government organisations funded by the agency**

This was addressed through new service agreements with non government organisations; $1.2M additional funding was provided to disability service providers.

**Improve accuracy, timeliness and relevance of resource management services and reporting processes**

THS has two in house management reports, the Quarterly Executive Report and Monthly Management Report. The quarterly report identifies trends in service use and expenditure while the monthly report provides expenditure updates by activity. This information provided performance reporting for the Report on Government Services published nationally for the Council of Australian Governments as well as THS Annual Report.

**Provide vaccine coverage at the rates recommended by the National Health and Medical Research Council**

NT immunisation rates for children 12-15 months were 88.7 percent and for children 24-27 months 85.5 percent, slightly below the national average, but increased percentages from the previous year. See figure on page 137.
Develop and promote the nutrition component of an award scheme for remote community stores

Seventy communities were visited for the Tidy Towns Stores Award and 18 officially participated. Ten businesses achieved the FoodSafe Award.

Adopt healthy nutrition policies in public and commercial food services

Healthy Choices Award was launched in Alice Springs in November 2000. Four premises received the award.

Increase community capacity to make choices which will improve community health status and wellbeing

Capacity increased with the establishment of two health zones with their own management boards and approval to set up five more.

Provide information and support to communities to implement strategies to improve local food supply

Training workshops were held in eight communities during the year. The annual store survey/market basket showed:
- no significant increase in cost of a basket of food over 12 months
- over 90 percent of the healthy items from the basket were available in stores surveyed.

Provide education and promotional material to promote community attitudes, behaviours and environments that minimise harm related to substance abuse

Community education and grants to organisations were key strategies to minimise harm arising from substance abuse. These are detailed in the Alcohol and Other Drugs report.

Conduct research and evaluation projects

Alcohol and Other Drugs continues to participate in regular research and evaluation activities such as household surveys, Australian Secondary School surveys and the Arnhemland Drug Use survey.

The NT Disease Control Bulletin was produced quarterly and distributed to over 500 individuals and organisations. The AIDS/STD Surveillance update was produced half yearly with distribution to health professionals and organisations.

Respond to public inquiries on public health issues and provide media presentations

Twenty media releases were initiated complemented by television/radio interviews alerting the public to health risks. Food and packaging tampering, mosquito alerts and melioidosis outbreaks featured during the past year.
Provide services related to managing and controlling communicable and non communicable diseases

TB programs were targeted to prisons because of their high risk populations. Ongoing monitoring of STDs and mosquito borne diseases occurred with public bulletins issued to keep the community informed.

Coordinate the implementation of the Preventable Chronic Disease Strategy

The Chronic Diseases Network with membership drawn from all sectors and geographic areas increased its membership to 450 demonstrating expanding interest and expertise. Further details on the Preventable Chronic Disease Strategy are provided on page 11.

Provide in/out patient mental health consultations and care

The volume of patients receiving consultations is reported in Mental Health Services section. These reflect the emphasis placed on community based services. The gap in providing services in remote areas was addressed with the employment of Aboriginal Mental Health Workers who visited smaller communities rather than individuals having to travel to urban areas for consultations.

Develop child care places fostering early childhood development

There was a net increase of 807 child care centre places between July 1996 and June 2001. Young children’s care and education services were integrated at Jingili Kindergarten and Royal Darwin Hospital child care centre. Two pilot projects in Moulden and Alice Springs provided a broader range of care and support services for children and families from a single school site.

Provide structured support for people with disabilities who reside in rural and isolated areas of the Territory

Two initiatives occurred that assisted both remote and urban areas. Local Area Coordinators assisted families to identify and access needed support services. Where these were unavailable, coordinators assisted development of local solutions. The second initiative was direct funding to consumers for unmet service needs. Grants were made to 79 applicants under this scheme. Home and Community Care services in remote areas increased the number of services from 23 to 36 over the past four years.

Provide subsidies and concessions to eligible persons through Pensioner Concessions and Taxi Subsidy Schemes

The take up rate for pensioner concessions increased from 16 508 for 1999/00 to 17 025 for 2000/01. People using taxi subsidies grew from 642 during 1998/99 to 860 this year.
**Improve access to primary health care services in urban and rural communities**

Coordinated care trials, health zone developments, upgrading of health clinics, visiting medical specialists, immunisation programs, nutrition projects and growth assessment activities worked in combination to improve access and quality of primary health care in remote communities. Also important was an agreement reached with the Commonwealth to fund drugs not previously accessible through the national Pharmaceutical Benefit Scheme.

**Improve child and maternal health**

The nutrition program in remote areas resulted in a reduction in poor nutrition and consequent illnesses for a number of communities. In one area the rates of low height for age in the 0-5 years fell from over 25 percent in 1997 to five percent in 2000. Maternal primary health care focused on early antenatal care.

**Provide primary health care in remote health clinics by resident and visiting health professionals**

Health services were delivered within remote communities through health centres and associated out station clinics to almost 19,000 people. Visiting health professionals provided direct client services, professional support and training for remote health staff and work with community organisations.

**Develop specialised resource team support to primary level services**

Specialist resource services were increased with the transfer to THS of school therapy services to support primary care initiatives.

The specialist adult health team, community health paediatric team, hearing services, and palliative care combined to provide consultancy and education services to primary care providers.
Workforce Development

Overview
Workforce Development enhances the quality of health and community services in the NT through the promotion of a learning culture and the development of best practice strategies to ensure a skilled workforce.

Outputs

♦ Workforce Development has a specific focus to enhance Aboriginal participation in the THS workforce.
♦ There are regionally based operational Workforce Development Units in the Top End and Central Australian Service Networks.
♦ Within Workforce Development there are three teams;
  – Aboriginal Workforce Development
  – Workforce Improvement
  – Workforce Information Support.

Outcomes

Aboriginal Workforce Development
♦ Health and community services career information facts sheets were developed for Indigenous people wishing to pursue a career in THS.

♦ Four Aboriginal students continued their cadetships with THS. Two graduates who completed their cadetship work as a nurse and a social worker in THS.

♦ Expenditure on Studies Assistance grants for Aboriginal and Torres Strait Islander people in 2000/01 totalled $69,612. $44,007 was allocated in new grants.
Central Australian Service Network (CASN) operated Structured Training and Employment and Project (STEP) in partnership with Tangentyere Council, Arrente Council, the Department of Employment, Work Relations and Small Business. This project won the regional category for the NTPS Equity and Diversity Awards for 2000.

Table 2: STEP Trainees in Central Australia

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Trainees</th>
<th>Location</th>
<th>Number employed post STEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>12</td>
<td>Alice Springs Hospital</td>
<td>5 in Alice Springs Hospital (including the first apprentice in ASH for 20 years)</td>
</tr>
<tr>
<td>2001</td>
<td>20</td>
<td>ASH, Alcohol and Other Drugs</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>11 first intake</td>
<td>Remote Health Services</td>
<td></td>
</tr>
</tbody>
</table>

Stage 3 of the Aboriginal Health Worker Career Structure (AHWCS) implementation project is nearing completion. Over 70 percent of eligible AHWs employed by THS completed skills self assessment against AHW competency standards.

An agreement with Batchelor Institute of Indigenous Tertiary Education for formal recognition of AHW competency achievement was signed by THS in December 2000.

Aboriginal Community Services Worker Career Structure (ACSWCS) Implementation project was endorsed by THS Executive.

THS Aboriginal Mentorship program guidelines and processes were developed with a pilot project to begin in 2001.

Competency standards were developed in conjunction with Community Services and Health Training Australia on working effectively with Indigenous colleagues, clients and organisations.

The number of people in positions designated as Aboriginal Health and Community Services professionals decreased. This is due to the transfer of service provision to non-government health service providers such as the Tiwi Health Board; hence AHWs have become employees of these providers.
Table 3: Positions Designated as Aboriginal Health and Community Services Professionals

<table>
<thead>
<tr>
<th>Position Title</th>
<th>Staff Nov 2000</th>
<th>Staff June 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Worker</td>
<td>157</td>
<td>145</td>
</tr>
<tr>
<td>Aboriginal Health Promotions Officers</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Aboriginal Mental Health Workers</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Aboriginal Environmental Health Workers</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Aboriginal Liaison Officers</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Aboriginal Cultural Awareness Program</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Aboriginal Community Nutrition Workers</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Aboriginal Nutrition Advisers</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Aboriginal Specialist Child Protection Officers/ Aboriginal Community Workers (FACS)</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Aged Care Assessment Team Aboriginal Liaison Officers</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Aboriginal Male Health Unit Officers</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Aboriginal Employment and Career Strategy Officers</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Strong Women Coordinators and Workers</td>
<td>16.5</td>
<td>21</td>
</tr>
<tr>
<td>Living With Alcohol Workers</td>
<td>17</td>
<td>2</td>
</tr>
<tr>
<td>STD/AIDS Educators</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Life Promotion Officers (new positions)</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>275.5</strong></td>
<td><strong>267</strong></td>
</tr>
</tbody>
</table>

Workforce Improvement

♦ Expenditure on Studies Assistance grants totalled $388 253 in 2000/01; $318 785 was allocated for new grants.

Table 4: New THS Studies Assistance Grants 2000/01

<table>
<thead>
<tr>
<th>Category</th>
<th>New Recipients</th>
<th>New Grants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>22</td>
<td>$44 007</td>
</tr>
<tr>
<td>THS Employees</td>
<td>57</td>
<td>$125 050</td>
</tr>
<tr>
<td>Non THS Employees</td>
<td>29</td>
<td>$145 728</td>
</tr>
</tbody>
</table>

♦ Of the total THS recipients, 13 were from RDH, 21 from TESN and 17 from CASN. Of the total Indigenous 13 were THS employees.

♦ Nursing was the most common professional affiliation of the funded activities with 43 people supported.
Remote health was the most common specific area of study, followed by maternal and child health and childcare.

**Figure 18:** Studies Assistance Recipients by Professional Affiliation

**Figure 19:** Studies Assistance Provided by Mode of Study
♦ THS supported employees studying through reimbursement of Higher Education Contribution (HECS) and course fees. This totalled $157,348 including $7,000 to the four Aboriginal and Torres Strait Islander cadets.

♦ The THS Leadership Development Strategy was endorsed by Executive June 2001. A key component of this strategy is the THS Leadership Development Program which has been developed in partnership with OCPE.

♦ Partnership initiatives to improve skills of remote area staff included: Midwifery Upskilling Project, Remote Area Nursing Training Pathway, exchanges of remote area medical staff with hospital based medical staff and the first joint THS/ NTDE orientation program.

♦ Community based and acute care programs provided for nursing staff included: Basic and Advanced Life Support, Palliative Care, Coronary Care, High Dependency Nursing, Wound Management, Continence, Pain Management, Burns Management, and Preceptorship. The most popular course was Basic Life Support with over 200 attending.

♦ Forty six nurses including six enrolled nurses are currently undertaking the RDH New Graduate Program, four more than last year.

♦ Forty four FACS staff across the NT have undertaken the THS Introduction to Child Protection Course this year. More than 30 non FACS personnel attended relevant components of this training in recognition of the multidisciplinary nature of child protection.
Workforce Relations and Planning

Overview

Workforce Relations and Planning was formed to provide strategic management services internally to THS. In February 2001, THS assumed responsibility from the Department of Corporate and Information Services (DCIS) for operational human resource advice for Darwin and surrounds, including Royal Darwin Hospital. In Central Australia, Katherine, and Gove DCIS provides operational human resource advice. Other operational services provided by DCIS for all regions, include payroll, recruitment, establishment/staffing records (PIPS), Job Evaluation System, executive contracts, superannuation, workers compensation and occupational health and safety.

For Territory Health Services to be able to continue to provide a comprehensive range of health services in the future, consideration must continue to be given to issues such as:

♦ future demand for services and funding of health care
♦ recruitment and retention within particular professions where demand for services is increasing relative to staff availability
♦ management skills and provision of employment relations information.

The Graduate Development Program improved recruitment and retention. It began in 1996 with 22 graduates recruited through the program. The aim is to develop a graduate’s skill, knowledge and experience to be an effective junior manager. The program has been a successful workforce initiative with 82 percent of graduates currently employed at the AO6 level or above.

Table 5: Profile of THS Graduate Development Program 1996 to 2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Employed</th>
<th>Retained in THS as at 1 July 2001</th>
<th>Retained in NTPS as at 1 July 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>6</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>1997</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1998</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1999</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2000</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>2001</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>15</td>
<td>18</td>
</tr>
</tbody>
</table>
Outputs

Workforce Relations and Planning Branch comprises:
♦ Workforce Planning
♦ Employment Relations
♦ Darwin Human Resource Services
♦ Industrial Relations.

Outcomes

Outcomes achieved included:
♦ development of the Employee Profile Information System to collect and analyse THS workforce data and provision of reports on this data
♦ meeting commitments under the THS/Commonwealth Five Year Labour Agreement
♦ a survey to collect EEO census data
♦ participation in the THS Nursing Recruitment and Retention Taskforce through benchmarking the nursing workforce
♦ management of the Nursing Career Structure Review and Nursing Recruitment and Retention Projects
♦ provision of an on call Human Resource visiting service to all workplaces throughout the Darwin region
♦ establishment of the Workforce Relations and Planning intranet site
♦ a review of Employment Relations policies and guidelines
♦ management of the Employment Relations Graduate Development Program
♦ coordination of Industrial Relations activity in THS
♦ collection of data relevant to the practising clinician workforce to facilitate macro workforce forecasting
♦ demonstration of the value of strategic workforce planning at all levels within Territory Health Services
♦ development of a system of strategic partnerships at the Executive level internally and externally
♦ improved employment relations information for managers and staff
♦ coordination of the Graduate Development Program for the administrative stream.
Human Resource Accountability

As required by Sections 18 and 28 of the Public Sector Employment and Management Act, the following information is provided in relation to Human Resource Management.

Section 28 Public Sector Employment and Management Act

♦ (f) equal opportunity management programs and other initiatives designed to ensure that employees employed in the Agency have equal employment opportunities

Workforce Relations and Planning developed and conducted an Equal Employment Opportunity (EEO) survey on a representative sample of THS staff to provide information on workplace diversity. It will also assist THS in the development of specific programs and future initiatives to ensure equity in employment. The survey will be completed in August 2001.

The feasibility of a THS Harassment Contact Officer (HCO) network is under consideration for introduction during the next financial year. A network has been successfully implemented at RDH.

♦ (g) management training and staff development programs in the agency

THS Graduate Development Program administrative stream combines on the job experience with formal training resulting in an effective career enhancement program. Coordination of the program is the responsibility of Workforce Relations and Planning. Several initiatives are planned for next year including management coaching for graduate supervisors, the development and implementation of a Management Development Program for first year graduates and a stronger focus on leadership training for graduates in their second year of employment. Executive endorsed the Leadership Development Strategy in June 2001.
Section 18 Public Sector Employment and Management Act

♦ *(2)(b) measures taken to improve human resource management in the agency*

Communication is a key element in human resource management. Information sessions were held throughout the year to increase awareness of the following procedures: selection panels, probation, job evaluation, establishment and recruitment protocols. The Workforce Relations and Planning intranet site was launched in April 2001. The site allows employees access to employment relations policies and guidelines, employment conditions, support services, workforce planning information, contacts, links to relevant Human Resource sites and the latest information regarding Human Resource issues. Query and feedback, audit and evaluation mechanisms are also incorporated into the site.

♦ *Employment Instruction 1 – Advertising, Selection and Appointment*

As of 1 February 2001, the Recruitment Essentiality Committee was disbanded across THS and replaced by Job Evaluation, Establishment and Recruitment Protocols. The protocols are a practical guide detailing the appropriate action and delegation for job evaluation, staff recruitment and maintenance of staff positions. The protocols have been an effective communication tool enabling managers to become more familiar with the processes. Eleven information sessions were conducted in Alice Springs, Tennant Creek and Darwin. DCIS PIPS Information Services client visits were incorporated into some presentations.

♦ *Employment Instruction 2 – Probation*

Managers were supported in their roles through revised probation guidelines and reporting mechanisms. The guidelines outline in a step by step approach the fundamentals of effective management for supervisors and probationers. The guidelines and report were revised in consultation with THS employees and HR service delivery areas.

♦ *Employment Instruction 4 – Performance Management*

Performance management has been a priority for managers in THS. The performance management system provides best practice information enabling managers and staff to apply a well established system.

♦ *Employment Instruction 6 – Inability to Discharge Duties*

Managers have sought Human Resource advice on inability issues and have accessed EI 6 information from the THS Workforce Relations and Planning intranet site. During 2000/01 there were no inability cases.

♦ *Employment Instruction 7 – Discipline*

Managers continued to use EI 7 and the THS Workforce Relations and Planning intranet site. A total of four formal discipline cases occurred during this reporting year.
Employment Instruction 8 – Management of Grievances
Management of grievances was coordinated by DCIS in Central Australia, and by Darwin HR Services in the Top End Service Network. Managers accessed information available on the intranet site. Managers and staff were assisted through the Employee Assistance Program.

Employment Instruction 10 – Employee Records
All employee records were kept in strict adherence to EI 10 and legislative requirements. Security and confidentiality were maintained with systems in place regarding authorised access to employee information.

Employment Instruction 11 – Equal Opportunity Management Plan
THS Equal Opportunity Management Plan was actioned through a new initiative for a THS wide Harassment Contact Officer network and the Equal Employment Opportunity survey. Both of these major projects are to be completed in 2001/02.

Employment Instruction 12 – Occupational Health and Safety Plan
The Occupational Health and Safety Management System (OHSMS) continues to be used by THS managers. As part of the revised Workforce Relations and Planning intranet site, all electronic OHS information was simplified. As part of the quality assurance process, the OHSMS is currently being revised.

Employment Instruction 13 – Code of Conduct
A checking process was conducted to determine if the Principles and Code of Conduct were made available to THS staff. Results show that all THS employees have access to the Code of Conduct through the distribution of the booklet and Workforce Relations and Planning intranet site. New employees were provided with a booklet as part of the recruitment and orientation process. The booklet is also available electronically and is featured as one of the top four quick hits. Accompanying the electronic link is a practical explanation of the Principles and Code of Conduct highlighting that all employees are bound by the content.

Employment Instruction 14 – Part Time Employment
Development of flexible work practices is ongoing. Analysis of part time employment arrangements was undertaken to incorporate these practices into the employment opportunities offered by THS. It is critical to offer flexible work practices to ensure the workforce is diverse, skilled and motivated. Permanent part time hours, temporary work, working from home and job sharing are being used as employment options. Twenty percent of THS workforce was employed on a part time employment basis.
(2)(c) Extent to which disciplinary, redeployment and inability procedures were invoked.

Table 6: Summary of Human Resource Activity by Area

<table>
<thead>
<tr>
<th>Area</th>
<th>Formal Inability</th>
<th>Summary Dismissal</th>
<th>Disciplinary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin area</td>
<td>Nil</td>
<td>Nil</td>
<td>3</td>
</tr>
<tr>
<td>Gove</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Katherine</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Tennant Creek</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Alice Springs region</td>
<td>Nil</td>
<td>Nil</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>Nil</td>
<td>Nil</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 7: Summary of Redeployment Activity

<table>
<thead>
<tr>
<th></th>
<th>As at 1 July 2000</th>
<th>New Notifications</th>
<th>Placed</th>
<th>Voluntary Redundancy</th>
<th>As at 1 July 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>THS</td>
<td>7</td>
<td>12</td>
<td>5</td>
<td>10</td>
<td>4</td>
</tr>
</tbody>
</table>
Occupational Health and Safety (OHS)

The Department of Corporate and Information Services manages OHS, Workers Compensation and rehabilitation functions for THS under a service agreement which includes performance measures.

In May 2000 THS approved the Occupational Health and Safety Management System (OHSMS) and a Managers Hands On Guide for self assessment in the workplace. Over the past 12 months these strategies have become the keystone of the THS OHS Management Plan.

This report measures Territory Health Services Occupational Health and Safety performance for 2000/01 against a five year period from 1996/97.

The graph below shows the costs of compensation injuries as a percentage of gross salary. A benchmark of 1.8 percent was based on national health industry performance for 1992. At the time the Australia wide average for the health industry was 2.3 percent. THS 1993 rate of 3.2 percent was systematically reduced and is 1.9 percent for the 2000/01 period. The continued maintenance of costs close to or below the THS benchmark is a reflection of strategic management and staff commitment to reduce workplace injuries.

Figure 20: Workers Compensation as a Percentage of Salary
There was a 41 percent reduction in the cost of compensation since 1993, measured as a percent of salary, and the continued maintenance of costs close to or below the THS benchmark. Compared with the previous year, there was a 45 percent decrease in costs of back injuries Territory wide. At Royal Darwin Hospital the decrease was 53 percent in number and 88 percent in the cost of back injury claims. There was a 42 percent reduction in the cost of aggression related claims and a marginal reduction in the number of claims.

Figure 21: Incidents Causing Back Injury: All THS Staff and RDH Pilot

There was an overall reduction in the number and cost of back injuries for THS. The reduction by 88 percent in the cost for claims at Royal Darwin Hospital was consistent with the performance goal for the year.

The performance goal for 2001/02 is to maintain the current strategy of training, early intervention and rehabilitation programs to further reduce the frequency of injuries and associated time lost.
Figure 22: Work Related Stress Injuries: Cost and Number of Claims

Figure 22 shows that there has been a decrease in both the number and costs of claims meeting the performance goal to reduce the severity of individual claims.

The performance goal for 2001/02 is to continue the early intervention program to further reduce the number of claims and associated costs.

Figure 23: Cost of Stress Claims by Designation
Figure 23 shows the cost of claims by designation. There has been a significant decrease in the cost of claims from the AO5 to professional group. This was an emerging risk which was targeted during the year. An increased risk is identified in remote area staff which needs to be addressed in the coming year. A performance goal for 2001/02 is to identify the at risk designations and through early intervention strategies reduce the number of claims.

Performance goals for 2001/02 are to implement an early intervention program to minimise stress related injuries where critical incidents are the cause.

Figure 24: Claims Caused by Physical and Non Physical Aggression

Figure 24 shows that the number of claims and associated costs of aggressive incidents was further reduced. Costs were significantly reduced indicating a lower severity rate. These injuries were mostly stress related.
Figure 25 shows a continued reduction in the number of claims. There was a further increase of 20 percent in days lost which is an indicator of injury severity.

Performance goals for 2000/01 are to further reduce the number of injuries to nurses. There will be a focus on early intervention, rehabilitation and return to work programs to facilitate a decrease in days lost.
Aboriginal Health

Improving Aboriginal health status is paramount for all Territorians. This section summarises the current health status of Indigenous people compared to other Australians, strategies to reduce the gap in their health status and progress during the past year to improve the health of Aboriginal people.

Health Status of Indigenous People

Aboriginal people comprise 28 percent of the population in the Northern Territory. The death rate is three times that of other Australians and is worse than for Indigenous people in other developed countries.

Figure 26: Trends in Annual Directly Standardised* Mortality Rates All Causes

*Note: World standard population 1960

Source: Ring IT and Firman
There have been declining infant mortality rates for Indigenous people since 1970, but life expectancy has changed little due to continued high adult mortality rates. Comparable mortality rates for Australian Indigenous people were at the rates observed in Indigenous people of countries like New Zealand and the United States 20 years ago. Trends in these countries indicate that rapid health gains were experienced from 1970 onwards. This suggests the potential for similar gains in Australia. Relatively few causes account for most of the mortality rate difference, thus the importance of the Preventable Chronic Disease Strategy targeting major causes of death.

<table>
<thead>
<tr>
<th>Years</th>
<th>Male Aboriginal</th>
<th>Male NT non</th>
<th>Difference</th>
<th>Female Aboriginal</th>
<th>Female NT non</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986-1990</td>
<td>55.0</td>
<td>74.1</td>
<td>19.1</td>
<td>60.7</td>
<td>86.8</td>
<td>26.1</td>
</tr>
<tr>
<td>1991-1995</td>
<td>57.7</td>
<td>74.6</td>
<td>16.9</td>
<td>62.2</td>
<td>83.8</td>
<td>21.6</td>
</tr>
<tr>
<td>1996-1999</td>
<td>60.3</td>
<td>76.6</td>
<td>16.3</td>
<td>66.4</td>
<td>83.1</td>
<td>16.7</td>
</tr>
</tbody>
</table>

Source: THS Epidemiology Branch

Life expectancy at birth is a useful measure of the health status of a population and provides an indication of changes over time between Aboriginal and non Aboriginal people in the Territory.

The life expectancies of non Aboriginal males and females residing in the NT were slightly higher than corresponding life expectancies for the total Australian population. In the period 1996–1999, Australian male life expectancy was 76.2 years (ABS Cat No 3302.0, 1999) compared with 76.6 years for NT males. Corresponding levels for females were 81.8 years for all Australian females and 83.1 years for NT females.

There has been a substantial improvement in life expectancy of both Aboriginal and non Aboriginal Territorians over the last 15 years. The difference between the two groups is reducing from 19.1 to 16.3 years for males and from 26.1 to 16.7 years for females.
An additional way of presenting information on health status is years of life lost. It is measured as the difference between average life expectancy for an individual of a specific age and the age at which that individual actually dies. This measure places greater weight on deaths at younger ages.

Using the 1996 total Australian population life expectancy at each age as a standard, the number of years life lost at each age was calculated for Aboriginal and non Aboriginal populations over the period 1989 to 1998. The direct method of standardisation was used to adjust for age differences between these two groups over the specified time period.

There has been a reduction in years of life lost, indicating health gains, for the Aboriginal population of the NT. When analysed by cause of death, the results indicated that gains over this time period were due to improving and more accessible primary, secondary and tertiary health care. There was little evidence of much change in the external causes category.
Figure 28: NT Infant Mortality Rates

Source: ABS mortality data
ABS Births, Australia cat no 3301.0

Table 9: NT Infant Mortality Rates 1980 to 1999

<table>
<thead>
<tr>
<th>Year of Registration</th>
<th>Aboriginal Neonatal</th>
<th>Aboriginal Post Neonatal</th>
<th>Aboriginal Infant</th>
<th>Non Aboriginal Neonatal</th>
<th>Non Aboriginal Post Neonatal</th>
<th>Non Aboriginal Infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980-1983</td>
<td>14.2</td>
<td>18.3</td>
<td>32.5</td>
<td>9.7</td>
<td>3.8</td>
<td>13.6</td>
</tr>
<tr>
<td>1984-1987</td>
<td>13.9</td>
<td>13.3</td>
<td>27.2</td>
<td>5.9</td>
<td>3.8</td>
<td>9.8</td>
</tr>
<tr>
<td>1988-1991</td>
<td>15.9</td>
<td>13.5</td>
<td>29.4</td>
<td>5.7</td>
<td>3.2</td>
<td>8.9</td>
</tr>
<tr>
<td>1992-1995</td>
<td>14.6</td>
<td>10.2</td>
<td>24.8</td>
<td>6.3</td>
<td>1.9</td>
<td>8.3</td>
</tr>
<tr>
<td>1996-1999</td>
<td>13.0</td>
<td>9.4</td>
<td>22.4</td>
<td>4.4</td>
<td>1.5</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Note: Rates are expressed as number of deaths per 1 000 live births
“Year of registration” refers to the year that the birth or death was registered with
Births, Deaths and Marriages

Source: ABS mortality data
ABS Births, Australia cat no 3301.0

The infant mortality rate has long been used as an indicator of hygiene and health conditions prevailing in a population. The rate is composed of the rate prevailing in two time periods of an infant’s life: the neonatal period (the first four weeks of life) and the post neonatal period (4 to 51 weeks of life). The neonatal period mostly reflects the effectiveness of health services and the post neonatal period reflects social conditions.
The NT Aboriginal infant mortality rate fell by a third during the period 1980 to 1999. This decrease primarily occurred in the post neonatal period where the rate fell by 50 percent from 18.3 to 9.4 deaths per 1,000 livebirths. Over the same period non Aboriginal infant mortality rates halved reflecting reductions in both the neonatal and post neonatal rates.

The burden of disease that many Indigenous people endure is evidenced by hospitalisation rates that are three times the rate of other Territorians.

**Figure 29: Public Hospitalisation Rates per Thousand Population**

![Bar chart showing hospitalisation rates](chart.png)

**Source:** AIHW Report, *Australia’s Health 2000*

NT Aboriginal people require a greater level of hospital services because of their worse health status. Among the most common causes of hospitalisation for Indigenous people were circulatory, respiratory, genito urinary and endocrine diseases, particularly diabetes, and injuries. In the last decade, NT hospitalisation rates for Aboriginal Territorians:

- increased considerably for endocrine, genito urinary, circulatory and respiratory diseases and cancers
- remained almost unchanged for injury
- decreased for infectious diseases, though the incidence of infectious diseases remained significantly higher than the national figures.
Meeting the Challenge

There is recognition that the gap in health status is not narrowing fast enough. Lower access to primary health services contributes to the disproportionate number of hospitalisations. The National Aboriginal Health Strategy 1989 and NT Aboriginal Health Policy 1996 were developed to tackle health issues. More recently Territory Health Services revised Strategy 21, features of which include:

♦ involving Aboriginal people in planning and delivery of their services
♦ improving access to primary health care
♦ delivering specialist services to remote communities
♦ ensuring partnerships with Aboriginal communities
♦ collaborating with other agencies involved in housing, the environment and education
♦ promoting health
♦ delivering greater resources.

Examples of THS initiatives linked to Strategy 2001 are detailed elsewhere in the annual report. Notable are:

♦ the Preventable Chronic Disease Strategy
♦ health zones involving Aboriginal people in administration and delivery of health services
♦ Growth Assessment and Action
♦ Strong Women, Strong Babies, Strong Culture
♦ Aboriginal Health Worker Career Structure Implementation project
♦ immunisations.

Funding Issues

The Australian Institute of Health and Welfare (AIHW) report on Expenditures on Health Services for Aboriginal and Torres Strait Islander people 1998/99 released recently, revealed that the Northern Territory Government recurrent expenditure on health services for Aboriginal and Torres Strait Islander people for 1998/99 was estimated at $174 M. This accounted for 52.6 percent of the Territory’s total health services recurrent expenditure of $330M. Expenditure for Aboriginal and Torres Strait Islander people was estimated to be $3 208 per person or 2.8 times the Territory’s non Indigenous per person expenditure of $1 139. It must be noted that the AIHW report excluded expenditure for Family and Children’s Services and Aged Disability Services from the analysis.
Nationally, expenditure for Aboriginal and Torres Strait Islander people was estimated to be $3,065 per head and $2,519 per person for non-Indigenous people.

The most recent reporting of NT Indigenous health expenditure provided to the Commonwealth under the NT Aboriginal Health Framework Agreement was based on total NT health expenditure for 1999/00. Expenditure on NT Indigenous health during 1999/00 was approximately $225 M or 56 percent of the total NT health expenditure of $434 M.

Lack of access to Federal funding through Medicare and Pharmaceutical Benefits Scheme by remote communities has inhibited early intervention and care. The NT is preparing to overcome its disadvantaged access to Medicare by entering into joint funding arrangements with the Commonwealth for primary health care services in a zone by zone rollout of the Commonwealth’s Primary Health Care Access Program (see highlights page 9).
Achievements and Health Gains

♦ 2000/01 is the first year in which the Commonwealth has been directly funding PBS drugs required by Aboriginal people in remote parts of the Northern Territory. THS has been able to use the funding previously spent on supplying these medications to implement the Preventable Chronic Disease Strategy.

♦ The signing of the second NT Aboriginal Health Framework Agreement for a three year period strengthened partnerships with ATSIC, the Aboriginal Medical Services Alliance of the NT (AMSANT) and the Commonwealth to jointly tackle the challenge of improving Aboriginal health.

♦ In Central Australia five health zones were approved for funding by the Commonwealth Government.

♦ The 1997 THS Aboriginal Employment and Career Development Strategy provided the impetus for THS Executive endorsement of the Aboriginal Community Services Worker Career Structure Implementation project.

♦ Stage 3 of the Aboriginal Health Worker Career Structure (AHWCS) implementation project is nearing completion. Over 70 percent of eligible AHWs employed by THS completed skills self assessment against AHW competency standards.

♦ An Auspicing Agreement with Batchelor Institute of Indigenous Tertiary Eduction for formal recognition of AHW competency achievement was signed by THS in December 2000. The agreement is linked to the Aboriginal Workforce Development program.

♦ Through the NT Remote Health Workforce agency, there has been an increase of six resident general practitioners in remote communities in the past two years. Four additional GPs were supported in the Top End and two in Central Australia.

♦ The success of the Tiwi and Katherine West Coordinated Care Trials resulted in the continued commitment of the Commonwealth and Territory Governments to an ongoing partnership with the Tiwi and Katherine West Health Boards. The new three year tripartite agreements will create a stable funding base for each health board.

♦ The percentage of low birth weight Aboriginal babies born is stable at approximately 13 percent of all live births. The Strong Women Strong Babies, Strong Culture Program is currently operating in 10 communities.
♦ In Central Australian remote communities, where Growth Assessment and Action has focused, there has been a 50 percent fall in the number of children with malnutrition since 1998.

♦ Awareness of Indigenous male health issues increased through the establishment of:
  − a Northern Territory Indigenous Male Health Committee to work towards establishing links with peak health agencies and organisations
  − male health centres in Top End and Central Australian communities; in Gapuwiyak this resulted in an increase of 600 percent attendance for treatment and health checkups
  − a mentoring program aimed at fostering the employment of more Aboriginal males at all levels of the health workforce
  − a series of regional, Territory wide and national Indigenous male health forums.

♦ The Central Australian Mental Health Service developed partnerships with local government councils resulting in the development of a respite house in a local community.

♦ A Tri State Working Group on petrol sniffing was established to enable a more efficient and coordinated approach to service delivery, promote the sharing of resources and improve resource allocation. It involved the Commonwealth Office of Aboriginal and Torres Strait Islander Health, the Northern Territory, South Australia and Western Australia.

♦ The establishment of the THS Aboriginal Interpreter Services (AIS) was a major service improvement for Aboriginal people. The budget allocation NT Wide was $275 000 with 382 services delivered. The AIS main languages used to date were:
### Service Outlets in Top End Service Network

#### Darwin Rural & Remote Area

**Royal Darwin Hospital**
- Darwin + ▼ ▲ △
  - Phone: 8922 8888

**Adelaide River**
- Phone: 8976 7027 Fax: 8976 7093

**Bagot**
- Phone: 8948 3166 Fax: 8948 3044

**Batchelor**
- Phone: 8976 0011 Fax: 8976 0105

**Belyuen (Delisaville)**
- Phone: 8978 9023 Fax: 8978 5181

**Jabukuta Association**
- Phone: 8979 2383 Fax: 8979 3770

**Jabiru**
- Phone: 8979 2018 Fax: 8979 2041

**Kunbarllanjnja (Oenpelli/ Gunbalanya)**
- Phone: 8979 0178 Fax: 8979 0159

**Milingimbi**
- Phone: 8979 2359 Fax: 8979 2538

**Woodycupildiya**
- Phone: 8978 2996 Fax: 8978 2968

#### East Arnhem Area

**Gove District Hospital**
- Nhulunbuy + ▼ ▲ △
  - Phone: 8978 1021

**Alyangula**
- Phone: 8976 2655 Fax: 8976 6116

**Anugeru**
- Phone: 8978 6311 Fax: 8978 6632

**Bickerton Island (Milyakburra)**
- Phone: 8978 6269

**Galilwinku (Elcho Island)**
- Phone: 8978 9031 Fax: 8978 9061

**Gapuwiyak (Lake Evella)**
- Phone: 8978 3800 Fax: 8978 3582

**Laynhapuy (Layna)**
- Phone: 8987 1242 Fax: 8987 1109

**Milingimbi**
- Phone: 8978 9903 Fax: 8978 9940

**Numbulwar**
- Phone: 8975 4670 Fax: 8975 4671

**Ramingining & homelands**
- Phone: 8975 9723 Fax: 8979 7930

**Umbakumba**
- Phone: 8987 6772 Fax: 8987 6779

**Yirrkala**
- Phone: 8978 0336 Fax: 8978 0366

#### Katherine Area

**Katherine Hospital**
- Katherine + ▼ ▲ △
  - Phone: 9873 9211

**Alyangula**
- Phone: 9873 8570 Fax: 9873 8620

**Amarinjidi (Kildurk)**
- Phone: 08 9167 8842 Fax: 9875 0748

**Barunga (Bamyili)**
- Phone: 9875 4501/4509 Fax: 9875 4602

**Binjari**
- Phone: 9871 0970 Fax: 9871 0186

**Borroko**
- Phone: 9875 8757 Fax: 9875 8718

**Bulla Camp**
- Phone: 08 9168 7303 Fax: 9875 0748

**Daguragu (Wattie Creek)**
- Phone: 9875 0891 Fax: 9875 0792

**Gulin Gulin (Bulman)**
- Phone: 9875 4712/4350 Fax: 9875 4829

**Jilkminggan (Duck Creek)**
- Phone: 9875 4741 Fax: 9875 4621

**Kalkarindji (Wave Hill)**
- Phone: 9875 0785 Fax: 9875 0792

**Lajamanu (Hooker Creek)**
- Phone: 9875 0782 Fax: 9875 0748

**Mataranka**
- Phone: 9875 4547 Fax: 9875 4621

**Manyallaluk (Eva Valley)**
- Phone: 9875 4864/8975 4501 Fax: 9875 4602

**Minyerri (Hodgson Downs)**
- Phone: 9875 9959 Fax: 9875 9809

**Ngukurr (Roper River)**
- Phone: 9875 4688 Fax: 9875 4689

**Pine Creek**
- Phone: 9876 1268 Fax: 9876 1325

**Pigeon Hole**
- Phone: 9875 0910

**Robinson River**
- Phone: 9875 9985 Fax: 9875 9857

**Timber Creek**
- Phone: 9875 0727 Fax: 9875 0748

**Urapunga**
- Phone: 9875 4688 Fax: 9875 4689

**Wugularr (Beswick)**
- Phone: 9875 4345/8975 4688 Fax: 9875 4820
Overview

Top End Service Network (TESN) provides community and health services across the Top End of the Northern Territory as well as public hospital services in Katherine and Nhulunbuy. The Top End has a population in excess of 143,000 across 614,000 sq kms.

TESN comes under the leadership of a Regional Director who reports directly to the Deputy Secretary, Service Provision. A Regional Executive Team, comprised of General Managers and Senior Managers, meet fortnightly to ensure that TESN services are aligned with corporate strategic directions and that all services are accountable for both expenditure incurred and outcomes achieved.

TESN aims to:
- incorporate the principles of primary health care and health promotion in the planning and delivery of services
- establish and sustain services that provide the community with quality care options
- improve health services to remote Aboriginal communities
- ensure recruitment and retention practices and outcomes meet organisational goals and customer needs
- provide leadership, direction and support in the design and implementation of continuous improvement throughout TESN.

TESN implements Territory Health Services strategies for:
- Strong Women, Strong Babies, Strong Culture Program
- Preventable Chronic Disease Strategy
- Disabilities Services Strategy.

Expenditure $105.6 M    Employing 1094 (excluding Royal Darwin Hospital)
Outputs

As a provider of health services, TESN either delivers or supports services including:

- Palliative Care
- Hearing Services
- School Nursing and Therapy Services
- Sexual Assault Referral Centre
- Health Development including Alcohol and Other Drugs and Tobacco Action Project
- Disability Resource, Adult Guardianship, Public Guardians
- Family and Children’s Services
- Aged Care
- Oral Health Services
- Mental Health Services
- non government organisations contracted across community and primary health care program areas.
Outcomes

Achievements for the year:

♦ developed a comprehensive Application Package for Remote Area Nurses
♦ produced a Resource Manual to provide new staff with information about TESN programs and services
♦ implemented a work based learning model for Aboriginal Health Workers
♦ prepared a Special Care Nursing Course for registered and enrolled nurses that is receiving accreditation at the Graduate Certificate level through NTU
♦ developed eight self directed learning packages for midwifery
♦ implemented a No Risk Lifting policy and provided training for 270 RDH staff
♦ established a committee to coordinate and monitor Occupational Health and Safety issues and outcomes
♦ developed the document A Coordinated Response to Child Sexual Assault in the Top End
♦ signed a three year service level agreement with Northern Territory Education Department for provision of school therapy services from THS
♦ provided basic alcohol and other drug training to primary health care workers in East Timor
♦ developed, launched and distributed to all Territory secondary schools Choose Yourself Website and Activity Plans for young people
♦ presented a paper on Milikapiti smoke free buildings and areas to the National Tobacco Control Conference in Adelaide
♦ introduced an induction and development program for mental health support workers in East Arnhem to educate local community AHWs in mental health needs
♦ implemented the healthy skin program at Wadeye, Kunbarrlanjinja, Maningrida and Galiwinku
♦ negotiated a new service agreement with Tiwi Health Board for provision of visiting support services
♦ achieved accreditation for Batchelor Health Centre
♦ included public oral health services in the Palmerston Health Precinct
♦ provided education to market stall operators on the new National Food Safety Standards and the role of the environmental health officers
♦ reached agreement with Robinson River to provide enhanced services from Remote Community Incentive funding for a two year period
♦ continued development of Katherine West Health Board in readiness for handover of all Katherine West services on 1 July
♦ assisted with the development of Borroloola Region Community Controlled Health Service
♦ participated in development of the Jawoyn Coordinated Care Trial
♦ redeveloped health centres at:
  – Maningrida
  – Barunga
  – Nguiu.
Central Australian Service Network

Service Outlets

LEGEND

+ Hospital
▼ Resident General Practitioner
■ THS Staffed
☐ Serviced by THS Mobile Staff
● THS Funded
★ THS/Commonwealth Funded
▲ Other Community Service Outlet
♦ Community Controlled Health Boards
Service Outlets in Central Australian Network Service

Alice Springs Remote Area

Alice Springs Hospital
Alice Springs \n
Phone: 8951 7777   Fax: 8951 7988
Aherrenge (Ampilatwatja) ▼★▲
Phone: 8956 9942   Fax: 8956 9971
Alpururrulam (Lake Nash) ▲
Phone: 07 4748 3111   Fax: 07 4748 4874
Amunturrngu (Mt Liebig) ▲
Phone: 8956 8595   Fax: 8956 8984
Aputula (Finke) ○▲
Phone: 8956 0961   Fax: 8956 0778
Attijere (Harts Range) ▲
Phone: 8956 9778   Fax: 8956 9947
Bonya ■
Phone: 8956 6300   Fax: 8566 390
Engawala (Alcoota) ●
Phone: 8956 9944   Fax: 8956 9944
Ikuntji (Haasts Bluff) ◆▲
Phone: 8956 8472   Fax: 8956 8547
Imanpa (Mt Ebenezer) ★▲
Phone: 8956 7484   Fax: 8956 7826
Kaltukatjarra (Docker River) ▲
Phone: 8956 7342   Fax: 8956 7741
Laramba (Napperby) ▲
Phone: 8956 8792   Fax: 8956 8432
Liyentye Aputure(Santa Teresa) ○▲★
Phone: 8956 0911   Fax: 8956 0910
Mtjulu (Ayers Rock) ○▲▼
Phone: 8956 2353   Fax: 8956 2031
Naria (Hermannsburg) ▲
Phone: 8956 7433   Fax: 8956 7473
Nturiya (Ti Tree Station) ▲▼
Phone: 8956 9820   Fax: 8956 9820
Nyrripi ▲
Phone: 8956 8835   Fax: 8956 8840
Papunya ▲
Phone: 8956 03/5   Fax: 8956 8512
Pmara Jutunya (6 Mile) ▲
Phone: 8956 9847
Tara (Neutral Junction) ■
Phone: 8956 9789   Fax: 8956 8979
Ti-Tree ▲
Phone: 8956 9736   Fax: 8956 9829

Tijikala (Maryvale) ■
Phone: 8956 0906   Fax: 8956 0742
Ukakali ■
Phone: 8956 7828
Urapuntja (Utopia) ▼★▲
Phone: 8956 9846   Fax: 8956 9863
Utju (Arengonia) ○▲
Phone: 8956 7308   Fax: 8956 7308
Wallace Rockhole ■
Phone: 8956 7763   Fax: 8956 7763
Walunguru (Kintore/Pintupi Homelands) ◆▼▲
Phone: 8956 8593   Fax: 8956 8582
Watarrka (Kings Canyon) ■
Phone: 8956 7807/97   Fax: 8956 7183
Wilora (Stirling) ■
Phone: 8956 9950   Fax: 8956 9850
Wirliyatjarriyai (Willowra) ▲
Phone: 8956 8788   Fax: 8956 8979
Yulara ▼○▲
Phone: 8956 2286   Fax: 8956 2373
Yuelamu (Mt Allan) ▲
Phone: 8956 8747   Fax: 8956 8847
Yuendumu ▲
Phone: 8956 4030   Fax: 8956 4051

Barkly

Tennant Creek Hospital
Tennant Creek ▼▼▲▼
Phone: 8962 4399   Fax: 8962 4207
Ali-Curung (Murray Downs) ▲
Phone: 8964 1954   Fax: 8964 1971
Barkly Mobile
Phone: 8962 4399   Fax: 8962 4207
Canteen Creek (Orwaitilla) ▲
Phone: 8964 1510
Elliott ▲
Phone: 8969 2060   Fax: 8969 2070
Epnarra (Wuturrurrurru) ▲
Phone: 8964 1559
McLaren Creek (Mungkarta) ■
Phone: 8962 2385   Fax: 8964 1961
Marlinja ○
Phone: 8964 4590
Overview

The Central Region covers an area in excess of 1.1M sq kms extending from the borders of South Australia, Western Australia and Queensland and as far north as Elliott.

Territory Health Services Central Australian Services Network (CASN) provides or supports the delivery of services to approximately 42 500 residents including an Aboriginal population of 15 000. Emergency services are provided to 4 000 people who live in areas adjacent to the borders of Western Australia and South Australia. An average of 4 200 tourists receive medical assistance annually.

There was a change in structure in May 2000 moving to a collaborative funder, purchaser, provider framework. Work on the consolidation of the new Alice Springs District, and improved integration of the Barkly District and Alice Springs Hospital within CASN. this assisted CASN initiatives such as the Primary Health Care Access Program and the development of partnerships with private providers.

CASN Strategies are to:
♦ advance remote health services and improve Aboriginal access to services
♦ focus regional activities on health priorities and outcomes
♦ create a supportive environment for all staff.

Expenditure $ 97.2 M  Employing 1037

Outputs

CASN includes:
♦ CASN Executive made up of the Regional Director and Senior Managers
♦ Alice Springs Hospital and Renal Unit
♦ Alice Springs District consisting of health development, community services and community health services for urban and rural areas
♦ Barkly Health Services and Tennant Creek Hospital comprising health development, community services, community health, and acute services.
Outcomes

♦ Stages 1, 2 and 3 of the Alice Springs Hospital Redevelopment opened including a new Mental Health Unit, Paediatrics Ward, kiosk with landscaped dining areas, Outpatient, Medical Imaging Areas, Maternity / Special Care Nursery / Birthing Suite, Surgical and Medical Wards, Intensive Care and High Dependency Unit.

♦ The Structured Employment Training Program (STEP) was launched at Alice Springs Hospital providing training opportunities for young, long term unemployed Aboriginal people. Two trainees gained full time employment at Alice Springs Hospital.

♦ Memoranda of Agreement were signed with Bonya and Haasts Bluff communities for provision of community based primary health care services in those communities.

♦ Community consultations were conducted with communities in the first five zones to be rolled out as part of the Primary Health Care Access Program. This was undertaken in collaboration with the Commonwealth, ATSIC and AMSANT.

♦ Projects were undertaken to establish links between health and education as part of Healthy Educated Territorians. One highlight was the joint orientation for remote area nurses and community based teachers.

♦ The Preventable Chronic Disease and Health Zones Operational Management Groups were formed to support planned effort in these areas.

♦ A regional framework for quality improvement was developed with implementation through the Regional Quality Improvement Committee.

♦ All Aboriginal Health Workers completed self assessments as part of the Aboriginal Health Worker Career Restructure Program.

♦ CASN was involved in the Alice in Ten programs and chaired the Quality of Life project group.

♦ The Emergency Department at Alice Springs Hospital obtained official accreditation in August 2001 and is now recognised as a training centre for emergency medicine specialists.

♦ The Regional Allied Health Action Plan was developed in consultation with all key stakeholders.
♦ An evaluation of health outcomes in a Central Australian community associated with the National Aboriginal Health Strategy was undertaken with a report presented to the community in January 2001.

♦ A pilot Memorandum of Agreement was developed between the Central Australian Remote Health Training Unit and staff at a Central Australian community based health centre. This agreement outlines processes regarding the training of Aboriginal Health Worker team members.

♦ The Hunting for Health program was launched to improve the nutritional and physical activity status of school aged children. This was undertaken in conjunction with the Departments of Education and Sport and Recreation.

♦ There was management and control of significant outbreaks of Murray Valley Encephalitis and Rotavirus in the region.

♦ Partnerships were developed with the Cooperative Research Centre.
Acute Care (Hospital Services)

Territory Health Services operates five public hospitals located in the major population centres with a combined total of 570 beds. The hospitals form a network of general and specialist medical services providing primary screening, prevention, acute and chronic care.

Remoteness, scattered population and absence of alternative health care providers place demands on hospital services that differ from many other parts of Australia. Public hospitals in the Territory provide many non acute services usually available elsewhere in the private sector. People are moved between NT based hospitals or interstate for specialised services when not available in the individual’s community. These factors add costs to achieve the same level of services provided for other Australians.

- Royal Darwin Hospital     expenditure $114.0M
- Katherine Hospital       expenditure $14.6M
- Gove District Hospital (Nhulunbuy) expenditure $11.9M
- Alice Springs Hospital    expenditure $57.2M
- Tennant Creek Hospital   expenditure $6.2M
- Payment for Territorians treated interstate expenditure $9.1M

Payment for Territorians treated interstate is apportioned between Royal Darwin and Alice Springs Hospitals. With the expenditure for interstate payments RDH was $119.1M and ASH was $61.2M which are the figures listed in the Financial Statements.
Hospital Workload
This section considers the performance of public hospitals as an integrated system to better understand issues such as patient travel, waiting times, workloads and costs. Individual reports are also provided for each of the five hospitals.

Measuring Acute Inpatient Activity by Weighted Inlier Equivalent Separations (WIES)
Hospital workload is measured in terms of why people are admitted to and how long they stay in hospital. WIES is a measure which addresses both factors and is used in this section to report hospital workloads. The measurement is important as it gives a value to a workload of the hospital rather than simply counting the number of people admitted. The method of calculating WIES is reviewed annually and revised to reflect any changes in technologies or inefficiencies that may affect hospital costs / workloads.

The total workload for all Northern Territory hospitals is measured by WIES and represented as a percentage increase or decrease in comparison with 1999/00.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>WIES Adjusted 99/00</th>
<th>WIES Adjusted 00/01 *</th>
<th>% Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Darwin Hospital</td>
<td>22031</td>
<td>22165</td>
<td>0.6%</td>
</tr>
<tr>
<td>Alice Springs Hospital</td>
<td>10741</td>
<td>11872</td>
<td>10.5%</td>
</tr>
<tr>
<td>Katherine Hospital</td>
<td>3177</td>
<td>3069</td>
<td>-3.4%</td>
</tr>
<tr>
<td>Tennant Creek Hospital</td>
<td>1052</td>
<td>888</td>
<td>-15.6%</td>
</tr>
<tr>
<td>Gove District hospital</td>
<td>1798</td>
<td>1666</td>
<td>-7.4%</td>
</tr>
<tr>
<td>Total</td>
<td>38799</td>
<td>39660</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

Note: Acute inpatient refers to Hospital Funding Model Generation 5 patient classification which receive a WIES payment.
* Uncoded records for RDH, ASH and TCH are approximated

Alice Springs Hospital experienced a ten percent growth in demand while overall the five hospitals had a two percent growth in workload.
Figure 31: Acute Inpatient Activity by Weighted Inlier Separations (WIES)

Weighted Inlier Equivalent Separations

Royal Darwin Hospital Katherine Hospital Gove District Hospital Alice Springs Hospital Tennant Creek Hospital

Indigenous Non Indigenous
Major Diagnostic Categories

The top five major diagnostic categories across the Northern Territory are pregnancy and childbirth, disorders of the respiratory, digestive, circulatory and musculoskeletal systems. Same day treatment for renal dialysis is considered separately.

The top five categories for Indigenous people indicate that a significant number of babies and neonates with conditions originate in the perinatal period. In 1999/00 there were 1,548 in this category which decreased slightly in 2000/01 to 1,440.

Within the digestive system category there is a significant difference in the type of digestive disorders between Indigenous and non Indigenous patients. The majority of digestive disorders in Indigenous patients were recorded as gastroenteritis. Non Indigenous patients were recorded as having colonoscopies and appendectomies.

Figure 32: Major Diagnostic Categories 2000/01

<table>
<thead>
<tr>
<th>Major Diagnostic Category</th>
<th>Indigenous</th>
<th>Non Indigenous</th>
<th>Total WIES</th>
<th>Average Length of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>WIES</td>
<td>WIES</td>
<td>WIES</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and Childbirth</td>
<td>5,222</td>
<td>2,347</td>
<td>2875</td>
<td>6,889</td>
</tr>
<tr>
<td>Respiratory System</td>
<td>5,118</td>
<td>2,585</td>
<td>1,302</td>
<td>3,887</td>
</tr>
<tr>
<td>Musculoskeletal System</td>
<td>3,506</td>
<td>1,437</td>
<td>2,070</td>
<td>3,157</td>
</tr>
<tr>
<td>Digestive System</td>
<td>3,228</td>
<td>1,514</td>
<td>1,714</td>
<td>4,061</td>
</tr>
<tr>
<td>Circulatory System</td>
<td>2,784</td>
<td>1,292</td>
<td>1,491</td>
<td>2,499</td>
</tr>
</tbody>
</table>
The number of renal dialysis treatments continues to grow, but the rate of growth has slowed to 1 percent for 2000/01, compared to 6 percent in 1999/00. Kidney transplants of which there were nine during 2000, contributed to the slowing of dialysis treatments.

### Table 11: Organ Transplants for Territorians

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Number of Kidney Transplants</td>
<td>4</td>
<td>17</td>
<td>11</td>
<td>17</td>
<td>9</td>
</tr>
</tbody>
</table>

*Source: South Australia Organ Donation Agency*

Organ harvesting and transplanting is done interstate. During 2000 nine Territorians received kidney transplants, three from Alice Springs and six from Darwin. There were two donors, both from Alice Springs, supplying four kidneys and one liver.
Figure 34:  Organ Donors Selected Countries

Source:  Council of Europe, 1999

Of the selected countries in the graphic Australia had the lowest rate of organ donors.
Average Length of Stay (ALOS)
The length of hospital stay relates to both efficiency and complexity. A change in average length of stay may infer efficiency, but is balanced against the availability of specialty services where more complex cases may be treated. In the last two years more speciality services have become available such as cardiology and dermatology. Complexity may translate into longer stay in hospital.

Figure 35: Average Length of Stay 2000/01 Excluding Same Day

A reduction in the length of stay is a key outcome in managing demand for services delivered by Territory Health Services hospitals. The Northern Territory average length of stay is lower than the Australian average.
Waiting Times for Elective Surgery

Elective surgery waiting time is an indicator of access to public acute care hospitals. Each urgency category has a performance target percentage. The urgency categories and percentage targets used for elective surgery are:

♦ Category 1 Urgent: where admission is desirable within 30 days and the performance target is 5 percent
♦ Category 2 Semi urgent: where admission is desirable within 90 days and the performance target is 15 percent
♦ Category 3 Non Urgent: where admission in the future is acceptable. There is no specified desirable wait for Category 3. Patient waiting times of longer than 12 months are considered extended. The performance target is 10 percent.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>56.3%</td>
<td>57.0%</td>
<td>16.1%</td>
<td>33.3%</td>
<td>0%</td>
<td>47.5%</td>
</tr>
<tr>
<td>Category 2</td>
<td>43.7%</td>
<td>46.5%</td>
<td>16.5%</td>
<td>26.9%</td>
<td>41.8%</td>
<td>35.6%</td>
</tr>
<tr>
<td>Category 3</td>
<td>19.5%</td>
<td>16.5%</td>
<td>7.5%</td>
<td>3.7%</td>
<td>6.1%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

Waiting lists alone cannot be used to assess Territorians level of access to services. Although the number of elective surgery admissions overall was static compared to last year, the number of patients on the waiting list grew. In Alice Springs Hospital growth in total hospital admissions limited the ability to reduce the number of patients waiting for elective surgery.

<table>
<thead>
<tr>
<th>Category</th>
<th>1999/00</th>
<th>2000/01</th>
<th>1999/00</th>
<th>2000/01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>1512</td>
<td>1545</td>
<td>38</td>
<td>72</td>
</tr>
<tr>
<td>Target 5%</td>
<td>8.7%</td>
<td>9.1%</td>
<td>13.2%</td>
<td>31.9%</td>
</tr>
<tr>
<td>Category 2</td>
<td>1222</td>
<td>1184</td>
<td>546</td>
<td>407</td>
</tr>
<tr>
<td>Target 15%</td>
<td>18.8%</td>
<td>18.0%</td>
<td>6.8%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Category 3</td>
<td>915</td>
<td>873</td>
<td>825</td>
<td>767</td>
</tr>
<tr>
<td>Target 10%</td>
<td>6.0%</td>
<td>8.9%</td>
<td>0.1%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>
Royal Darwin Hospital Otolaryngology (ear, nose and throat) represents the highest percentage of overdue patients in category 1 (20 percent) and category 3 (33 percent) where general surgical speciality is recorded. Otolaryngology comes second (37 percent) to plastic and reconstructive surgery (47 percent) in category 2. The highest percentage of overdue patients at Royal Darwin Hospital occurs in category 2 at 18 percent.

Alice Springs Hospital Ophthalmology represents the highest percentage of overdue patients in category 1 (67 percent) with obstetrics and gynaecology (7 percent) the highest percentage in category 2. Orthopaedic surgery has the second highest percentage of patients waiting in the categories 1 (25 percent) and 2 (7 percent). Category 3 had no overdue patients recorded with general surgical speciality.
Emergency Department Waiting Times

Patients attending emergency departments are classified within five triage categories according to the urgency of treatment required.

♦ Category 1 Resuscitation: patients seen immediately, national target is 100 percent
♦ Category 2 Emergency: patients seen within 10 minutes, national target is 70 percent
♦ Category 3 Urgent: patients seen within 30 minutes and the national target is 70 percent
♦ Category 4 Semi Urgent: patients seen within 60 minutes, no specified target
♦ Category 5 Non Urgent: patients seen within 120 minutes, no specified target.

Royal Darwin Hospital and Alice Springs Hospital met the national targets for the two most urgent categories.

Figure 36: RDH and ASH Emergency Departments: Percent of Patients Treated Within Timeframe
Private Health Insurance

Private health insurance covering Territorians peaked in September 2000 at 37.1 percent declining to 34.2 percent in June 2001 compared to 45.2 percent for the rest of Australia.

Despite the increase in the number of Territorians with private health insurance, the number of people declaring private patient status in Northern Territory public hospitals has not varied significantly. As the Northern Territory has only one private hospital provider located in Darwin, the impact of rates of private health insurance primarily affect the Top End.

Figure 37: Private Health Insurance in the Northern Territory

Source: Private Health Insurance Administration Council
Patients Travelling
Territorians face particular challenges in accessing specialised medical services due to the remoteness and distribution of our population. Under the Australian Health Care Agreement (AHCA) the Northern Territory Government pays for Territory residents treated in a public hospital interstate while visitors using Territory hospitals are paid for by their state of residence.

Travel is measured by three categories:
- The Patient Assistance Travel Scheme (PATS) assists Northern Territory residents to access essential medical services. This usually relates to planned intra or interstate medical appointments.
- Medical Evacuation (Medivac) occurs when a patient has an acute medical condition and requires evacuation to a hospital for further assessment and treatment.
- Inter Hospital Transfer (IHT) occurs when a patient is transferred to another hospital intra or interstate.

The Northern Territory is increasing specialist services available in the Territory to reduce the need to travel interstate. In some cases specialists such as cardiologists are provided locally, but are not supported by the technology and facilities required for higher level interventions. The challenge for Territory Health Services is to endeavour to treat as many Territorians locally as possible by providing specialists and treatment facilities.

Intrastate travel has risen only marginally over the past five years due to increased services provided in rural and remote areas by specialist outreach services.

Patients travelling interstate reduced slightly in 2001 as compared to 2000. The major reduction in interstate travel was due to the establishment of a coronary angiography service based in Darwin. In the longer term, interstate travel may grow due to unmet demand for more complex interventions such as angioplasty and cardiac surgery.
The major specialities which were accessed interstate were cardiac interventions, neurosurgery and radiotherapy/oncology.
Royal Darwin Hospital

Overview

Royal Darwin Hospital improved services to the public through a number of initiatives during the year.

RDH fostered partnerships in Aboriginal development, a major goal of Strategy 21. Support provided for the on site Aboriginal Interpreter Service and for training of Aboriginal Health Workers are prime examples, along with cooperation with Larrakia Nation for the establishment of a Bushtucker Garden on the RDH campus.

The on site Aboriginal Interpreter Service was launched in October last year. This improved communication for better delivery of health care to Indigenous patients. Since its launch, the service has provided more than 700 interpreting sessions.

Emergency Department waiting times were lowered to a record level following a change in work practices. The improvements led to RDH exceeding national guidelines and put RDH in front of 22 peer hospitals in this area. Elective surgery waiting lists have been reduced by 60 percent.

Royal Darwin Hospital received the Prime Minister's NT Employer of the Year Award. The award, in the large business category, recognised the employment of staff with disabilities in the laundry, kitchen and central sterilising.

NT Imaging installed a new $2M MRI machine, which replaced a seven year old machine, enabling a higher quality of imaging than was previously available.

Royal Darwin Hospital's accreditation under the Australian Council of Healthcare Standards was renewed for a further four years with 14 commendations awarded by the ACHS survey team. One commendation was for external disaster planning following RDH's integral role in dealing with evacuees during the East Timor crisis; another was for the work of the Clinical Ethics Committee.

The commissioning of an Angiography Unit, a joint venture with NT Cardiac Service and Healthscope, in March this year enabled 135 public patients to have angiography carried out locally. This new service will save an estimated 300-400 patients per year travelling to Adelaide.
Outputs

Services provided during the past year included:

- a major teaching and reference hospital for northern Australia and South East Asia including rural and remote training placements for doctors
- 268 authorised beds, plus 25 mental health beds as part of Top End Mental Health Services
- delivery of services through staff or visiting specialists in the areas of anaesthetics, cardiology, dermatology, emergency medicine, ear nose and throat, endocrinology, forensic pathology, gastroenterology, histopathology, infectious diseases, intensive care, general medicine, hyperbaric medicine, microbiology, neurology, neurosurgery, oro-maxillo facial surgery, obstetrics and gynaecology, oncology, ophthalmology, orthopaedics/trauma, paediatrics, paediatric respiratory physician, pain, plastic reconstructive surgery, psychiatry, radiology (including nuclear medicine, CT scan and MRI), rehabilitation services, renal, reproductive medicine, adult respiratory medicine, rheumatology, sleep studies, spinal, general surgical and urological
- allied health services including prosthetics and orthotics, physiotherapy, occupational therapy, speech pathology, social work, Aboriginal liaison, audiology, nutrition/dietetics, ECG/EEG, hospital chaplains, interpreter services and SEAT (Seating, Equipment and Technical)
- hospital in the home services
- support services including food services, linen services and sterilising
- a pharmacy
- specialist outreach services in conjunction with the Commonwealth Government.

Outcomes

Achievements were:

- reduced Emergency Department waiting times to meet or exceed national guidelines
- lowered inappropriate elective surgery waiting list numbers across all categories
- improved quality of patient care by using a culturally effective flip chart for diabetic patients assisting with learning and understanding
- better patient comfort through the reprogramming of air conditioning units for the main ward block
- continued reductions in the average length of stay (ALOS) with eight top 10 DRGs below the national average
♦ reduced waiting times through a change in procedures in the midwives clinic

♦ Aboriginal training in the health field through collaboration with Batchelor Institute of Indigenous Tertiary Education which led to the development of an Advanced Diploma in Renal Health

♦ reduced amputation rates for diabetic patients from 14 to six through improved education and service

♦ greater efficiency of the food services division following a remodelling of the kitchen and a review of catering services

♦ access to medical records improved by completing a cull of 70 percent of the active and inactive records

♦ improved communication with GPs, District Medical Officers and community health staff by implementing a system of written notifications in relation to patients

♦ quality improvements of patient care through the implementation of environmental inspections involving housekeeping, infection control and engineering

♦ increased hospital throughput by providing the equivalent of 5865 nights accommodation in the self care centre for patients who would otherwise have taken up acute beds

♦ enhanced patient safety and freedom from pain on Ward 2A through implementation of regular inservices and daily assessments by the Acute Pain Management Team
Katherine Hospital

Overview

Katherine Hospital is a 60 bed facility servicing the Katherine Region. The area covered is approximately 340 000 kms between the Western Australian and Queensland borders extending as far as Dunmarra in the south and Pine Creek in the north. The area has a population of approximately 19 000 people with an annual tourist presence in excess of 500 000 visitor nights.

Katherine Hospital management works closely with Wurli Wurlinjang Aboriginal Health Service to ensure collaboration, continuity of services for common staff and a reduction in service duplication. Katherine Hospital and regional services have an integrated approach to service provision across the hospital and community.

Katherine Hospital is part of Top End Service Network. As such its business plan is in keeping with the directives of Strategy 21. Objectives and strategies are identified to enable the four stretch goals to be met.

Outputs

Services provided:

♦ general medical, diagnostic and treatment services
♦ general surgery, paediatrics, medicine, gynaecology, ophthalmology, ear nose and throat, orthopaedics, cardiology and paediatric cardiology specialist services
♦ a four chair renal dialysis unit
♦ participation in the Royal Australian College of General Practitioners training program and the training program for overseas doctors
♦ placements from various universities of nursing and allied health students.

Outcomes

♦ The Australian Council on Healthcare Standards pre survey self assessment was completed by staff.
♦ The midwifery ward is undertaking accreditation as a Baby Friendly Hospital.
◆ The Palliative Care Unit is being upgraded and refurbished to give more comfortable accommodation for clients and their families.

◆ Cultural and ethical issues were promoted through: the employment of Aboriginal Health Workers and Aboriginal Liaison Officers, encouragement of boarder mothers or carers for babies admitted to hospital and recognition of men’s health issues for Aboriginal men in hospital.

◆ Visiting specialist appointments increased from the previous financial year resulting in:
  – improved client access to specialist appointments
  – decreased need for patients to travel to Darwin for appointments
  – decreased costs with Patients Assistance Travel Scheme (PATS).

**Figure 40:** Visiting Specialist Appointments by Year Katherine Hospital

◆ There was an increase in the number of clients able to be treated locally.

◆ Episodes of acute care increased by 886 from the previous financial year.

◆ Average length of stay decreased by 0.3 of a day per episode of acute care from the previous financial year which lowered cost per episode of care and decreased the chance for hospital acquired infection.
Figure 41: Acute Episodes of Care Katherine Hospital

Figure 42: Average Length of Stay Katherine Hospital
Gove District Hospital

Overview

Gove District Hospital (GDH), a 30 bed facility located in Nhulunbuy, services the East Arnhem district. Approximately 14,000 people live in 12 main communities and numerous smaller Aboriginal homelands located on the mainland and adjacent islands.

As part of Top End Service Network the GDH business plan is in line with the directions of Strategy 21. Organisational restructure was put in place throughout both GDH and East Arnhem District. This restructure promoted the integration of services across GDH and the District.

Outputs

Services offered by the hospital include:
- employment of eight doctors and 40 nurses
- emergency services
- general surgical, medical and paediatric care
- elective and emergency surgery
- gynaecology
- obstetrics and 24 hour emergency services
- visiting specialists including physicians, surgeons, paediatricians, ENT specialists, gynaecologists, psychiatrists and ophthalmologists
- hospital doctors who provide routine medical visits to the remote communities and assist with the emergency aerial evacuation of clients from these communities
- support services including radiography, pharmacy, physiotherapy, pathology, occupational therapy, speech therapy and dietetics.

Outcomes

- GDH began the accreditation process under the Australian Council on Health Care Standards by undergoing the self assessment phase.
- An upgrade to the fire exits throughout the hospital was completed providing increased safety levels for staff and clients.
♦ The hospital air conditioning system was upgraded to provide a more reliable service.

♦ Installation of an emergency back up generator for the administration/staff quarters was completed for power supply during periods of outage.

♦ An energy saving program within the hospital was installed.

♦ GDH reduced the average length of stay of inpatients.

♦ Ultrasonography services were improved by purchasing new equipment reducing the number of people transferred to RDH for treatment.

♦ The involvement of the Aboriginal Interpreter Service and employment of an Aboriginal Liaison Officer and Aboriginal Health Worker in the hospital facilitated services to Aboriginal clients.

♦ Patient menus included traditional foods in their selection.

♦ Medical service providers collaborated with private providers to better serve the area.

♦ Closer cooperation with GPs and Miwatj Aboriginal Health Corporation resulted in an increase in service provision by more effective sharing of available resources. This closer cooperation with Miwatj has resulted in Aboriginal representation on the Hospital Management Board.
Alice Springs Hospital

Overview

Alice Springs Hospital is a 164 bed facility servicing the Central Australia Region. The area covered is approximately 1,000,000 sq kms between the Western Australian, Queensland and South Australia borders and extending north to Elliott. The area has a population of approximately 45,000 people with an annual tourist presence of around 400,000 people. The closest referral centres are Darwin and Adelaide, both over 1,500 kms from Alice Springs.

In addition to hospital beds, ASH manages the Renal Dialysis Unit at the Community Health Centre, Flynn Drive. This has the capacity for 26 haemodialysis chairs, provides outreach services for patients receiving peritoneal dialysis and coordinates renal transplantation services.

Construction for hospital redevelopment began in July 2000 and is due for completion July 2002. As of 30 June 2001, 51 percent of the building work was completed. Hospital services were maintained during construction and the work is approximately three percent ahead of schedule. It is anticipated that a modern redeveloped hospital, including a private patient wing of 15 beds, will greatly improve health provision and choice for Central Australian residents.

Outputs

Services provided are:

♦ general allied health, diagnostic and treatment services
♦ general surgery, paediatrics, medicine, obstetrics and gynaecology, ophthalmology, ear nose and throat, orthopaedics, emergency medicine, anaesthetics and intensive care
♦ visiting medical officer service providing neurology, neurosurgery, oncology, rheumatology, urology, cardiology, respiratory, pain service, gastroenterology, plastic surgery, sleep studies, allergy service, dermatology, rehabilitation medicine, endocrinology
♦ renal services including haemodialysis for 78 patients and outreach services for peritoneal dialysis patients
♦ the only 24 hour emergency service available to Central Australians, fulfilling a retrieval and interhospital transfer role in conjunction with district medical officers and the Royal Flying Doctor Service
outreach services to rural communities for eye clinics, ENT clinics, paediatric services, and orthopaedic clinics

Implementation of the Structured Training and Employment Program (STEP) for Aboriginal people and school leavers training program in Business and Administration Certificate.

Outcomes

The Emergency Service was accredited.

Opening of newly redeveloped services, including:
- Maternity Ward
- Special Care Nursery
- Medical Ward
- Staff and Visitor Kiosk
- Rehabilitation Unit
- Mental Health ward
- Paediatric Ward, Outpatients and Administrative Area.

Ward clerk coverage in all patient ward areas improved.

A frontline management course for junior and middle managers of the hospital was implemented in partnership with Centralian College.

Cultural and ethical issues were promoted through the employment of Aboriginal Health Workers, Aboriginal Liaison Officers and Aboriginal people in a number of other work areas including an apprentice mechanical engineer.

Aboriginal Liaison Officers were employed to implement a model of ambulatory care in the Emergency Department. These staff provided interpreting and social intervention skills to facilitate individual episodes of care and provide appropriate care/social options.

Demand for hospital services increased during the year. At the same time the hospital’s bed capacity was temporarily reduced due to hospital redevelopments. This increased pressure on hospital staff, stretched services and required careful management over the year.

Average length of stay decreased slightly to 3.48 days. Case complexity was 45 percent higher for Aboriginal patients excluding those for dialysis. Aboriginal patients occupied 73 percent of available beds.
The average waiting period for elective surgery increased due to urgent admission requirements.

New Patient Service Assistant positions were established for emergency, night duty adult wards, X ray, operating theatre, outpatients and paediatrics to alleviate expanding workloads previously covered by nursing staff.
Tennant Creek Hospital

Overview

Tennant Creek Hospital is part of an integrated health service offered by Barkly Health Services. The hospital is a 20 bed facility serving 6,000 residents across the 250,000 sq km Barkly Region which extends from just north of Ti-Tree in the south to Elliott in the north and east to the Queensland border.

The hospital provides inpatient, domiciliary, outpatient and emergency services. Visiting specialist services are provided by Alice Springs Hospital and include general surgery, ophthalmology, obstetrics/gynaecology, paediatrics, orthopaedics, physician, rehabilitation and ear, nose and throat. Day surgery facilities are available.

Support services include pharmacy, pathology, radiology, ultrasound, physiotherapy, occupational therapy, speech pathology, disease control and dietetics. Family and Children's Services staff provide social work, child protection and substitute care services.

The hospital employs Aboriginal Health Workers, an Aboriginal Liaison Officer and two interpreters to address the special needs of Aboriginal people in a culturally appropriate manner.

Aero medical evacuations are undertaken by medical and nursing staff using either the hospital's twin engine plane or the Royal Flying Doctor Service. Patients requiring services not available in Tennant Creek are referred to Alice Springs Hospital through either inter hospital transfers or the Patient Assisted Travel Scheme.

Serving a dual role as hospital and district medical officers, doctors provide hospital care and conduct routine medical visits to outlying Aboriginal communities and cattle stations. Other services provided to these areas include prevention and early intervention programs with a focus on nutrition, environmental health, disease control and health promotion.

Barkly Health Services staff liaise closely with other Aboriginal health services and community organisation councils within Tennant Creek. This ensures collaboration, continuity of service for common clients and reduction in service duplication within the context of Strategy 21 to foster partnerships in Aboriginal development.

A decreased town population was reflected by reduced bed occupancy. It is anticipated that this phenomenon will be short lived as the railway camps, sleeper factory and new mine
become operational. Accident and emergency and other services remained as busy as previous years.

**Outputs**

Services provided:
- Accident and Emergency Services
- Aeromedical Service
- General medical, surgical, midwifery, and paediatric inpatient services
- Diagnostic and treatment services
- Visiting specialists including general surgeon, orthopaedic surgeon, ear nose and throat, ophthalmologist, physician, paediatrician, gynaecologist.

**Outcomes**

- Services provided were within budget allocations.
- Two Aboriginal Health Workers and an Aboriginal Liaison Officer addressed the cultural needs of Aboriginal clients.
- Tennant Creek Hospital introduced an interpreter service through the Aboriginal Interpreter Service Program.
- Admissions via accident and emergency remained stable at 996 compared to 998 for the previous year.
Average length of stay decreased by .1 of a day per episode of acute care from the previous financial year.

Figure 46: Average Length of Stay Tennant Creek Hospital
Number of live births remained stable at 36 compared to 41 for 1999/00.

Figure 47: Number of Live Births Tennant Creek Hospital

- Visiting specialist appointments remained stable at 1,006 compared to 971 for 1999/00.

Figure 48: Visiting Specialist Appointments Tennant Creek Hospital
Community Health

Overview

Community Health aims to reduce the burden of ill health in the community and the need for hospitalisation. This is achieved by:

♦ building the capacity of individuals, families and communities to maintain and improve their health through community education and development
♦ enhancing prevention and early intervention activities to reduce illness and injury
♦ ensuring individuals and families have access to community based assessment, treatment and support services to rapidly restore or maintain their health
♦ ensuring people possess adequate personal resources and access to appropriate supports that enable chronic disease or disability to be managed in the community for as long as possible.

Community health services are delivered via a network of government, non government and private providers. Service delivery models vary to meet the needs of people living in urban and remote areas.

The community health workforce is comprised of general practitioners in private practices, or as salaried staff of community controlled Aboriginal Health Services, district medical officers, community nurses, Aboriginal Health Workers, dentists and allied health professionals.

♦ Expenditure $95.9 M

Outputs

Community Health provides the following services (refer to Service Outlet Map page 24):

♦ Primary Care provided from:
  Urban centres
  – 6 THS Community Care Centres
  – 5 community controlled Aboriginal health services
  – 56 general practices.
  Remote communities
  – 66 THS Community Health Centres
  – 14 community managed health services
  – 7 community controlled Aboriginal health services
  – 12 community health centres in two Coordinated Care Trial Health Zones managed by health boards
  – 22 general practices.
♦ Oral Health services to primary school children, high school students and disadvantaged people, provided by dentists and dental therapists from eight dental clinics, 47 school dental clinics in urban centres, 26 remote dental clinics and 3 mobile dental clinics

♦ Maternal and Child Health services, emphasising disease prevention, immunisation, health promotion and health education, provided by multidisciplinary health teams

♦ Domiciliary Care encompassing treatment, education, assessment and coordinated care in the home

♦ Palliative Care is coordinated by a team of medical, nursing, allied health and volunteer workers

♦ Food and Nutrition services focusing on maternal and child health, food supply and healthy lifestyle through Remote Stores Project, Community Nutrition Worker program, Growth Assessment and Action program, nutrition education in schools and food and nutrition monitoring

♦ Aboriginal Hearing Health involving Indigenous community awareness, teacher training, Aboriginal Health Worker training and classroom acoustics

♦ Emergency and Retrieval Services comprising the NT Aerial Medical Services (Top End) Royal Flying Doctor Services (Central Australia), outsourced aviation (Barkly District), round the clock medical consultations, accident and trauma services, St John’s Ambulance and Royal Darwin Hospital Accident and Emergency service

♦ Male Health Policy Unit with a central coordinating role across programs on male health needs for strategies, policy advice, monitoring and evaluation

♦ Women’s Health Strategy Unit for a coordinated approach to the delivery of services for women through improved access to services, health education and training programs.

Outcomes

♦ Regional health authorities operated under the governance of an elected health board. The Tiwi Islands and Katherine West District established health boards and provided primary health care to over 5000 residents.

♦ Five health zones similar to health boards, are in the planning stages in Central Australia.

♦ 21 509 and 32 897 vaccinations were administered to Aboriginal and non Aboriginal children respectively.

♦ 2 351 (80 percent) children in participating remote Aboriginal communities were screened by Growth Assessment and Action.
There was a fall in the number of children with malnutrition by as much as 70 percent in some communities through a combination of Strong Women Strong Babies Strong Culture, Community Education and Training, Healthy Lifestyle Programs, and Growth Assessment and Action initiatives.

571 Aboriginal children (58 percent) and 1,641 non-Aboriginal children (65 percent) were screened at school entry.

4,437 Aboriginal and 13,870 non-Aboriginal community health cases were active in urban centres for all service categories.

45 percent and 52 percent of community health cases in urban centres for Aboriginal and non-Aboriginal people respectively were closed indicating the completion of health care needs for these people.

Note: Growth Assessment and Action operates in all THS districts, however it has dedicated funding in Alice Springs and coverage rates are high. Coverage rates are low in other districts and data is therefore unreliable.
20 remote health centres in Aboriginal communities employed one or more resident general practitioners.

An increase of six resident general practitioners in remote communities in the past two years improved access to primary care services for people requiring treatment and referral to hospital for serious illness.

THS funded 5,069 medical flight / evacuations from remote communities.

9,242 and 18,381 dental examinations / treatments were performed on Aboriginal and non-Aboriginal clients respectively.

The waiting period for general dental treatment at the Darwin Dental Clinic was 18-24 months. All emergency cases were treated immediately.

Figure 50: Number of Dental Visits
There were 246 palliative care clients for the year, excluding bereaved clients.

A three fold increase in the use of enhanced primary care Medicare services, up from 183 in 1999/00 to 540 last year, followed education and training of the multidisciplinary health team.
Community Services

The Community Services Activity consists of three service or output groups;

- Mental Health Services  expenditure $13.9M
- Family and Children’s Services  expenditure $28.1M
- Aged and Disability Services  expenditure $35.8M

The three output groups deliver or purchase services from non government agencies. These services support families and communities to be self sufficient and to improve their health and wellbeing. How this is achieved is reported in this section for each of the output groups.

Mental Health

Overview

The Northern Territory Government has a commitment to services that deliver continuing improvement in the mental health and wellbeing of individuals, families and the community. This is reflected in the NT government’s endorsement of the Second National Mental Health Plan 1998-2003 and the renewal of the National Mental Health Strategy. The Strategy provides a national framework for future activity in mental health reform and comprises the Mental Health Statement of Rights and Responsibilities 1991, the National Mental Health Policy 1992, the Second National Mental Health Plan and Schedule B of the Australian Healthcare Agreements 1998.

Consistent with the National Mental Health Strategy, objectives of Mental Health Services are to:

- promote the emotional and social wellbeing of the NT community, and where possible, prevent the development of mental health problems and mental disorders
- reduce the impact of mental health problems and mental disorders on individuals, families and the community
- improve the emotional and social wellbeing of Aboriginal and Torres Strait Islander communities, families and individuals
- work collaboratively to create and strengthen partnerships that involve consumers, families, carers, service providers and communities in policy and service planning, development and evaluation
- improve the quality and effectiveness of service responses
♦ adopt a whole of government and community approach
♦ increase the focus on promotion, prevention and early intervention initiatives.

Outputs

Services provided include:
♦ inpatient facilities in Darwin and Alice Springs
♦ specialist child and youth services
♦ community based adult mental health and forensic services
♦ extended hours teams
♦ education and training programs
♦ consultation liaison services to the Royal Darwin and Alice Springs Hospitals,
♦ rural and remote services
♦ partnerships in service reform involving consumers, carers, service providers and other community partners.

Outcomes

Figure 53: Mental Health Inpatient Activity

*Note: Includes figures from regional feeder hospitals (Gove, Katherine and Tennant Creek)
Table 14: Mental Health Inpatient Separations by Diagnostic Group

<table>
<thead>
<tr>
<th>Diagnostic Category (ICD10-AM)</th>
<th>CAMHS</th>
<th>TEMHS</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>F00-09 Organic Disorders</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>F10-19 Disorder due to Psychoactive Substance Abuse</td>
<td>30</td>
<td>102</td>
<td>132</td>
</tr>
<tr>
<td>F20-29 Delusional Disorders</td>
<td>67</td>
<td>230</td>
<td>297</td>
</tr>
<tr>
<td>F30-39 Mood Disorders</td>
<td>41</td>
<td>172</td>
<td>213</td>
</tr>
<tr>
<td>F40-49 Neurotic Disorders</td>
<td>28</td>
<td>102</td>
<td>130</td>
</tr>
<tr>
<td>F50-59 Disorders Associated with Physical Factors</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>F60-69 Adult Personality Disorders</td>
<td>9</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>F70-79 Mental Retardation</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>F90-98 Childhood Associated Disorders</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Other Conditions</td>
<td>24</td>
<td>46</td>
<td>70</td>
</tr>
<tr>
<td>Not Stated</td>
<td>0</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>203</td>
<td>680</td>
<td>883</td>
</tr>
</tbody>
</table>

*Note: Includes figures from regional feeder hospitals (Gove, Katherine and Tennant Creek)
  Central Australian Mental Health Services (CAMHS)
  Top End Mental Health Services (TEMHS)

- Mental Health Services continued to provide services to an increasing proportion of the Northern Territory population. Twelve percent more people were seen over the previous year in both inpatient and community settings.

Table 15: NT Mental Health Client Population by Gender and Indigenous Status

<table>
<thead>
<tr>
<th>Indigenous Status</th>
<th>Male</th>
<th>Female</th>
<th>Not Stated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal</td>
<td>708</td>
<td>427</td>
<td>0</td>
<td>1135</td>
</tr>
<tr>
<td>Non Aboriginal</td>
<td>1331</td>
<td>1034</td>
<td>1</td>
<td>2366</td>
</tr>
<tr>
<td>Not Stated</td>
<td>97</td>
<td>40</td>
<td>26</td>
<td>163</td>
</tr>
<tr>
<td>Total</td>
<td>2136</td>
<td>1501</td>
<td>27</td>
<td>3664</td>
</tr>
</tbody>
</table>

- Thirty six percent of all clients seen are in the 5-25 year age group. This level of service provision has remained constant over the past three years of data collection.
### Table 16: Community Mental Health Clients by Age and Service District

<table>
<thead>
<tr>
<th>Age group (ten years)</th>
<th>District</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Stated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darwin Urban</td>
<td>100</td>
<td>2419</td>
</tr>
<tr>
<td>Darwin Rural</td>
<td>0</td>
<td>146</td>
</tr>
<tr>
<td>Katherine</td>
<td>0</td>
<td>162</td>
</tr>
<tr>
<td>East Arnhem</td>
<td>5</td>
<td>321</td>
</tr>
<tr>
<td>Barkly</td>
<td>0</td>
<td>107</td>
</tr>
<tr>
<td>Alice Springs Urban</td>
<td>18</td>
<td>602</td>
</tr>
<tr>
<td>Alice Springs Remote</td>
<td>0</td>
<td>121</td>
</tr>
<tr>
<td>Total</td>
<td>123</td>
<td>3878</td>
</tr>
</tbody>
</table>

Note: Some clients are seen in more than one service district.

### Table 17: Community Mental Health Service Provision by Indigenous Status and District

<table>
<thead>
<tr>
<th>District</th>
<th>Indigenous</th>
<th>Non Indigenous</th>
<th>Not Stated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darwin Urban</td>
<td>525</td>
<td>2269</td>
<td>157</td>
<td>2951</td>
</tr>
<tr>
<td>Darwin Rural</td>
<td>131</td>
<td>20</td>
<td>2</td>
<td>153</td>
</tr>
<tr>
<td>Katherine</td>
<td>73</td>
<td>92</td>
<td>4</td>
<td>169</td>
</tr>
<tr>
<td>East Arnhem</td>
<td>208</td>
<td>135</td>
<td>0</td>
<td>343</td>
</tr>
<tr>
<td>Barkly</td>
<td>43</td>
<td>64</td>
<td>0</td>
<td>107</td>
</tr>
<tr>
<td>Alice Springs Urban</td>
<td>289</td>
<td>369</td>
<td>9</td>
<td>667</td>
</tr>
<tr>
<td>Alice Springs Remote</td>
<td>114</td>
<td>16</td>
<td>0</td>
<td>130</td>
</tr>
<tr>
<td>Total</td>
<td>1383</td>
<td>2965</td>
<td>172</td>
<td>4520</td>
</tr>
</tbody>
</table>

Note: Some clients are seen in more than one service district.

### Table 18: Community Mental Health Client Service by Gender and District

<table>
<thead>
<tr>
<th>District</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darwin Urban</td>
<td>1783</td>
<td>1168</td>
<td>2951</td>
</tr>
<tr>
<td>Darwin Rural</td>
<td>94</td>
<td>59</td>
<td>153</td>
</tr>
<tr>
<td>Katherine</td>
<td>98</td>
<td>71</td>
<td>169</td>
</tr>
<tr>
<td>East Arnhem</td>
<td>184</td>
<td>159</td>
<td>343</td>
</tr>
<tr>
<td>Barkly</td>
<td>58</td>
<td>49</td>
<td>107</td>
</tr>
<tr>
<td>Alice Springs Urban</td>
<td>427</td>
<td>240</td>
<td>667</td>
</tr>
<tr>
<td>Alice Springs Remote</td>
<td>74</td>
<td>56</td>
<td>130</td>
</tr>
<tr>
<td>Total</td>
<td>2718</td>
<td>1802</td>
<td>4520</td>
</tr>
</tbody>
</table>

Note: Some clients are seen in more than one service district.
Table 19: Community Mental Health Occasions of Service Provision by Program and District

<table>
<thead>
<tr>
<th>District</th>
<th>Adult Community Education &amp; Training</th>
<th>Child &amp; Youth/ Early Intervention</th>
<th>Forensic</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin Urban</td>
<td>14839</td>
<td>7851</td>
<td>4873</td>
<td>3227</td>
</tr>
<tr>
<td>Darwin Rural</td>
<td>631</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Katherine</td>
<td>1445</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>East Arnhem</td>
<td>1190</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Barkly</td>
<td>1006</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Alice Springs Urban</td>
<td>4425</td>
<td>0</td>
<td>321</td>
<td>881</td>
</tr>
<tr>
<td>Alice Springs Remote</td>
<td>538</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24074</strong></td>
<td><strong>7851</strong></td>
<td><strong>5194</strong></td>
<td><strong>4108</strong></td>
</tr>
</tbody>
</table>

Note: Above data is only provided from discretely identified programs. Districts may incorporate elements of specific programs within their general service provision.

♦ Both Top End and Central Australian Mental Health Services established quality improvement plans that included a commitment to be fully accredited by 2003.

♦ The Northern Territory Consumer Advisory Group (NTCAG) on Mental Health provided advice to the Minister for Health, Family and Children’s Services, and to the Mental Health Program.

♦ The Top End Mental Health Service involved consumer/carers in:
  – collaborative planning and implementation of services committees
  – quality committees on service development, inpatient and community services
  – staff recruitment and selection panels
  – service restructure planning groups.

♦ Central Australian Mental Health Services involved their Consumer Advisory Group in staff recruitment and selection panels.

♦ The Mental Health Program established partnerships with government, non government and private sector agencies. Memoranda of Understanding were developed with Police and Correctional Services.

♦ The Life Promotion Program is now firmly established with Life Promotion Officers employed in both Top End and Central Australia. There are three Life Promotion Officers in Central Australia including two Indigenous officers. In the Top End there are two full time and one part time position including two Indigenous officers.

♦ Interdepartmental and inter agency meetings with community and private sector organisations coordinated suicide prevention strategies.
Family And Children’s Services

Overview

The Family and Children’s Services Program administers NT and Commonwealth funds to provide services for the protection and care of children and the improvement of individual and family wellbeing. Some services are available to all families in the NT. Others are targeted at meeting the needs of specific groups of people including children and young people whose families are unable to safely care for them.

Objectives are to:

♦ promote responsibility and growth in family and community life
♦ ensure families, children and individuals grow in safe, supportive and culturally appropriate communities
♦ encourage families, children and individuals to reach their full potential.

Family and Children’s Services identified five strategic directions to guide future action. These directions are consistent with Territory Health Service’s Strategy 21 to strengthen community capacity by supporting families and individuals to grow and participate fully in community life. The key directions are:

♦ individuals, families and communities are supported to achieve independence and develop capacity to improve their own well being
♦ individuals and families are supported through crisis
♦ children are protected from harm and their future wellbeing is enhanced
♦ individuals, families and children receive quality services appropriate to their needs
♦ community service integration is improved through participation and collaboration.

Activities and services are linked to the benefits they will provide for clients with reference to the above outcomes. This client focused model provides for a continuum of service including:

♦ crisis and medium term accommodation for adults and young people who are homeless
♦ counselling and family support assistance to people in crisis including survivors of domestic violence and sexual assault
♦ prevention of child maltreatment and provision of substitute care for children unable to live with their families
♦ children’s care and development, support and parenting assistance options.
 Outputs

♦ Twenty two community based organisations providing 33 services across the Territory are funded under the Supported Accommodation Assistance Program (SAAP) and Partnerships Against Domestic Violence (PADV). These services provide accommodation and support for people who are homeless or at risk of homelessness. Crisis and medium term accommodation is available to youth, single adults, families, women and children escaping domestic violence.

♦ FACS funds 53 organisations to provide 70 services which offer support services such as individual and family counselling, information and parenting advice.

♦ Counsellors in Central Australian and Top End Service Networks provide sexual assault counselling and support.

♦ Child protection services are delivered by Family and Children’s Services staff from offices in the main centres which also provide outreach services to remote Aboriginal communities.

♦ Out of home care placements are primarily provided by registered foster carers across the Territory. Residential care placements are funded for children and young people unable to be placed in foster care.

♦ FACS purchases recruitment and support services from KARU to assist in the provision of Aboriginal foster care to Aboriginal children.

♦ The Prevention and Education, Child Abuse and Neglect (PECAN) unit coordinates child abuse prevention activities.
Outcomes

♦ Child care and development
  – The most recently available data is derived from the Commonwealth Government census of child care services. 5,500 children aged 0-12 years used Commonwealth funded and/or NT regulated services during a reference week in 1997/98. Of these children about 3,500 were aged 0-5.
  – Of NT children using Commonwealth funded or NT regulated children’s services in 1997/98, 14.5 percent were Indigenous. Indigenous children comprise close to 36 percent of the 0-12 age cohort in the NT.
  – Between June 2000 and June 2001, access improved in Darwin remote, Alice Springs urban and Alice Springs remote areas. In 2001/02, it is expected that access will improve in the Darwin northern suburbs, Palmerston and Alice Springs remote areas.

Figure 54: Access to Child Care Places

Note: Assessment of access to funded and/or regulated child care places is based on labourforce and population data provided by the Australian Bureau of Statistics, and information about the availability of child care centre and family day care places by area.
− The number of unaccredited centres reduced significantly since July 1999. The Commonwealth has reviewed the accreditation scheme so that from 2001/02 centres will attract either accredited or not yet accredited status.

Figure 55: Child Care Centre Accreditation Status 1999/00

Note: Accreditation of child care centres is managed by a Commonwealth and industry funded accreditation council. Accreditation focuses on practice and outcomes, while NT child care licensing ensures that minimum input standards are met. Both systems contribute promoting good quality child care.

♦ Crisis Support
− Crisis support was provided for individuals and families to minimise further harm and promote wellbeing and independence. This included support for survivors of family and domestic violence, sexual assault and people who are at risk of homelessness. Data for this report was derived from the 1999/00 Supported Accommodation Assistance Program National Data Collection managed by the Australian Institute of Health and Welfare and published in February 2001.
Each individual client can receive support on more than one occasion. In 1999/00, 3,050 clients had a total of 4,700 support periods. In the NT there were 177 SAAP clients per 10,000 of population aged over 10. This is considerably higher than any other state or territory.

Table 20: People Accessing Crisis Support Services

<table>
<thead>
<tr>
<th></th>
<th>1999/00</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of SAAP clients</td>
<td>3,050</td>
<td></td>
</tr>
<tr>
<td>Clients/10,000 population aged 10 years +</td>
<td>177</td>
<td>(average for Australia 55)</td>
</tr>
<tr>
<td>Number of support periods</td>
<td>4,700</td>
<td></td>
</tr>
</tbody>
</table>

The increased use of support plans for clients accessing SAAP services indicated an increasingly comprehensive service response.

Table 21: People with an Agreed Support Plan

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Support plan</td>
<td>26.1%</td>
<td>49.5%</td>
<td>68.1%</td>
<td>63.0%</td>
</tr>
<tr>
<td>No support plan</td>
<td>23.9%</td>
<td>20.3%</td>
<td>10.6%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Not appropriate</td>
<td>50.0%</td>
<td>30.3%</td>
<td>21.4%</td>
<td>23.7%</td>
</tr>
</tbody>
</table>

Indigenous Australians were over represented relative to their representation in the overall population.

Table 22: SAAP Service Users by Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>NT Population 1996</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>20.6%</td>
<td>63.1%</td>
<td>42.8%</td>
<td>28.5%</td>
</tr>
<tr>
<td>Non English speaking background</td>
<td>6.2%</td>
<td>4.0%</td>
<td>5.1%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Other</td>
<td>73.2%</td>
<td>32.9%</td>
<td>52.1%</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

Indigenous Australians and those from non English speaking backgrounds averaged fewer support periods.

Table 23: Support Periods per Person

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>1.75</td>
<td>1.76</td>
<td>1.76</td>
</tr>
<tr>
<td>Non English speaking background</td>
<td>1.94</td>
<td>1.34</td>
<td>1.69</td>
</tr>
<tr>
<td>Other</td>
<td>2.29</td>
<td>1.64</td>
<td>2.08</td>
</tr>
<tr>
<td>Total support periods</td>
<td>42.6%</td>
<td>57.4%</td>
<td>100%</td>
</tr>
</tbody>
</table>
– For persons who specifically requested assistance to obtain independent housing, there were marked changes before and after support. Accommodation in public or community housing and private rental had more than doubled. Service users were much less likely to be living in a car/tent/street or squat after assistance was provided going from 16.1 percent before support to 6.4 percent after.

Table 24: Persons Living in Independent Accommodation After Leaving a Crisis Service

<table>
<thead>
<tr>
<th>Type of Accommodation</th>
<th>Before Support</th>
<th>After Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAAP or other emergency housing</td>
<td>14.3%</td>
<td>14.6%</td>
</tr>
<tr>
<td>Living rent free in house or flat</td>
<td>17.2%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Private rental</td>
<td>10.8%</td>
<td>21.8%</td>
</tr>
<tr>
<td>Public or community housing</td>
<td>11.5%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Rooming house/hostel/hotel/caravan</td>
<td>5.4%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Boarding in private home</td>
<td>19.8%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Own home</td>
<td>2.2%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Living in car/tent/park/street/squat</td>
<td>16.1%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Institutional</td>
<td>2.0%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Other</td>
<td>0.8%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

♦ Child Protection and Out of Home Care
– These services include; investigation of reports of abuse, protective assessments, placement of children in the care of the Minister where they are no longer able to safely stay with their families, family reunification, services for children leaving care and support for young people who have left care.

Table 25: Child Protection Reports Received 2000/01

<table>
<thead>
<tr>
<th>Report Outcome</th>
<th>Number of Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegations did not constitute maltreatment</td>
<td>478</td>
</tr>
<tr>
<td>Child/family moved interstate</td>
<td>13</td>
</tr>
<tr>
<td>False allegation</td>
<td>16</td>
</tr>
<tr>
<td>Insufficient information</td>
<td>257</td>
</tr>
<tr>
<td>Proceed to investigation</td>
<td>784</td>
</tr>
<tr>
<td><strong>Total reports</strong></td>
<td><strong>1548</strong></td>
</tr>
</tbody>
</table>
− In the Northern Territory any person who believes that a child is being or has been abused or neglected is required by law to report that belief to the Minister or to the police. Not all reports result in a child protection investigation being undertaken. Fifty four percent of reports resulted in a child protection investigation being undertaken.

− For 17 reports with the outcome proceed to investigation an investigation had not started at the time of data collection.

Figure 56: Outcomes of Child Protection Investigations 2000/01

- For 13 reported cases an investigation began but had not been finalised. In 43 cases no investigation was possible.
- Of the 711 finalised investigations, 349 (49 percent) were substantiated as cases of abuse or neglect. This is consistent with previous years.

Table 26: Investigations by Indigenous Status of Child 2000/01

<table>
<thead>
<tr>
<th>Indigenous Status of Child</th>
<th>Number of Investigations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>353</td>
<td>46%</td>
</tr>
<tr>
<td>Non Indigenous</td>
<td>389</td>
<td>51%</td>
</tr>
<tr>
<td>Not stated</td>
<td>25</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>767</td>
<td>100%</td>
</tr>
</tbody>
</table>

− In the Northern Territory 36 percent of people under 18 years of age are of Indigenous decent. As in previous years they are over represented in the child protection data.
Figure 57: Type of Maltreatment Substantiated

Following national reporting conventions, only the most serious type of substantiated maltreatment is recorded here. Thus a child may be the subject of both neglect and physical abuse but the case is recorded here as physical abuse only. All cases of maltreatment involve some form of emotional abuse, but in only 39 cases was emotional abuse the only substantiated form of maltreatment.

Table 27: Substantiated Investigations by Indigenous Status of Child 2000/01

<table>
<thead>
<tr>
<th>Indigenous Status of Child</th>
<th>Number of Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous</td>
<td>167</td>
<td>48%</td>
</tr>
<tr>
<td>Non Indigenous</td>
<td>173</td>
<td>50%</td>
</tr>
<tr>
<td>Not stated</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>349</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
At 30 June 2001, 61 percent of children in the care of the Minister were of Aboriginal or Torres Strait Islander descent.

This table provides a snapshot of where children in the care of the Minister were placed on one particular day (30/6/2001). During their time in care children may
move from one type of placement to another. For example they may move from foster care to parental home or to care by relatives while still remaining under a care order.

Table 29: Placement of Aboriginal Children as at 30/6/2001

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/guardian</td>
<td>16</td>
</tr>
<tr>
<td>Extended family</td>
<td>45</td>
</tr>
<tr>
<td>Non related Aboriginal carers</td>
<td>26</td>
</tr>
<tr>
<td>Other Aboriginal carers in accordance with customary law</td>
<td>3</td>
</tr>
<tr>
<td>Non Aboriginal carers</td>
<td>29</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>127</strong></td>
</tr>
</tbody>
</table>

♦ The Aboriginal Child Placement Principle (ACPP) is enshrined in the Community Welfare Act. The ACPP requires that where possible Aboriginal children who cannot live with their parents be placed with carers with the appropriate kin relationship. If that cannot be arranged then they must be placed in accordance with customary law or, in consultation with the child’s family, with other Aboriginal carers. If no suitable Aboriginal carers can be found a child may be placed with non Aboriginal carers. Sometimes Aboriginal families request placement with nominated non Aboriginal carers. In some cases, for example where a child has a severe disability, placement with non Aboriginal carers is the only feasible option.
Stability of placement is important for the wellbeing of children in care. Ideally, children in care should have only one or two placements while the family situation is stabilised sufficiently for them to return home. These placements usually consist of an initial crisis placement followed by either return home or movement to a longer term placement.

An Aboriginal Community Services Worker Career Pathways review was finalised and endorsed. In recognition of the fact that 36 percent of people under the age of 18 years in the NT are of Aboriginal descent, Executive endorsed the proposal that over time 36 percent of FACS staffing positions would be converted to designated Aboriginal positions. The Aboriginal Community Services Worker Career Pathways review relates directly to the Strategy 21 Stretch Goal of increasing Aboriginal involvement in the workforce.

FACS outcomes meet government’s NTsafe Strategy and the Domestic Violence Strategy. Directly provided and funded services to address issues of domestic and family violence, and services which enhance parenting skills, are essential components of NTsafe.
Aged, Disability and Community Care / Office of Senior Territorians

Overview

Aged, Disability and Community Care and the Office of Senior Territorians provide services for older people and people with disabilities supporting them to enjoy optimum health, independence and wellbeing.

The program aims to develop positive attitudes and create accessible services in communities that support the involvement and independence of older people and people with disabilities in community, workforce, education and leisure activities. For those people where in home support is no longer feasible, residential aged care and supported accommodation services are provided.

Older people and people with disabilities are valued and contributing members of our community which is in accordance with the intent of Strategy 21.

Outputs

♦ The Aged, Disability and Community Care Policy and Program Development Unit source funding, allocate resources, undertake research and develop policies and programs. Funds are allocated to the Community Services Purchasing Division to develop and monitor the most appropriate mix of services for older people and people with disabilities throughout the Northern Territory.

♦ Some specialist Aged and Disability services are provided by Territory Health Services Top End and Central Australia Service Networks. Aged, Disability and Community Care spent 69.2 percent of its budget to purchase quality specialised disability services from community based and private sectors.

♦ Seniors Cards are provided to Territorians 60 years and older to support them in maintaining financial independence, health, fitness and community participation.
Outcomes

♦ Enrolment of Seniors Card members throughout the Northern Territory continued to grow. Refer to Performance Highlights for details, page 21.

♦ The NT Pensioner Concession Scheme provided concessions on electricity, water, sewerage, property rates, garbage charges, motor vehicle registration, drivers licence, urban bus travel, spectacles and interstate travel to eligible members.

Table 30: Number of Pensioner Concession Scheme Members

<table>
<thead>
<tr>
<th>Year</th>
<th>Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999/00</td>
<td>16,508</td>
</tr>
<tr>
<td>2000/01</td>
<td>17,025</td>
</tr>
</tbody>
</table>

♦ Taxi Subsidy Scheme vouchers were distributed to eligible frail aged persons and people with disabilities unable to use public transport.

Table 31: Taxi Subsidy Scheme

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Clients</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998/99</td>
<td>642</td>
<td>$219,000</td>
</tr>
<tr>
<td>1999/00</td>
<td>720</td>
<td>$274,000</td>
</tr>
<tr>
<td>2000/01</td>
<td>860</td>
<td>$340,000</td>
</tr>
</tbody>
</table>

♦ Equipment and appliances were provided to people with disabilities through the Territory Independence and Mobility Equipment (TIME) Scheme to maximise their participation at home, work and in the community.

Table 32: Territory Independence and Mobility Equipment Scheme Expenditure

<table>
<thead>
<tr>
<th>Year</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998/99</td>
<td>$632,000</td>
</tr>
<tr>
<td>1999/00</td>
<td>$828,000</td>
</tr>
<tr>
<td>2000/01</td>
<td>$824,000</td>
</tr>
</tbody>
</table>
Customised mobility and seating equipment were supplied to people with disabilities through the Seating and Equipment Assessment Team (SEAT).

Assessment services were provided to the frail aged through Aged Care Assessment Teams (ACATs) to ensure that they received community care services most appropriate to their needs and to facilitate access to residential aged care when required. 590 ACAT assessments were completed in 2000/01.

Table 33: Aged Care Assessments by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin</td>
<td>308</td>
</tr>
<tr>
<td>Alice Springs Urban</td>
<td>119</td>
</tr>
<tr>
<td>Alice Springs Remote</td>
<td>48</td>
</tr>
<tr>
<td>Katherine</td>
<td>72</td>
</tr>
<tr>
<td>East Arnhem</td>
<td>30</td>
</tr>
<tr>
<td>Barkly</td>
<td>13</td>
</tr>
</tbody>
</table>

Advocacy and information services were provided to older people and people with disabilities to empower and support them in accessing services to meet their needs.

Local Area Coordination services were available to people with disabilities to assist them to determine and access the services and supports they require to remain with their family and community. In 2000/01 the Local Area Coordination (LAC) model was implemented as a new service throughout the Northern Territory. Coordinators worked...
with people with disabilities, their families and carers supporting them to make individual choices about needed services. Where services do not exist, Local Area Coordinators worked within the community to develop local solutions.

- Recurrent NT funding was allocated for the ongoing operation of the Transitional Care Project which supports aged people and people who have a disability at risk of preventable admission to residential aged care or hospital.

- The Disability Program secured a total of $1.2M in 2000/01 from the Commonwealth and Northern Territory Governments to address unmet needs for disability services. Funding was directed to consumers allowing people with disabilities, their families and guardians to apply for funding on their own behalf. Seventy nine applicants were successful in acquiring new or additional funding, 68 percent were located in the Top End and 32 percent were residents of Central Australia.

<table>
<thead>
<tr>
<th>Table 34: Disability Services Total Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Northern Territory</td>
</tr>
<tr>
<td>Commonwealth</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*Note: These figures show the total expenditure on Disability Services for THS, being a combination of CSDA, equipment services and the full cost of administration.*

- Ongoing funding and expansion of Home and Community Care services occurred throughout the Northern Territory to support frail aged and people with disabilities and their carers to prevent premature admission to long term residential care.

- 27 percent of HACC clients received services from agencies based in remote communities.

- In 2000/01 40.5 percent of HACC clients were of Aboriginal or Torres Strait Islander descent.
♦ Adult guardianship services involving court orders were provided to adults with disabilities who require support to make daily living decisions.

Figure 62:  Adult Guardianship Waiting List and Orders Made 1991-2000

♦ Adult Guardianship received 95 new applications during 2000; the waiting list was reduced from 129 to 84. An additional officer was funded to accommodate the increased guardianship caseload.
Supported accommodation and residential aged care places were made available for older people and people with disabilities. A further $1.5M in capital funding was released to Frontier Services for the redevelopment of the Chan Park Nursing Home in Palmerston which will be known as Terrace Gardens. An additional 16 residential aged care beds were allocated to the new facility.
Health Development

Health Development works to focus the health system on strategies that increase people’s capacity for healthy living through prevention, promotion and protection strategies against disease. This is achieved by working with individuals and communities in the development and delivery of services and by changing attitudes and behaviours harmful to health.

A constellation of services makes up Health Development including;

♦ Alcohol and Other Drugs expenditure $10.3M
♦ Disease Control expenditure $9.2M
♦ Environmental Health expenditure $2.5M
♦ Health Promotion expenditure $2.0M
♦ Menzies School of Health expenditure $2.5M

Alcohol and Other Drugs

Overview

Alcohol and Other Drugs Program (AODP) develops and coordinates strategies to address the harmful effects of substance use in the Territory. Reducing the harm caused by substances contributes directly to health and wellbeing responsibilities as outlined in Foundations for Our Future and Strategy 21.

Program aims are to:

♦ minimise the incidence and prevalence of substance misuse through community education
♦ minimise rates of anti social behaviour, related to alcohol and other substance misuse
♦ minimise the rates of premature death, disease and injury resulting from alcohol, tobacco and other substance misuse
♦ increase the capacity among individuals, families, communities and services to cope with substance issues.

AODP incorporates Tobacco Action Project, Public Behaviour Program, National Drug Strategy and Living With Alcohol. The Tobacco Action Project (TAP) is allocated $500,000 per year to address smoking issues. TAP priorities are prevention of smoking by minors, cessation for adults and indigenous people, and protection from environmental
tobacco smoke. The National Drug Strategy has its principal focus on substances other than alcohol. The Public Behaviour Program supports local activities aimed at reducing anti social behaviour resulting from public drinking and substance use. Living With Alcohol is a Territory initiative designed to reduce alcohol related harm.

**Outputs**

♦ The Alcohol and Other Drug program is responsible for policy and program development, research and evaluation for the whole of the Territory.

♦ Community support workers provide local AOD and capacity building expertise in all major urban centres.

♦ 65 percent of AODP funds are allocated to non government agencies to deliver the bulk of intervention services such as sobering up shelters, counselling programs, outpatient and residential treatment options.

**Outcomes**

♦ A consortium comprising TAFE NSW, Next Step Specialist Drug and Alcohol Services WA and Territory Health Services Living with Alcohol Program won the Commonwealth Department of Health and Aged Care national tender to develop training for frontline professionals responding to the needs of youth experiencing drug problems.

♦ Partnerships with other registered training organisations increased training and assessment opportunities for frontline workers through the provision of a value added approach to training delivery.

♦ Staff were involved in international family coping research, originally seeded by the World Health Organization and conducted in the NT, United Kingdom and Mexico. A final report of the LWA funded NT component focusing on alcohol usage by Aboriginal people was completed.

♦ A review of the Wine Cask Levy Program was undertaken by Network Australia NT between April and June 2000 to evaluate projects funded through the five year history of the program. Administrative changes have since been made including a name change to the Public Behaviour Program and the funding of limited term projects. These included night patrols and wardens’ schemes. As the Wine Cask Levy is no longer imposed, approximately $1M annually is allocated as replacement funding.
Per capita consumption from 1992/93 to 1999/00 remains relatively stable with pure alcohol consumption averaging around 15 litres per person during this period.

The percentage of alcohol related road accidents continues to decline decreasing alcohol related road trauma by 11 percent since 1990.

Source: NT Department of Transport and Works

'alcohol related' refers to an accident where an operator, pedestrian or other person who contributed to the accident records a BAC $\geq 0.03$ or where other evidence indicates obvious alcohol impairment.
♦ The percentage of fatal road accidents illustrates the variability in the percentage of NT related road fatalities. Since 1996, road fatalities have fallen around 20 percent. In 1998 this dropped to 25 percent or just below the national average of around 30 percent.

Figure 65: Percentage of Fatal Road Accidents Related to Alcohol NT and Australia

Source: NT Department of Transport and Works

♦ During 1999/00, 2630 clients accessed alcohol and other drugs treatment services throughout the NT. Assessment, counselling and referrals were the main service type provided with 1905 episodes recorded. There were 807 episodes of clients seeking treatment at a residential treatment facility, and 314 clients accounted for 487 episodes of detoxification service during this period.
THS participated in the Alcohol and Other Drugs and the Early Intervention Working Groups of NTsafe. Strategies to meet the aims of NTsafe included:

- Public Behaviour Program funding for services such as night patrols that aim to address substance related to antisocial behaviour
- Living with Alcohol projects providing diversionary and educative options.
Disease Control

Overview

Disease Control provides services to prevent, monitor and control communicable and non-communicable diseases in the Northern Territory. Activities are coordinated through Centre for Disease Control (CDC) units in each health district. Implementation of Strategy 21 resulted in the incorporation of Women’s Cancer Prevention and Medical Entomology into Disease Control.

Disease Control activities include: policy development; surveillance activities for selected communicable and non-communicable diseases and endemic and exotic mosquito vectors; outbreak investigation; appropriate control measures; development, coordination, promotion and monitoring of preventive programs; and involvement in research, education and health promotion activities. Screening and clinical services are provided for tuberculosis (TB), leprosy, sexually transmissible infections (STIs), including HIV and hepatitis, Australian bat lyssavirus immunisation and breast and cervical screening.

Outputs

♦ District CDC Units work with urban and remote primary health care services to provide clinical services, immunisation, contact tracing, community screening and professional education.

♦ Surveillance programs monitor invasive *Haemophilus influenzae* type b (Hib) disease, meningococcal disease, enteric disease, measles, malaria, TB, influenza, invasive pneumococcal disease, hepatitis C, antibiotic resistant gonorrhoea, rheumatic fever and rheumatic heart disease and adverse reactions following immunisation and vaccine use.

♦ The TB/Leprosy Control Unit screens at risk groups and provides curative treatment of all cases and increased treatment of latent TB.

♦ The AIDS/STD program aim is to decrease the rates of sexually transmissible infections and blood borne viruses and prevent associated complications.

♦ Clinic 34 offers specialised clinical services in urban areas. Sexual health staff support primary care providers to undertake community prevention and education programs in urban and remote/rural areas.
♦ The Immunisation section provides vaccines and advice on all aspects of child and adult immunisation, collects childhood immunisation data for transmission to the Australian Childhood Immunisation Register and coordinates vaccine funding and distribution throughout the NT.

♦ The Noncommunicable Diseases section has strategic input into the implementation of the NT Preventable Chronic Disease Strategy and operates the Chronic Diseases Network which links an intersectoral group of stakeholders with interests in chronic disease. The section also delivers specialist clinical services in internal medicine and coordinates the delivery of such services to all major communities in the Top End.

♦ The Community Paediatric Program develops and evaluates policies for paediatric communicable and noncommunicable diseases with a particular focus on prevention and early detection. It provides specialist paediatric input into disease control policies and programs as well as paediatric expertise in education, training and research for CDC.

♦ The Rheumatic Heart Disease Program assists in coordinating the clinical care of people with rheumatic heart disease (RHD) in remote areas, provides staff education and promotes the standardisation of treatment.

♦ Women’s Cancer Prevention program provides breast screening and assessment services to women 40 years and over, a rural and remote Well Woman’s Screening Program and practitioner training courses. The program administers the Pap smear register and works with culturally and linguistically diverse (CALD) women through the bilingual educator program.

♦ Medical Entomology Branch reduces the impact of biting insects through intersectoral mosquito and mosquito borne disease awareness, surveillance and control programs, provision of advice on biting insects for developments, a public inquiry service and incidental research.

Outcomes

♦ The new childhood pneumococcal vaccine was introduced onto the NT Childhood Vaccination Schedule on 1 June 2001.

♦ A process was implemented to ensure all Aboriginal infants born in NT public hospitals are enrolled with Medicare prior to discharge. NT now has the shortest Medicare enrolment lag times of all jurisdictions in Australia.
Figure 67: Percentage of Children Aged 12-<15 Months Fully Immunised for Age

Source: Australian Childhood Immunisation Register

Figure 68: Percentage of Children Aged 24-<27 Months Fully Immunised for Age

Source: Australian Childhood Immunisation Register
♦ A treatment program for latent TB infection in two high risk communities was implemented.

♦ A procedure for screening of international prisoners at increased risk of TB led to early detection of TB and no documented transmission within the prison system.

Figure 69: Notification Rates of TB in the Northern Territory 1991-2000
Participation rates in the NT Cervical screening program were 65 percent of the eligible target population.

**Figure 70: NT Pap Smear Screening Rates for Women with a Cervix, 20-69 years**

A sexual health workshop for Aboriginal Health Workers and senior women from throughout the NT made recommendations to the Sexual Health Advisory Committee of the NT Indigenous Health Forum.

An educational resource for women in remote Top End communities, *The Women’s PID Story Book*, was prepared and distributed.
♦ The rates of HIV notifications including Indigenous cases remained relatively stable. This does not include cases diagnosed in non residents. From September 1999, when East Timor gained independence, until December 2000 there have been eight cases notified in people working in that country. The cases were diagnosed in Darwin after admission to hospital or because of a related condition such as an STI.

Figure 72: HIV Notifications in the Northern Territory 1985–2000 by Indigenous Status
♦ 815 people were registered on the rheumatic fever/rheumatic heart disease database for follow up in the Top End.

♦ Three full time Master of Applied Epidemiology placements, medical student placements and CDC training placements for rural and urban based general practitioners were made available.

♦ Mosquito control in the Darwin area resulted in a decrease in the average number of all species of mosquitoes per trap. There was a corresponding decrease in the reported number of Ross River virus cases in the area, an absence of Murray Valley encephalitis and no Indigenous transmission of malaria.

♦ Importations of exotic mosquitoes including three classified as high risk were assessed in cooperation with AQIS. Eradication measures taken have maintained the NT free of the mosquito vectors of dengue.

♦ The biting midge research project at Fairway Waters in Palmerston was completed and provided new knowledge pertinent to future urban expansion.

♦ Murray Valley encephalitis was detected in Alice Springs with two confirmed cases. The branch issued a MVE disease alert with repeated media warnings as mosquito numbers, sentinel chicken data and case details became available.
Ross River cases showed an overall rise in the NT, up from 161 last year to 235 this year due to rises in the Barkly region from 9 to 70 and the Katherine region from 28 to 48.

**Figure 73:** Incidence of Barmah Forest and Ross River Virus Disease

**Table 35:** Notified Cases of Vaccine Preventable Diseases in the Northern Territory by report date 1999 and 2000

<table>
<thead>
<tr>
<th>Disease</th>
<th>Total Cases</th>
<th>Cases Among Children Aged 0-5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1999</td>
<td>2000</td>
</tr>
<tr>
<td>Congenital rubella syndrome</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><em>Haemophilus influenza</em> type b</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Measles</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Mumps</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Pertussis</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Poliomyelitis, paralytic</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rubella</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Tetanus</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 36: Northern Territory Notifiable Diseases 1996 – 2000 (Total Number Of Cases)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaccine Preventable Diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphtheria</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Haemophilus influenzae type b (invasive)</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Invasive Pneumococcal Disease</td>
<td>75</td>
<td>86</td>
<td>72</td>
<td>77</td>
<td>63</td>
</tr>
<tr>
<td>Measles</td>
<td>26</td>
<td>11</td>
<td>1</td>
<td>22</td>
<td>0</td>
</tr>
<tr>
<td>Pertussis</td>
<td>16</td>
<td>24</td>
<td>23</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Tetanus</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Mosquito Borne Diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Murray Valley Encephalitis</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Barmah Forest Virus</td>
<td>27</td>
<td>42</td>
<td>21</td>
<td>21</td>
<td>9</td>
</tr>
<tr>
<td>Dengue Fever (imported)</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>15</td>
<td>111</td>
</tr>
<tr>
<td>Kunjin Virus</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Malaria (imported)</td>
<td>26</td>
<td>38</td>
<td>27</td>
<td>62</td>
<td>82</td>
</tr>
<tr>
<td>Ross River Virus</td>
<td>131</td>
<td>223</td>
<td>121</td>
<td>142</td>
<td>153</td>
</tr>
<tr>
<td><strong>Blood Borne Viruses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hepatitis B (incident cases)</td>
<td>5</td>
<td>19</td>
<td>18</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>Hepatitis C (unspecified cases)</td>
<td>209</td>
<td>296</td>
<td>224</td>
<td>196</td>
<td>183</td>
</tr>
<tr>
<td>HIV</td>
<td>6</td>
<td>11</td>
<td>11</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>HTLV-1</td>
<td>27</td>
<td>33</td>
<td>29</td>
<td>33</td>
<td>25</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>645</td>
<td>655</td>
<td>783</td>
<td>855</td>
<td>999</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>785</td>
<td>1031</td>
<td>1184</td>
<td>1137</td>
<td>1162</td>
</tr>
<tr>
<td>Syphilis</td>
<td>290</td>
<td>271</td>
<td>335</td>
<td>339</td>
<td>194</td>
</tr>
<tr>
<td>Trichomonas</td>
<td>NN</td>
<td>NN</td>
<td>NN</td>
<td>869</td>
<td>1222</td>
</tr>
<tr>
<td><strong>Enteric Diseases</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Campylobacter</td>
<td>262</td>
<td>206</td>
<td>196</td>
<td>242</td>
<td>188</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>76</td>
<td>92</td>
<td>47</td>
<td>85</td>
<td>49</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>153</td>
<td>259</td>
<td>183</td>
<td>405</td>
<td>264</td>
</tr>
<tr>
<td>Salmonella</td>
<td>422</td>
<td>347</td>
<td>411</td>
<td>367</td>
<td>322</td>
</tr>
<tr>
<td>Shigella</td>
<td>149</td>
<td>169</td>
<td>98</td>
<td>116</td>
<td>115</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Rheumatic Fever</td>
<td>44</td>
<td>45</td>
<td>46</td>
<td>45</td>
<td>27</td>
</tr>
<tr>
<td>Adverse Vaccine Reactions</td>
<td>12</td>
<td>16</td>
<td>19</td>
<td>11</td>
<td>27</td>
</tr>
<tr>
<td>Acute Post-Streptococcal Glomerulonephritis</td>
<td>16</td>
<td>15</td>
<td>17</td>
<td>7</td>
<td>54</td>
</tr>
<tr>
<td>Leprosy</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Meningococcal infection</td>
<td>9</td>
<td>15</td>
<td>17</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>34</td>
<td>34</td>
<td>32</td>
<td>98</td>
<td>60</td>
</tr>
</tbody>
</table>

NN = not notifiable

Dengue and malaria are not endemic in the NT. All cases were acquired elsewhere.
The 1999 measles and tuberculosis figures have been modified from previous reports to include cases notified from East Timorese refugees.
Figure 74: Northern Territory Notifiable Diseases 1999–2000

Source: NT estimated residential population 1999 – 192 877; 2000 – 195 905
Supplied by Epidemiology and Statistics Branch, THS
Environmental Health

Overview

Environmental Health is encompassed within the broader area of public health. It is distinct from environmental protection, but the two do overlap in some areas. Environmental health practice covers the assessment, correction, control and prevention of environmental factors adversely affecting human health. Environmental health practice provides opportunities for improved health outcomes and working towards health promoting environments.

Objectives of Environmental Health are to:

♦ strengthen health promotion practice at the community level
♦ develop a flexible funding strategy enabling communities to train and employ their own environmental health workers
♦ work with other THS programs and with other agencies
♦ support at risk groups in conjunction with communities and key stakeholders
♦ assist in the development of large scale housing and environmental health infrastructure projects under both the National Aboriginal Health Strategy – Environmental Health Program (NAHS-EHP) and the Indigenous Housing Authority of the Northern Territory (IHANT)
♦ monitor, audit, inspect and risk assess all premises including take away food shops, markets, restaurants, boarding houses and ear and body piercing establishments
♦ conduct environmental health research and development
♦ promote and contribute to workplace development and training.

Environmental Health is comprised of several discrete services:

♦ Aboriginal and Community Environmental Health
♦ Environmental Health Standards
♦ Environmental Planning, Sanitation and Waste Management
♦ Food Safety
♦ Radiation Health
♦ Poisons.
Outputs

♦ A Policy Unit is responsible for legislative and policy development activities for all Environmental Health services including advice to other agencies.

♦ Operational Environmental Health Units are located in all regional centres. These provide services for the enhancement of environmental health standards in urban, rural areas and remote Aboriginal communities. This includes food safety, environmental planning, sanitation and waste management.

♦ Poisons and Pharmacy Control Services are provided by an operational unit located in Darwin supported by hospital based pharmacists in regional centres. These services include advising, undertaking investigations and controlling the supply and use of therapeutic drugs and devices, as well as the supply and use of industrial, agricultural and veterinary chemicals.

♦ Radiation Health Services are provided to minimise the health impact of radiation on the population. These services ensure that radioactive materials and radiation emitting devices are used in a responsible manner according to scientific practice and appropriate controls.

Outcomes

♦ A video was produced in collaboration with Western Australia Health Department illustrating the roles and responsibilities of AEHWs on communities in WA and the NT.

♦ Delivery of apprentice training in remote communities was coordinated by the Indigenous Environmental Health Worker Project in collaboration with Human Services Training Advisory Council.

♦ A protocol was agreed to with PAWA for the NT wide water monitoring program.

♦ Assistance was provided at the Katherine Evacuation Centre to the Kalkaringi and Dagaragu communities affected by floods in those areas.

♦ Thirty six nationwide food recalls of unsafe or potentially unsafe food were actioned.

♦ The Foodsafe Food Handler Program was implemented. Ten businesses were successful in achieving and maintaining the FoodSafe Award.
♦ The Healthy Choices Award was launched in Alice Springs and three businesses achieved this award. The Healthy Choices Award recognised premises that:
  − undertake food safety training and hygienic practices
  − provide non-smoking areas
  − encourage responsible drinking
  − offer nutritionally sound meal choices.

♦ THS provided comment on the GTL resources Methanol Plant, proposed Litchfield Planning and Land use objectives, strategy of marine diversity, Draft NT Planning Scheme, aquaculture project Blackmore River and Darwin to Moomba Gas Pipeline.

♦ Comments were prepared for a total of 29 applications and 69 proposals to vary the Australian Food Standards Code. Proposals included the pre-market safety assessment of novel food and the alterations to the maximum residue levels of agricultural and veterinary chemicals used in food production.

♦ Due to the success of the THS Septic Tank Upgrade projects, ATSIC approved Environmental Health to act as grantee of a water supply upgrade project involving outstations in Jabiru, East Arnhem and Katherine Regions.

♦ Two matters for breaches of the Food Act 1986 were prosecuted.

♦ The Toilet Book was launched in November 2000 to educate people in remote communities on how to use and clean the family toilet.

♦ The publication Environmental Health Standards for Remote Communities in the NT was reviewed and amended.

♦ A monograph entitled The Indigenous Environmental Health Report of the 3rd National Conference was completed for the National Health Council.

♦ Radiation Health:
  − issued 141 licences under the provisions of the Radiation (Safety Control) Act. Six new apparatus were registered. Compliance inspections were carried out on 173 items of irradiating apparatus at 105 premises throughout the Territory, including eight remote communities. Nineteen other inspections were undertaken in relation to the provisions of the Act
  − participated in the Joint National Competition Policy Review of Radiation Protection Legislation, coordinated by the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) which resulted in publication of the Final Report in May 2001
contributed to the Commonwealth/State National Uniformity Implementation Panel (Radiation Control) aimed at achieving nationwide uniformity of radiation protection practices and legislation

represented THS on the standing Radiation Health Committee of ARPANSA and the Commonwealth/State Consultative Committees on Nuclear Codes and the Management of Radioactive Wastes

assisted in the revision of the Commonwealth Code of Practice for the Safe Transport of Radioactive Substances 1990

commenced preparatory proceedings related to the intended revision of the Radiation (Safety Control) Act.

Poisons:

- carried out 149 major compliance inspections on pharmacies, health professionals, medical kit holders, pest control operators, primary producers and manufacturers, wholesalers, retailers of scheduled drugs and poisons

- assisted THS hospitals with accreditation requirements to ensure continuation of funding for highly specialised drugs to the NT by the Commonwealth

- issued 341 licences, 39 registrations and 1365 authorisations to supply and use scheduled drugs and poisons under the provisions of the Poisons and Dangerous Drugs Act

- actioned 274 national recalls and safety alerts for unsafe therapeutic drugs and devices

- assisted with the national assessment of the handling of the extortion related recalls of the paracetamol products Panadol and Herron Paracetamol

- amended Schedules to the Poisons and Dangerous Drugs Act to maintain national uniformity. The most significant scheduling changes were to restrict the availability of pseudoephedrine tablets (in packs of more than 30) and insulin to doctor's prescription only. Both changes were necessitated by increasing diversion and abuse of these substances: pseudoephedrine in illicit amphetamine manufacture and insulin as a performance enhancing drug in sport.

- included several essential oils in the poisons schedules for the first time to ensure suitable packaging and labelling to alert the public of the poisonous nature of these natural substances

- assisted with the drafting of the new S29 notices under the Poisons and Dangerous Drugs Act, which detail the possession and supply of scheduled medicines by nurses and Aboriginal Health Workers

- monitored 21,694 prescriptions for Schedule 8 (S8) drugs, including narcotics, to control prescription drug abuse. Data was used to identify people who visit several doctors to obtain multiple prescriptions in excess of their current therapeutic needs. These persons are encouraged to sign a contract with one prescriber. The
prescriber may then notify Poisons Control, THS of the contract details. This voluntary notification system for S8 contracts began in February 1999 and is proving an effective tool for medication management thereby reducing S8 prescriptions.

Figure 75: Schedule 8 Drug Prescriptions and Patient Contracts in the NT

- assisted Asthma NT with the introduction of the Asthma Friendly Schools Program, aimed at improving outcomes for asthmatic students by working with students, teachers and parents/carers to improve awareness and management skills
- worked with the Education Department and school councils on pest control management in schools and school grounds.
Health Promotion

Overview
The goal of THS is to shift the balance of its core business to individual and community health instead of sickness (Strategy 21). Health Promotion takes a lead role across the health system to support practices that strengthen the capacity of individuals and communities to make informed health choices. Health Promotion aims to foster community partnerships particularly with Indigenous people.

Outputs
♦ Twenty health promotion specialists work in teams to deliver services across the Northern Territory; half of these positions are dedicated Aboriginal Health Promotion Officer positions. An additional six staff support policy development.

♦ Health Promotion services included:
  – professional development and support for health system staff through training, advice and support to service providers
  – health action in communities, in particular rural and remote Aboriginal communities
  – policy/program development including research, evaluation and standards development.

Outcomes
♦ Across the Territory, 27 community initiated health promotion projects were funded through the Aboriginal Health Promotion Incentive Funds to a total of $36,848. The projects targeted nutrition (14), environmental health (6), women’s health (3), youth (2) and resource development (1).

♦ There were 129 participants who completed at least one of the three modules of the Health Promotion Principles and Practices training program.

♦ At the national level, Health Promotion successfully lobbied the review team of the Community Services Training Package to include health promotion as a qualification in the revised package.
Participation in or support of a number of other health promotion projects included:

- Child health education sessions at the Remote Area Literacy Festival at Harts Range involving 23 schools and 450 children from remote communities.
- A workshop in East Arnhem to identify current strategies and to plan further action to deal with petrol sniffing issues.
- Delivery of the NTU Certificate 1 in Kitchen Operations in two East Arnhem communities to ensure environmental hygiene during food preparation.
- A Central Australian falls prevention awareness project to reduce the physical, financial and social impact of falls on older people and the community.
- Development and dissemination of educational materials aimed at preventing the spread of rotavirus in Central Australia.
- An awareness raising campaign to promote the availability of services to improve the social and emotional wellbeing of Indigenous women in the NT as part of the Women's Health Expo.
- Funding to print a new women's health resource, the PID storybook, developed by the AIDS/STD unit.
- In partnership with Department of Education, a Resourceful Adolescents Program for Year 8 students in high school to build self esteem of youth and prevent suicide.
- Development of a ‘Men’s Place’ at a remote Aboriginal community dedicated to caring for their physical, social and emotional wellness.
- A healthy lifestyle project in Central Australia to improve the long term weight management of 7-12 year olds.
Performance Management

Overview

Organisational goals and performance indicators were developed through:

♦ THS Corporate Plan, Strategy 21
♦ Business Plans
♦ Information Management
♦ Program Evaluations.

Strategy 21 covering the five year period 1999–2003 began in January 1999. Considerable progress has been made implementing an organisational structure to support the four Stretch goals identified by staff and major stakeholders. Achievements in meeting the goals are provided in each Activity report.

Business plans and work unit action plans are currently in use. As implementation of the planning and purchasing framework progresses, it is anticipated that funding agreements, purchasing plans, and service agreements will become important accountability mechanisms used by THS.

Quarterly reporting of program performance and service usage trends continued to improve the Agency’s performance monitoring and effectiveness of its overall decision making and priority setting.

A number of programs were evaluated during 2000/01. Executive monitored quarterly status reports on the implementation of key recommendations from major program evaluations. Outcomes are reported as follows and in the relevant Activity sections of this Annual Report.
Program evaluations commenced or completed during 2000/01:

<table>
<thead>
<tr>
<th>Performance Review</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Cultural Awareness Program (Roman &amp; Assoc)</td>
<td>Program to continue, standards developed to identify knowledge/skills for working effectively with Aboriginal colleagues, clients and organisations. These are to be used as benchmarks in the NT and in national Health Training Packages</td>
</tr>
<tr>
<td>Aboriginal Incentive Grants (TAP) Program (THS)</td>
<td>In progress</td>
</tr>
<tr>
<td>Children's Services 5 Year Plan (THS)</td>
<td>Current plan extended two years to allow Health and Education to jointly develop policy and new five year plan</td>
</tr>
<tr>
<td>Darwin Detoxification Unit Client Satisfaction (THS)</td>
<td>Found high levels of client satisfaction. Ways to improve success were identified</td>
</tr>
<tr>
<td>Darwin Detoxification Unit Operational Model (Watson)</td>
<td>For completion Dec 01</td>
</tr>
<tr>
<td>Employment of Aboriginal Staff with Organisations Delivering Health Services in the Northern Territory</td>
<td>ATSI Community Services Career Pathway Strategy developed, target set to increase FACS Indigenous staff from 14 percent to 36 percent</td>
</tr>
<tr>
<td>Health Impact of Infrastructure Changes in Remote Aboriginal Communities of the Top End (THS)</td>
<td>Provided evidence of general health improvement, increased birthweights, significant improvement in child growth (826g increase at age 5)</td>
</tr>
<tr>
<td>Indigenous Health Expenditure (Commonwealth Grants Commission)</td>
<td>Awaiting publication to inform funding decisions</td>
</tr>
<tr>
<td>Information Privacy (THS)</td>
<td>In progress</td>
</tr>
<tr>
<td>Legal Services (Jarrett, Warren &amp; Associates)</td>
<td>In progress</td>
</tr>
<tr>
<td>Life Promotion Project (THS)</td>
<td>Project determined to be worthwhile, funding to be continued by NT Government</td>
</tr>
<tr>
<td>Mental Health Reform &amp; Incentive Funding (THS)</td>
<td>Some projects were considered completed, several were funded to continue</td>
</tr>
<tr>
<td>Mental Health and Related Services Act</td>
<td>Rescheduled to commence early 2001/02</td>
</tr>
<tr>
<td>Nursing Recruitment and Retention (Internal Taskforce)</td>
<td>Fifty recommendations to improve recruitment and retention of nurses in the NT accepted by THS Executive</td>
</tr>
<tr>
<td>Nursing Career Structure Review (THS)</td>
<td>Barriers identified, a new streamlined model for nursing career development was developed</td>
</tr>
<tr>
<td>TIME Scheme Review (THS)</td>
<td>Pending Executive endorsement</td>
</tr>
<tr>
<td>Project</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Primary Health Care Access Program, Costing Study (THS)</td>
<td>Information provided used to develop integrated (Commonwealth/NT) funding model</td>
</tr>
<tr>
<td>Public Health Act &amp; Regulations (THS)</td>
<td>Drafting instructions being finalised for new Public and Environmental Health Bill</td>
</tr>
<tr>
<td>Remote Area Well Women’s Screening (THS)</td>
<td>Pending Executive endorsement</td>
</tr>
<tr>
<td>Primary Medical Services Costing (THS)</td>
<td>Information provided used to develop integrated (Commonwealth/NT) funding model</td>
</tr>
<tr>
<td>Quality Use of Medicines in Remote Areas (THS)</td>
<td>New guidelines developed and distributed</td>
</tr>
<tr>
<td>Wine Cask Levy Program (Network Australia)</td>
<td>Administrative changes implemented. Levy discontinued. $1M replacement funding allocated to Public Behaviour Program</td>
</tr>
<tr>
<td>Workforce Planning &amp; Development (R. Parker)</td>
<td>Top End structure approved, Workforce Advisory Committee confirmed</td>
</tr>
</tbody>
</table>
Internal/External Audits

Internal Audit

Territory Health Services worked with Strategic and Audit Services within the Department of the Chief Minister to arrange internal audits.

The THS Internal Audit Committee met three times during the 2000/01 financial year. The Internal Audit Committee comprised representatives from THS senior management, Strategic and Audit Services and a private accounting firm. The committee considered the findings, recommendations and outcomes of both internal and external audits conducted within the Agency or where THS was part of a broader whole of government audit.

Internal audit activities were undertaken to improve performance by providing assurance that systems and internal controls operating within the Agency were satisfactory.

During 2000/01 audits were undertaken in the following areas:

<table>
<thead>
<tr>
<th>Internal Audit</th>
<th>Date Completed</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation and Management of Resources by NT Aids Council</td>
<td>August 2000</td>
<td>Funding provided to the Council is directed in an efficient manner to meet the purpose of grants</td>
</tr>
<tr>
<td>Quality Assurance for GST Processes for NTG Agencies</td>
<td>2 February 2001</td>
<td>Monitor the accuracy of tax coding. The process and methodology adopted for input tax supplies is appropriate. The level of GST knowledge by THS staff, and procedures undertaken, ensures substantial accuracy of the BAS reconciliation</td>
</tr>
<tr>
<td>Payments to non Gov Employees/Contractors</td>
<td>December 2000</td>
<td>The audit detailed the types of payments and payment processes required for tax purposes</td>
</tr>
</tbody>
</table>
**External Audit**

Agency Compliance Audits arranged by the Auditor General for 2000/01 were:

<table>
<thead>
<tr>
<th>Agency Compliance Audits</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of Year Compliance – 1999/00</td>
<td>September 2000</td>
</tr>
<tr>
<td>Agency Compliance Audit – 2000/01 (Preliminary)</td>
<td>June 2001</td>
</tr>
<tr>
<td>Capital Works – Alice Springs Hospital</td>
<td>June 2001</td>
</tr>
</tbody>
</table>

Performance Management Audits undertaken by the Auditor General during 2000/01 included:

<table>
<thead>
<tr>
<th>Performance Management Audits</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT Environmental Controls over the Caresys Hospital System</td>
<td>April 2001</td>
</tr>
<tr>
<td>Performance Management Systems Audit–Disability Services</td>
<td>May 2001</td>
</tr>
</tbody>
</table>

These matters have been concluded successfully. Comment on the above audits are included in the Auditor General's Reports to Parliament.
Complaints Handling

The enactment of the Health and Community Services Complaints Act of 1998 resulted in the formation of the Health and Community Services Complaints Commission. The Act requires both public and private health providers to submit an annual statistical return to the Commissioner.

Complaints are seen as a valuable source of management information and as such THS Executive and the Best Practice Standing Committee endorsed the establishment of a Territory wide complaints handling position. This is to ensure a corporate approach to complaint handling across Territory Health Services. Executive also endorsed Complaints Handling Policy and Guidelines.

Territory Health Services recorded 613 complaints in 2000/01, an increase of 58 or 9 percent from the previous year.

Royal Darwin Hospital recorded 496 complaints of which 44 or 8.8 percent were complaints from Aboriginal people. Statistically, this appears to be an extremely low number of complaints considering the number of Aboriginal persons who are treated at Royal Darwin Hospital annually. An evaluation is being conducted to ascertain how Aboriginal patients can be more informed and able to access the complaints system.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Complaints</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Darwin Hospital</td>
<td>495</td>
<td>80.8%</td>
</tr>
<tr>
<td>Alice Springs Hospital</td>
<td>53</td>
<td>8.6%</td>
</tr>
<tr>
<td>Barkly</td>
<td>8</td>
<td>1.3%</td>
</tr>
<tr>
<td>Top End Service Network</td>
<td>34</td>
<td>5.5%</td>
</tr>
<tr>
<td>Central Australian Service Network</td>
<td>23</td>
<td>3.8%</td>
</tr>
<tr>
<td>Total</td>
<td>613</td>
<td>100%</td>
</tr>
</tbody>
</table>

It can be seen by the above table that Royal Darwin Hospital received a significantly higher number of complaints. The development of a Top End Service Network (TESN) Complaints Handling Policy for all services resulted in a 50 percent increase in the complaints received and finalised within TESN, not including RDH. In 1999/00 the number of complaints recorded by TESN was 17 or 3 percent of the overall number of complaints compared to 34 or 5.5 percent in 2000/01.
Table 38: Nature of the Complaints 2000/01

<table>
<thead>
<tr>
<th>Category</th>
<th>1999/00</th>
<th>Percent</th>
<th>2000/01</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Services</td>
<td>192</td>
<td>35 %</td>
<td>185</td>
<td>30.2 %</td>
</tr>
<tr>
<td>Other</td>
<td>85</td>
<td>15 %</td>
<td>102</td>
<td>16.6 %</td>
</tr>
<tr>
<td>Privacy</td>
<td>81</td>
<td>15 %</td>
<td>120</td>
<td>19.6 %</td>
</tr>
<tr>
<td>Quality of Treatment</td>
<td>107</td>
<td>19 %</td>
<td>86</td>
<td>14.1 %</td>
</tr>
<tr>
<td>Communication</td>
<td>65</td>
<td>12 %</td>
<td>76</td>
<td>12.4 %</td>
</tr>
<tr>
<td>Standards</td>
<td>11</td>
<td>2 %</td>
<td>17</td>
<td>2.8 %</td>
</tr>
<tr>
<td>Decision Making</td>
<td>8</td>
<td>1 %</td>
<td>12</td>
<td>2.0 %</td>
</tr>
<tr>
<td>Costs</td>
<td>3</td>
<td>0.5 %</td>
<td>7</td>
<td>1.1 %</td>
</tr>
<tr>
<td>Grievances</td>
<td>3</td>
<td>0.5 %</td>
<td>8</td>
<td>1.3 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>555</strong></td>
<td><strong>100 %</strong></td>
<td><strong>613</strong></td>
<td><strong>100 %</strong></td>
</tr>
</tbody>
</table>

There was a slight decrease in the Access to Service category from 192 or 35 percent in 1999/00 to 185 or 30 percent in 2000/01. At Royal Darwin Hospital this could be due to the employment of a dermatologist who was conducting sessional clinics.

In the Other category 50 percent of these were recorded at Royal Darwin Hospital, a significant proportion of those recorded related to the Patient Assistance Travel Scheme.

In the category Quality of Treatment there was a decrease from 1999/00 of 107 to 86 in 2000/01.

The increase in the number of Privacy/Consideration concerns rose from 81 or 15 percent in 1999/00 to 120 or 19 percent in 2000/01.
Table 39: Complaint Outcomes 2000/01

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apology Provided</td>
<td>16</td>
<td>19</td>
<td>19</td>
<td>14</td>
<td>68</td>
</tr>
<tr>
<td>Compensation Paid</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Concern Registered</td>
<td>18</td>
<td>9</td>
<td>13</td>
<td>20</td>
<td>60</td>
</tr>
<tr>
<td>Counselling / Mediation</td>
<td>3</td>
<td>4</td>
<td>10</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Refund Provided</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Disciplinary Action Taken</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Explanation Provided</td>
<td>55</td>
<td>44</td>
<td>55</td>
<td>30</td>
<td>184</td>
</tr>
<tr>
<td>Procedure Changed</td>
<td>0</td>
<td>1</td>
<td>18</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>Policy Changed / Developed</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Service Obtained</td>
<td>31</td>
<td>44</td>
<td>44</td>
<td>49</td>
<td>168</td>
</tr>
<tr>
<td>Conciliation</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Other – Pending</td>
<td>17</td>
<td>4</td>
<td>24</td>
<td>22</td>
<td>67</td>
</tr>
<tr>
<td>Other – Unresolved</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>151</td>
<td>134</td>
<td>194</td>
<td>152</td>
<td>631</td>
</tr>
</tbody>
</table>

On review it is apparent that Communication may have been a major problem for patients as the number of outcomes in the Explanation Provided category increased from 170 in 1999/00 to 184 in 2000/01.

There were 20 procedural changes and 17 policies developed in 2000/01, an increase from 9 and 5 respectively in 1999/00, validating the importance of feedback from our service users.

Examples of the changes were:

- Alice Springs Hospital reported that as a result of complaints against security guards cross cultural awareness training is provided to guards
- a new consent policy was devised for patients
- access to all hospital policies is now available through the intranet
- Royal Darwin Hospital reported changes in nursing practices reducing the length of time a burns patients wound are exposed while waiting for review
- protocols were developed and introduced between Day Care Unit (RDH) and Darwin Private Hospital for specific cardiac procedures
- changes to documentation in order to capture the administration of certain injections were made in the Day Care Unit (RDH)
- in terms of privacy, the Day Care Unit (RDH) altered the length of curtains and changed the layout of a lounge room
- breaches of confidentiality in the Day Care Unit (RDH) were addressed by changing the location of patient records and information
- a trial of all patients being able to accept telephone calls on the Orthopaedic Ward (RDH) was undertaken
- inservice training was conducted with nursing staff to reinforce the need for basic nursing care for long term immobile patients.
Purchasing

Overview

The Purchasing Division is a key player in the strategy by which THS ensures the delivery of services that maximise the health of all Territorians. This is achieved by working in collaboration with funders and providers to determine the best mix of health and community services, whether by non government organisations (NGOs) or within THS Service Networks.

Collaboratively negotiated performance agreements with service providers were monitored to ensure accountability. Such monitoring also identified where a provider’s capacity may need to be fostered with support from THS.

Outputs

The focus during 2000/2001 was to complete service agreements with all external providers and to progress service agreements with THS service providers.

Public tenders and proposals were invited for services during 2000/2001, including:

- Darwin Sobering-up Shelter
- Darwin Night Patrol
- Darwin Transportation
- Katherine Sobering up Shelter
- Top End Night Patrol Coordination
- Case Management Services for People with a Disability
- SAAP IV Growth and Reform Projects
- NT Aerial Medical Services
- Day Options in Alice Springs for Clients with Disabilities
- Mental Health Reform and Incentive Projects.
Outcomes

THS funded 225 organisations, including 45 child care centres:

Table 40: Purchasing Division - 2000/01 Grants and Subsidies Expenditure

<table>
<thead>
<tr>
<th>Activity</th>
<th>Output Group</th>
<th>Top End $000</th>
<th>Central $000</th>
<th>Total $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health</td>
<td></td>
<td>18 096</td>
<td>3 409</td>
<td>21 504</td>
</tr>
<tr>
<td>Community Services</td>
<td></td>
<td>22 870</td>
<td>8 116</td>
<td>30 986</td>
</tr>
<tr>
<td>Family and Children’s</td>
<td></td>
<td>9 642</td>
<td>3 237</td>
<td>12 879</td>
</tr>
<tr>
<td>Services (FACS)</td>
<td></td>
<td>12 637</td>
<td>4 357</td>
<td>16 994</td>
</tr>
<tr>
<td>Aged and Disability</td>
<td></td>
<td>591</td>
<td>522</td>
<td>1 113</td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td>591</td>
<td>522</td>
<td>1 113</td>
</tr>
<tr>
<td>Health Development</td>
<td></td>
<td>22 870</td>
<td>8 116</td>
<td>30 986</td>
</tr>
<tr>
<td>Environmental</td>
<td></td>
<td>233</td>
<td>274</td>
<td>507</td>
</tr>
<tr>
<td>Disease Control</td>
<td></td>
<td>858</td>
<td>173</td>
<td>1 031</td>
</tr>
<tr>
<td>Alcohol and Other Drugs</td>
<td></td>
<td>3 155</td>
<td>1 822</td>
<td>4 976</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>45 211</td>
<td>13 793</td>
<td>59 004</td>
</tr>
</tbody>
</table>

Note: FACS includes child care subsidies.

Additional funding was allocated during 2000/01 to improve the capacity of non government organisations to respond to increased demand for services:

Table 41: Non Government Organisations Growth and Reform Allocations 2000/01

<table>
<thead>
<tr>
<th>Activity</th>
<th>Program</th>
<th>Budget 2000-01 $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Development</td>
<td>Disease Control</td>
<td>211</td>
</tr>
<tr>
<td></td>
<td>Alcohol &amp; Other Drugs</td>
<td>31</td>
</tr>
<tr>
<td>Community Health</td>
<td>Community Health</td>
<td>190</td>
</tr>
<tr>
<td>Community Services</td>
<td>FACS</td>
<td>266</td>
</tr>
<tr>
<td></td>
<td>Alcohol and Other Drugs</td>
<td>302</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>1 000</td>
</tr>
</tbody>
</table>
Financial Statements

In the opinion of Management, the Financial Statements of Territory Health Services as set out, provide a true and fair account of the results of agency operations for the year ended 30 June 2001.

The Financial Statements are presented in accordance with Part 2 Section 5 of the Treasurer's Direction, and records have been kept as required by the Financial Management Act.

PAUL BARTHOLOMEW
Chief Executive Officer

JOANNE SCHILLING
Director Finance and General Service

The following tables detail the statements as indicated.

Table 1 2000/01 Expenditure by Activity and Program
Table 2 2000/01 Expenditure by Standard Classification
Table 3 2000/01 Expenditure by Category of Cost
Table 4 2000/01 Receipts by Account
Table 5 Accountable Officers Trust Account Transactions for the Year Ended 30 June 2001
Table 6 Accountable Officer Trust Account Balances as at 30 June 2001
Table 7 Write Offs, Postponement and Waivers for the Year Ended 30 June 2001
Table 8 Debtors as at 30 June 2001
Table 9 Creditor and Accruals as at 30 June 2001
Table 10 Employee Entitlements Outstanding as at 30 June 2001
Table 11 Lease Liabilities as at 30 June 2001

### Financial Table 1

2000/2001 Expenditure by Activity and Program

<table>
<thead>
<tr>
<th>Activity/Program</th>
<th>Staffing</th>
<th>Final Allocation 2000/2001 $000</th>
<th>Actual 2000/2001 $000</th>
<th>Actual 1999/2000 $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational Support</td>
<td>152</td>
<td>22,113</td>
<td>22,091</td>
<td>22,516</td>
</tr>
<tr>
<td>Executive and Support</td>
<td>18</td>
<td>2,549</td>
<td>2,968</td>
<td></td>
</tr>
<tr>
<td>Corporate Services</td>
<td>134</td>
<td>19,542</td>
<td>19,548</td>
<td></td>
</tr>
<tr>
<td>Acute Care</td>
<td>1,263</td>
<td>119,143</td>
<td>119,076</td>
<td>114,800</td>
</tr>
<tr>
<td>Royal Darwin Hospital</td>
<td>1,263</td>
<td>119,076</td>
<td>114,800</td>
<td></td>
</tr>
<tr>
<td>Other Acute Care</td>
<td>970</td>
<td>93,842</td>
<td>93,817</td>
<td>87,720</td>
</tr>
<tr>
<td>Katherine Hospital</td>
<td>171</td>
<td>14,579</td>
<td>13,471</td>
<td></td>
</tr>
<tr>
<td>Gove District Hospital</td>
<td>114</td>
<td>11,930</td>
<td>11,267</td>
<td></td>
</tr>
<tr>
<td>Tennant Creek Hospital</td>
<td>63</td>
<td>6,162</td>
<td>6,682</td>
<td></td>
</tr>
<tr>
<td>Alice Springs Hospital</td>
<td>622</td>
<td>61,146</td>
<td>56,300</td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>321</td>
<td>38,439</td>
<td>38,420</td>
<td>44,345</td>
</tr>
<tr>
<td>Public Health Services</td>
<td>183</td>
<td>19,837</td>
<td>22,303</td>
<td></td>
</tr>
<tr>
<td>Dental Services</td>
<td>73</td>
<td>5,786</td>
<td>5,897</td>
<td></td>
</tr>
<tr>
<td>Alcohol and Other Drugs</td>
<td>65</td>
<td>10,341</td>
<td>13,616</td>
<td></td>
</tr>
<tr>
<td>Menzies School of Health Research</td>
<td></td>
<td>2,456</td>
<td>2,529</td>
<td></td>
</tr>
<tr>
<td>Community Services</td>
<td>412</td>
<td>77,922</td>
<td>77,882</td>
<td>71,731</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>143</td>
<td>13,939</td>
<td>13,629</td>
<td></td>
</tr>
<tr>
<td>Family, Aged and Disability Services</td>
<td>269</td>
<td>61,051</td>
<td>55,048</td>
<td></td>
</tr>
<tr>
<td>Community Service Obligations</td>
<td>2,892</td>
<td>3,054</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>631</td>
<td>95,997</td>
<td>95,954</td>
<td>92,655</td>
</tr>
<tr>
<td>Program Development</td>
<td>73</td>
<td>10,051</td>
<td>9,010</td>
<td></td>
</tr>
<tr>
<td>Primary Health Care - Urban</td>
<td>199</td>
<td>23,678</td>
<td>20,384</td>
<td></td>
</tr>
<tr>
<td>Primary Health Care - Rural</td>
<td>359</td>
<td>62,225</td>
<td>62,536</td>
<td></td>
</tr>
<tr>
<td>Katherine Regional Floods</td>
<td>0</td>
<td>725</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>3,749</td>
<td>447,456</td>
<td>447,240</td>
<td>433,767</td>
</tr>
</tbody>
</table>
Explanations to Table 1: Variations between 1999/00 and 2000/01 Expenditures

ORGANISATIONAL SUPPORT expenditure decreased by $0.4M in 2000/01 mainly due to time limited projects being finalised. These included Hospital Development Review, upgrades to IT software and establishment of new information systems.

ACUTE CARE EXPENDITURE (Royal Darwin Hospital) increased by $4.3M. For the first time hospitals were subject to Fringe Benefits Tax payments in this case $0.5M. Enterprise Bargaining Agreement (EBA) payments increased expenditure by $1.9M. The continuing provision of new services such as cardiology and the transfer of palliative care services to RDH also increased expenditure.

OTHER ACUTE CARE (all other Hospitals) expenditure increased overall by $6.9M. There was a decrease in Tennant Creek Hospital expenditure due to decreased inpatient activity. An increase of $4.8M in Alice Springs Hospital ensured an overall rise. The Alice Springs Hospital increase was partly attributed to a 10 percent increase in admitted patients and improved levels of service in the Emergency Department and inpatient services. All hospitals had an increase in EBA payments. Gove and Katherine hospitals were affected by organisational restructure transfers from Primary Health Care.

PUBLIC HEALTH expenditure of $1.4M was transferred to Primary Health Care. Alcohol and Other Drug expenditure was reduced due to Living With Alcohol funding transferred to NTsafe with funding to other agencies provided directly through the Budget process.

COMMUNITY SERVICES increased expenditure as additional funds were provided for Youth Suicide Prevention and unmet demand in Aged and Disability Services. Community Services Obligations expenditure is reliant on public demand which decreased in this year.

PRIMARY HEALTH CARE expenditure increased as projects to reform the non government sector were undertaken. Primary Health Care Urban expenditure has been enhanced by the transfer of $1.4M from Public Health Services. Primary Health Care Rural expenditure dropped as expenditure for East Timor ceased, and the combined Northern Territory/Commonwealth funded Coordinated Care Trials project was wound down. Funding was transferred to Gove and Katherine hospitals as part of organisational change.
## Financial Table 2

### 2000/2001 Expenditure by Standard Classification

<table>
<thead>
<tr>
<th>Category of Cost/Standard Classification</th>
<th>Actual Expenditure $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel Costs</td>
<td></td>
</tr>
<tr>
<td>Salary Costs</td>
<td>242 008</td>
</tr>
<tr>
<td>Salaries</td>
<td>189 934</td>
</tr>
<tr>
<td>Payroll Tax</td>
<td>5 855</td>
</tr>
<tr>
<td>Fringe Benefits Tax</td>
<td>841</td>
</tr>
<tr>
<td>Superannuation</td>
<td>13 760</td>
</tr>
<tr>
<td>Other Personnel Costs</td>
<td>52 074</td>
</tr>
<tr>
<td>Higher Duties Allowance</td>
<td>2 633</td>
</tr>
<tr>
<td>Leave Loading</td>
<td>1 287</td>
</tr>
<tr>
<td>Northern Territory Allowance</td>
<td>928</td>
</tr>
<tr>
<td>Other Allowances</td>
<td>3 854</td>
</tr>
<tr>
<td>Other Benefits paid by Employer</td>
<td>3 923</td>
</tr>
<tr>
<td>Overtime</td>
<td>12 658</td>
</tr>
<tr>
<td>Penalty Payments</td>
<td>14 940</td>
</tr>
<tr>
<td>Perishable Freight Subsidy</td>
<td>19</td>
</tr>
<tr>
<td>Recreation Leave Fares</td>
<td>2 039</td>
</tr>
<tr>
<td>Salary Advances</td>
<td>- 61</td>
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<tr>
<td>Termination Payments</td>
<td>6 229</td>
</tr>
<tr>
<td>Workers Compensation</td>
<td>3 625</td>
</tr>
<tr>
<td>Operational Costs</td>
<td>123 791</td>
</tr>
<tr>
<td>Property Management</td>
<td>17 801</td>
</tr>
<tr>
<td>Repairs and Maintenance</td>
<td>2 366</td>
</tr>
<tr>
<td>Property Management</td>
<td>15 435</td>
</tr>
<tr>
<td>Other Operational Costs</td>
<td>105 990</td>
</tr>
<tr>
<td>Advertising</td>
<td>77</td>
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<tr>
<td>Audit Fees</td>
<td>6</td>
</tr>
<tr>
<td>Client Travel</td>
<td>12 018</td>
</tr>
<tr>
<td>Clothing</td>
<td>200</td>
</tr>
<tr>
<td>Communications</td>
<td>3 439</td>
</tr>
<tr>
<td>Consultants' Fees</td>
<td>7 193</td>
</tr>
<tr>
<td>Consumables/General Expenses (incl Stores)</td>
<td>2 441</td>
</tr>
<tr>
<td>Cross Border Patient Charges</td>
<td>9 172</td>
</tr>
<tr>
<td>Document Production</td>
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<tr>
<td>Item</td>
<td>Amount</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Entertainment</td>
<td>14</td>
</tr>
<tr>
<td>Food</td>
<td>2,311</td>
</tr>
<tr>
<td>Freight</td>
<td>711</td>
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<td>Furniture and Fittings</td>
<td>940</td>
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<tr>
<td>Information Technology Services</td>
<td>13,752</td>
</tr>
<tr>
<td>Insurance Premiums</td>
<td>28</td>
</tr>
<tr>
<td>Laboratory Expenses</td>
<td>3,059</td>
</tr>
<tr>
<td>Legal Expenses</td>
<td>2,125</td>
</tr>
<tr>
<td>Library Services</td>
<td>781</td>
</tr>
<tr>
<td>Marketing and Promotion</td>
<td>358</td>
</tr>
<tr>
<td>Medical/Dental Supplies</td>
<td>28,871</td>
</tr>
<tr>
<td>Memberships and Subscriptions</td>
<td>87</td>
</tr>
<tr>
<td>Mobile Plant</td>
<td>66</td>
</tr>
<tr>
<td>Motor Vehicles (excl. Insurance)</td>
<td>5,363</td>
</tr>
<tr>
<td>Office Requisites and Stationery</td>
<td>1,550</td>
</tr>
<tr>
<td>Official Duty Fares</td>
<td>2,471</td>
</tr>
<tr>
<td>Other Plant and Equipment</td>
<td>1,280</td>
</tr>
<tr>
<td>Payments to NT Government</td>
<td>126</td>
</tr>
<tr>
<td>Recruitment Expenses</td>
<td>2,776</td>
</tr>
<tr>
<td>Registration &amp; Advisory Boards/Committees</td>
<td>172</td>
</tr>
<tr>
<td>Relocation Expenses</td>
<td>296</td>
</tr>
<tr>
<td>Training and Study Expenses</td>
<td>1,907</td>
</tr>
<tr>
<td>Travelling Allowance</td>
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</tr>
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</table>

**Capital Expenditure**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>0</td>
</tr>
<tr>
<td>Furniture &amp; Fittings</td>
<td>0</td>
</tr>
<tr>
<td>Information Technology Software and Hardware</td>
<td>0</td>
</tr>
<tr>
<td>Mobile Plant/Vehicles</td>
<td>134</td>
</tr>
<tr>
<td>Other Plant and Equipment</td>
<td>2,208</td>
</tr>
</tbody>
</table>

**Grants And Subsidies**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grants</td>
<td>65,525</td>
</tr>
<tr>
<td>Personal Benefits</td>
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</tr>
</tbody>
</table>

**Interest Advances**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest Expenses</td>
<td>673</td>
</tr>
</tbody>
</table>

**Advances**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advances Paid</td>
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</tr>
</tbody>
</table>

**TOTAL**

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>447,240</td>
</tr>
</tbody>
</table>
## Financial Table 3

### 2000/2001 Expenditure by Category of Cost

<table>
<thead>
<tr>
<th>Activity/Program</th>
<th>Personnel $000</th>
<th>Operational $000</th>
<th>Grants &amp; Capital $000</th>
<th>Subsidies $000</th>
<th>Interest $000</th>
<th>Advances $000</th>
<th>Total $000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational Support</td>
<td>10 308</td>
<td>10 245</td>
<td>24</td>
<td>0</td>
<td>379</td>
<td>1 135</td>
<td>22 091</td>
</tr>
<tr>
<td>Executive and Support</td>
<td>1 570</td>
<td>973</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>2 549</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>8 738</td>
<td>9 272</td>
<td>23</td>
<td>0</td>
<td>378</td>
<td>1 131</td>
<td>19 542</td>
</tr>
<tr>
<td><strong>Acute Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Darwin Hospital</td>
<td>77 753</td>
<td>39 023</td>
<td>425</td>
<td>1 652</td>
<td>39</td>
<td>184</td>
<td>119 076</td>
</tr>
<tr>
<td><strong>Other Acute Care</strong></td>
<td>60 102</td>
<td>31 997</td>
<td>1 314</td>
<td>0</td>
<td>54</td>
<td>350</td>
<td>93 817</td>
</tr>
<tr>
<td>Katherine Hospital</td>
<td>9 956</td>
<td>4 369</td>
<td>162</td>
<td>0</td>
<td>13</td>
<td>79</td>
<td>14 579</td>
</tr>
<tr>
<td>Gove District Hospital</td>
<td>7 466</td>
<td>4 273</td>
<td>133</td>
<td>0</td>
<td>8</td>
<td>50</td>
<td>11 930</td>
</tr>
<tr>
<td>Tennant Creek Hospital</td>
<td>3 949</td>
<td>2 096</td>
<td>84</td>
<td>0</td>
<td>0</td>
<td>33</td>
<td>6 162</td>
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<tr>
<td>Alice Springs Hospital</td>
<td>38 731</td>
<td>21 259</td>
<td>935</td>
<td>0</td>
<td>33</td>
<td>188</td>
<td>61 146</td>
</tr>
<tr>
<td><strong>Public Health</strong></td>
<td>20 422</td>
<td>8 192</td>
<td>340</td>
<td>9 438</td>
<td>0</td>
<td>28</td>
<td>38 420</td>
</tr>
<tr>
<td>Public Health Services</td>
<td>12 407</td>
<td>5 348</td>
<td>190</td>
<td>1 892</td>
<td>0</td>
<td>0</td>
<td>19 837</td>
</tr>
<tr>
<td>Dental Services</td>
<td>4 203</td>
<td>1 458</td>
<td>105</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>5 786</td>
</tr>
<tr>
<td>Alcohol and Other Drugs</td>
<td>3812</td>
<td>1 361</td>
<td>45</td>
<td>5 115</td>
<td>0</td>
<td>8</td>
<td>10 341</td>
</tr>
<tr>
<td>Menzies School of Health Research</td>
<td>0</td>
<td>25</td>
<td>0</td>
<td>2 431</td>
<td>0</td>
<td>0</td>
<td>2 456</td>
</tr>
<tr>
<td><strong>Community Services</strong></td>
<td>27 598</td>
<td>7 017</td>
<td>17</td>
<td>43 053</td>
<td>29</td>
<td>168</td>
<td>77 882</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>10 493</td>
<td>2 205</td>
<td>9</td>
<td>1 113</td>
<td>17</td>
<td>102</td>
<td>13 939</td>
</tr>
<tr>
<td>Family, Aged and Disability Services</td>
<td>17 105</td>
<td>4 812</td>
<td>8</td>
<td>39 048</td>
<td>12</td>
<td>66</td>
<td>61 051</td>
</tr>
<tr>
<td>Community Service Obligations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2 892</td>
<td>0</td>
<td>0</td>
<td>2 892</td>
</tr>
<tr>
<td><strong>Primary Health Care</strong></td>
<td>45 825</td>
<td>27 317</td>
<td>222</td>
<td>21 667</td>
<td>172</td>
<td>751</td>
<td>95 954</td>
</tr>
<tr>
<td>Program Development</td>
<td>5 570</td>
<td>3 836</td>
<td>0</td>
<td>0</td>
<td>127</td>
<td>518</td>
<td>10 051</td>
</tr>
<tr>
<td>Primary Health Care - Urban</td>
<td>12 086</td>
<td>2 562</td>
<td>20</td>
<td>9 000</td>
<td>0</td>
<td>10</td>
<td>23 678</td>
</tr>
<tr>
<td>Primary Health Care - Rural</td>
<td>28 169</td>
<td>20 919</td>
<td>202</td>
<td>12 667</td>
<td>45</td>
<td>223</td>
<td>62 225</td>
</tr>
<tr>
<td>Katherine Region Floods</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL EXPENDITURE</strong></td>
<td>242 008</td>
<td>123 791</td>
<td>2 342</td>
<td>75 810</td>
<td>673</td>
<td>2 616</td>
<td>447 240</td>
</tr>
</tbody>
</table>
## Financial Table 4

### 2000/2001 Receipts by Account

<table>
<thead>
<tr>
<th>Consolidated Revenue Account</th>
<th>Estimated Receipts</th>
<th>Actual Receipts</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receipts from Territory Sources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fees and Charges</td>
<td>404</td>
<td>546</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Receipts</td>
<td>0</td>
<td>600</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Consolidated Revenue Account Receipts:</strong></td>
<td><strong>404</strong></td>
<td><strong>1,146</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>THS Operating Account Receipts</th>
<th>Estimated Receipts</th>
<th>Actual Receipts</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer from Consolidated Revenue Account</td>
<td>329,957</td>
<td>330,576</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charges for Goods and Services</td>
<td>18,320</td>
<td>18,551</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sale of Other Assets</td>
<td>20</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Receipts</td>
<td>-302</td>
<td>742</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commonwealth Payments</td>
<td>98,463</td>
<td>97,746</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intrasector Receipts</td>
<td>99</td>
<td>215</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipt Of Advances</td>
<td>0</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total THS Operating Account Receipts</strong></td>
<td><strong>446,557</strong></td>
<td><strong>447,855</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Explanations to Table 4:
2000/01 Receipts by Account

Consolidated Revenue Account fees and charges are collected by 11 professional boards on behalf of THS. These fees and charges relate to regulatory legislation and the issue of licences and permits to carry out otherwise prohibited or restricted activities. These consist mainly of registration fees for health professionals such as medical practitioners and nurses. The fees and charges are not tied to departmental activity, and therefore are receipted into the Consolidated Revenue Account. In 2000/01, $0.546M was collected which was $0.142M greater than budget.

The Northern Territory Government directs funds from the Consolidated Revenue Account to each agency to make up the shortfall between budgeted collections of revenue and budgeted expenditure through the year. This is the major source of funds for THS and provides a measure of the net cost of activities to the Northern Territory.

Charges are levied for services rendered and the provision of goods and services. THS collected $0.231M more revenue than originally estimated. This variation was due to increased Patient Charges $1.175M, the collection of Cross Border charges was less by $0.329M due to lower provision of services to interstate clients, Coordinated Care Trials revenue was $0.365M lower, sale of pharmaceuticals and other items was $0.458M lower as clients moved to provision by private suppliers.

Payments from the Commonwealth are a significant source of funds for THS and $97.746M was collected in 2000/01. Funds were received under the Australian Health Care Agreement, the Commonwealth /State Disability Agreement, the Public Health Outcomes Funding Agreement and Home and Community Care arrangements.

Intrasector Receipts are payments made by other Northern Territory Government agencies to THS. During 2000/01 $0.215M was received.
## Financial Table 5

### Accountable Officers Trust Account Transactions for the Year Ended 30 June 2001

<table>
<thead>
<tr>
<th>Nature of Trust Money</th>
<th>Opening Balance 1 July 2000</th>
<th>Receipts</th>
<th>Payments</th>
<th>Closing Balance 30 June 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Accommodation Bonds</td>
<td>128 383</td>
<td>169 690</td>
<td>161 868</td>
<td>136 205</td>
</tr>
<tr>
<td>Adoption Previous Subsidy Scheme</td>
<td>7 098</td>
<td>0</td>
<td>4 300</td>
<td>2 798</td>
</tr>
<tr>
<td>Deceased Estates</td>
<td>158</td>
<td>0</td>
<td>134</td>
<td>24</td>
</tr>
<tr>
<td>Electricity Security Deposits</td>
<td>5 182</td>
<td>0</td>
<td>-25</td>
<td>5 207</td>
</tr>
<tr>
<td>Keys Security Deposits</td>
<td>11 970</td>
<td>17 401</td>
<td>14 636</td>
<td>14 735</td>
</tr>
<tr>
<td>Nursing Airfares</td>
<td>40 569</td>
<td>1 866</td>
<td>689</td>
<td>41 746</td>
</tr>
<tr>
<td>Overseas Adoptions</td>
<td>-4 102</td>
<td>50 000</td>
<td>48 000</td>
<td>-2 102</td>
</tr>
<tr>
<td>Sessional Medical Officers Superannuation</td>
<td>5 512</td>
<td>0</td>
<td>0</td>
<td>5 512</td>
</tr>
<tr>
<td>Unclaimed Monies</td>
<td>44 398</td>
<td>1 846</td>
<td>34 154</td>
<td>12 090</td>
</tr>
<tr>
<td>Uniform Bonds</td>
<td>300</td>
<td>0</td>
<td>0</td>
<td>300</td>
</tr>
<tr>
<td>Bicycle Key Deposit</td>
<td>0</td>
<td>280</td>
<td>170</td>
<td>110</td>
</tr>
<tr>
<td>Community Donation</td>
<td>0</td>
<td>4 252</td>
<td>436</td>
<td>3 816</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>239 468</strong></td>
<td><strong>245 335</strong></td>
<td><strong>264 362</strong></td>
<td><strong>220 441</strong></td>
</tr>
</tbody>
</table>
Financial Table 6

Accountable Officers Trust Account Balances
As At 30th June 2001

<table>
<thead>
<tr>
<th>Nature of Trust Money</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Darwin</strong></td>
<td></td>
</tr>
<tr>
<td>Accommodation Bonds</td>
<td>51 045</td>
</tr>
<tr>
<td>Adoptions Previous Subsidy Scheme</td>
<td>2 798</td>
</tr>
<tr>
<td>Deceased Estates</td>
<td>24</td>
</tr>
<tr>
<td>Nursing Airfares</td>
<td>29 105</td>
</tr>
<tr>
<td>Overseas Adoptions</td>
<td>-2 102</td>
</tr>
<tr>
<td>Sessional Medical Officers Superannuation</td>
<td>5 512</td>
</tr>
<tr>
<td>Unclaimed Monies</td>
<td>2 278</td>
</tr>
<tr>
<td><strong>Sub Total Darwin</strong></td>
<td>88 660</td>
</tr>
<tr>
<td><strong>Katherine</strong></td>
<td></td>
</tr>
<tr>
<td>Accommodation Bonds</td>
<td>22 566</td>
</tr>
<tr>
<td>Bicycle Key Deposit</td>
<td>110</td>
</tr>
<tr>
<td>Deceased Estates</td>
<td>0</td>
</tr>
<tr>
<td>Keys Security Deposit</td>
<td>1 380</td>
</tr>
<tr>
<td>Uniform Bonds</td>
<td>300</td>
</tr>
<tr>
<td><strong>Sub Total Katherine</strong></td>
<td>24 356</td>
</tr>
<tr>
<td><strong>East Arnhem</strong></td>
<td></td>
</tr>
<tr>
<td>Accommodation Bonds</td>
<td>1 535</td>
</tr>
<tr>
<td>Electricity Security Deposits</td>
<td>5 207</td>
</tr>
<tr>
<td>Nursing Airfares</td>
<td>1 738</td>
</tr>
<tr>
<td><strong>Sub Total East Arnhem</strong></td>
<td>8 480</td>
</tr>
<tr>
<td><strong>Alice Springs and Barkly</strong></td>
<td></td>
</tr>
<tr>
<td>Accommodation Bonds</td>
<td>61 059</td>
</tr>
<tr>
<td>Community Donation</td>
<td>3 816</td>
</tr>
<tr>
<td>Keys Security Deposit</td>
<td>13 355</td>
</tr>
<tr>
<td>Nursing Airfares</td>
<td>10 903</td>
</tr>
<tr>
<td>Unclaimed Monies</td>
<td>9 812</td>
</tr>
<tr>
<td><strong>Sub Total Alice Springs and Barkly</strong></td>
<td>98 945</td>
</tr>
</tbody>
</table>

**Accountable Officers Trust Account Grand Total** 220 441
### Financial Table 7

**Write Offs, Postponements And Waivers**

For The Year Ending 30 June 2001

<table>
<thead>
<tr>
<th>Category</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amounts written off or waived by Delegated Officers</strong></td>
<td></td>
</tr>
<tr>
<td>Irrecoverable money written off</td>
<td>0</td>
</tr>
<tr>
<td>Losses or deficiencies of monies written off</td>
<td>0</td>
</tr>
<tr>
<td>Value of public property written off</td>
<td>1,548,921</td>
</tr>
<tr>
<td>Waiver of right to receive or recover money</td>
<td>0</td>
</tr>
<tr>
<td><strong>Amounts written off, postponed or waived by the Treasurer</strong></td>
<td></td>
</tr>
<tr>
<td>Irrecoverable money written off</td>
<td>17,617</td>
</tr>
<tr>
<td>Losses or deficiencies of monies written off</td>
<td>0</td>
</tr>
<tr>
<td>Value of public property written off</td>
<td>0</td>
</tr>
<tr>
<td>Postponement of money owing</td>
<td>0</td>
</tr>
<tr>
<td>Waiver of right to receive or recover money</td>
<td>0</td>
</tr>
<tr>
<td><strong>Write Offs, Postponements And Waivers</strong></td>
<td></td>
</tr>
<tr>
<td>Authorised Under Other Legislation</td>
<td></td>
</tr>
<tr>
<td>Amounts Written Off Or Waived By Delegated Officers</td>
<td>0</td>
</tr>
<tr>
<td>Losses or deficiencies of monies written off</td>
<td>0</td>
</tr>
</tbody>
</table>

**TOTAL**                                                             1,566,538
Financial Table 8

Debtors As At 30 June 2001

<table>
<thead>
<tr>
<th>Activity</th>
<th>_external_charges</th>
<th>internal_charges</th>
<th>Total Charges</th>
<th>Other Charges</th>
<th>CSO Total</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Organisational Support</td>
<td>0</td>
<td>1 639</td>
<td>1 639</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Acute Care</td>
<td>1 848</td>
<td>391</td>
<td>2 239</td>
<td>15</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Other Acute Care</td>
<td>807</td>
<td>77</td>
<td>884</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Public Health</td>
<td>12</td>
<td>33</td>
<td>45</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Community Services</td>
<td>24</td>
<td>73</td>
<td>97</td>
<td>0</td>
<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>618</td>
<td>185</td>
<td>803</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>3 309</strong></td>
<td><strong>2 398</strong></td>
<td><strong>5 707</strong></td>
<td><strong>25</strong></td>
<td><strong>20</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>

Less: Provision for Doubtful Debts

<table>
<thead>
<tr>
<th>Doubtful Debts</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 252</td>
<td>254</td>
<td>1 506</td>
<td>9</td>
</tr>
</tbody>
</table>

NET DEBTORS

<table>
<thead>
<tr>
<th>Current</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 057</td>
<td>2 144</td>
<td>4 201</td>
<td>16</td>
</tr>
</tbody>
</table>

Classified As:

<table>
<thead>
<tr>
<th>Non Current (Over 12 Months)</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

NET DEBTORS

<table>
<thead>
<tr>
<th>Current</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 057</td>
<td>2 144</td>
<td>4 201</td>
<td>16</td>
</tr>
</tbody>
</table>

Less: Provision for Doubtful Debts

<table>
<thead>
<tr>
<th>Doubtful Debts</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 252</td>
<td>254</td>
<td>1 506</td>
<td>9</td>
</tr>
</tbody>
</table>

NET DEBTORS

<table>
<thead>
<tr>
<th>Current</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 057</td>
<td>2 144</td>
<td>4 201</td>
<td>16</td>
</tr>
</tbody>
</table>

Less: Provision for Doubtful Debts

<table>
<thead>
<tr>
<th>Doubtful Debts</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 252</td>
<td>254</td>
<td>1 506</td>
<td>9</td>
</tr>
</tbody>
</table>
Financial Table 9

Creditors And Accruals As At 30 June 2001

<table>
<thead>
<tr>
<th>Activity</th>
<th>External Creditors</th>
<th>External Accruals</th>
<th>External Total</th>
<th>Intrasector Creditors</th>
<th>Intrasector Accruals</th>
<th>Intrasector Total</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
<td>$000</td>
</tr>
<tr>
<td>Organisational Support</td>
<td>969</td>
<td>197</td>
<td>1 166</td>
<td>95</td>
<td>67</td>
<td>162</td>
<td>1 328</td>
</tr>
<tr>
<td>Acute Care</td>
<td>3 466</td>
<td>1 984</td>
<td>5 450</td>
<td>86</td>
<td>288</td>
<td>374</td>
<td>5 824</td>
</tr>
<tr>
<td>Other Acute Care</td>
<td>1 832</td>
<td>1 549</td>
<td>3 381</td>
<td>86</td>
<td>78</td>
<td>164</td>
<td>3 545</td>
</tr>
<tr>
<td>Public Health</td>
<td>327</td>
<td>448</td>
<td>775</td>
<td>24</td>
<td>106</td>
<td>130</td>
<td>905</td>
</tr>
<tr>
<td>Community Services</td>
<td>669</td>
<td>549</td>
<td>1 218</td>
<td>37</td>
<td>142</td>
<td>179</td>
<td>1 397</td>
</tr>
<tr>
<td>Primary Health Care</td>
<td>1 760</td>
<td>900</td>
<td>2 660</td>
<td>16</td>
<td>256</td>
<td>272</td>
<td>2 932</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>9 023</td>
<td>5 627</td>
<td>14 650</td>
<td>344</td>
<td>937</td>
<td>1 281</td>
<td>15 931</td>
</tr>
</tbody>
</table>

Classified As:

- **Current**
  - **TOTAL** 9 023 5 627 14 650 344 937 1 281 15 931

- **Non Current**
  - **TOTAL** 0 0 0 0 0 0 0

**TOTAL** 9 023 5 627 14 650 344 937 1 281 15 931
# Financial Table 10

## Employee Entitlements Outstanding as at 30 June 2001

<table>
<thead>
<tr>
<th>Entitlement</th>
<th>$000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current</strong></td>
<td></td>
</tr>
<tr>
<td>Recreation Leave</td>
<td>22,416</td>
</tr>
<tr>
<td>Recreation Leave Fares</td>
<td>2,039</td>
</tr>
<tr>
<td>Leave Loading</td>
<td>3,284</td>
</tr>
<tr>
<td>Long Service Leave</td>
<td>16,540</td>
</tr>
<tr>
<td><strong>Non Current</strong></td>
<td></td>
</tr>
<tr>
<td>Long Service Leave</td>
<td>4,735</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>49,014</td>
</tr>
</tbody>
</table>

## Methodology

1. **Recreation Leave**
   
   The value of recreation leave entitlements are calculated by PIPS based on employees' actual salaries and entitlements at 30 June 2001.

2. **Recreation Leave Fares**
   
   Recreation Leave Fares entitlements are calculated based on 2000/01 actuals.

3. **Leave Loading**
   
   The value of leave loading entitlements are calculated by PIPS based on employees' actual salaries and entitlements at 30 June 2001.

4. **Long Service Leave**
   
   Long Service entitlement is calculated in accordance with Australian Accounting Standard AAS 30. The calculation takes into account the probability of employees reaching ten years of service, the future increases in salary costs and discount rates to achieve the net present value of the future liability.
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<table>
<thead>
<tr>
<th>Lease Commitments/ Liability</th>
<th>Information Technology</th>
<th>Furniture &amp; Fittings</th>
<th>Other Plant &amp; Equipment</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Hardware $000</td>
<td>Software $000</td>
<td></td>
<td></td>
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<tr>
<td>Not later than one year</td>
<td>247</td>
<td>495</td>
<td>0</td>
<td>742</td>
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<tr>
<td>Later than one year but not later than two years</td>
<td>57</td>
<td>372</td>
<td>0</td>
<td>429</td>
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<tr>
<td>Later than two years but no later than five years</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>12</td>
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<tr>
<td>Later than five years</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Minimum lease payments</td>
<td>316</td>
<td>867</td>
<td>0</td>
<td>1183</td>
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<tr>
<td>Less future financing charges</td>
<td>(33)</td>
<td>(138)</td>
<td>0</td>
<td>(171)</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>283</td>
<td>729</td>
<td>0</td>
<td>1012</td>
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</table>

Classified as:

- **Current**
  - Minimum lease payments: 222
  - Less future financing charges: 417
  - **Total**: 639

- **Non Current**
  - Minimum lease payments: 61
  - Less future financing charges: 312
  - **Total**: 373

**TOTAL**: 283, 729, 0, 1012
Note 1: Significant Financial and Account Policies

(a) Territory Health Services as an Agency
Territory Health Services is an Agency of the Northern Territory Government as defined by the Financial Management Act. The accompanying financial statements are prepared in accordance with Section 11 of the Financial Management Act and Part 2 Section 5 of the Treasurer's Directions which define the requirements of financial reporting by Northern Territory Government Agencies. These financial statements are included in this Annual Report in accordance with Section 12 of the Financial Management Act.

(b) Basis of Account
Territory Health Services' financial records are kept on a cash basis, and recognise events on receipt of monies or payment of monies and are reported within the financial accounting period concerned. No accrual entries (recognition of revenues as they are earned and expenses as they are incurred) are recorded in the General Ledger. There is no requirement for Territory Health Services to prepare a Balance Sheet for the year ending 30 June 2001.

Note 2: Investments
Territory Health Service had no investments held in corporation, trust, joint ventures or similar entities as at 30 June 2001.

Note 3: Contingent Liabilities
Details of all contingent liabilities have been provided to Northern Territory Treasury in accordance with Treasurer's Directions Part 2 Section 4 for consideration in global reporting in the Treasurer's Annual Financial Statement.

Note 4: Accountable Officer's Trust Account
The Accountable Officer's Trust Account is established in accordance with Section 7 of the Financial Management Act of the receipt and payment of monies held in trust on behalf of third parties where it is not intended that Territory Health Services will be a beneficiary, eg. conditional accommodation bonds paid by employees where it is intended to refund those monies.
List of Senior Contact Officers

**Executive Group**

Chief Executive Officer
*Paul Bartholomew*
Telephone: 8999 2761

Acting Deputy Secretary, Service Provision
*Dr Len Notaras*
Telephone: 8999 2416

Acting Assistant Secretary, Business and Operational Support
*Joanne Schilling*
Telephone: 8999 2416

Assistant Secretary, Health Development and Community Services and Chief Health Officer
*Dr Shirley Hendy*
Telephone: 8999 2768

Assistant Secretary, Community Health Aboriginal Health and Hospital Services
*Jenny Cleary*
Telephone: 8999 2752

Assistant Secretary, Purchasing Division
*Rose Rhodes*
Telephone: 8922 7 237

Regional Director, Top End Service Network
*David Ashbridge*
Telephone: 8922 7149

Regional Director, Central Australian Service Network
*Sue Korner*
Telephone: 8951 5113

Principal Medical Consultant
*Dr Len Notaras*
Telephone: 8922 8156
Executive Director, Royal Darwin Hospital
Stephen Muggleton
Telephone: 8922 8102

General Manager, Alice Spring Hospital
Joyce Bowden
Telephone: 8951 7992

**Executive Support**

Ministerial Liaison
Director, Jan Evans
Telephone: 8999 2886

Health Gain Planning Unit
Director, Cheryl Rae
Telephone: 8999 2873

Public Affairs
Acting Director, Janette Howard
Telephone: 8999 8430

**Top End Service Network**

Darwin Urban District
General Manager, Meribeth Fletcher
Telephone: 8922 7242

Darwin Rural District
General Manager, Lesley Kemmis
Telephone: 8922 8086

East Arnhem District
General Manager, Mark Watson
Telephone: 8987 0302

Katherine District
General Manager, Kathy Stow
Telephone: 8973 9034
Oral Health
General Manager, Noni Bickerstaff
Telephone: 8924 4484

Mental Health
General Manager, Vic Rowe
Telephone: 8999 4929

Central Australian Service Network

Health Development
Manager, Philippe Porihneaux
Telephone: 8951 6916

Community Service -Family and Children's / Aged and Disabilities
Manager, Jenny Mills
Telephone: 8951 5365

Community Services -Mental Health / Alcohol and Other Drugs
Manager, Linda Keane
Telephone: 8951 7716

Barkly Health Services
General Manager, Ashley Frost
Telephone: 8962 4266

Community Health Services Remote
General Manager, Malcolm Jonstone
Telephone: 8951 7800

Community Health Services Urban
General Manager, Del Hird
Telephone: 8951 6708
Health Development & Community Services

Social and Emotional Wellness
(comprising of Alcohol and Other Drugs, Health Promotion and Mental Health)
Director, Cheryl Furner
Telephone: 8999 2916

Disease Control
Director, Dr Vicki Krause
Telephone: 8928 8510

Environmental Health (including Radiation Health and Poisons)
Director, Xavier Schobben
Telephone: 8999 2714

Medical Entomology
Director, Peter Whelan
Telephone: 8922 8333

Women's Cancer Prevention
Director, Cynthia Croft
Telephone: 8922 5500

Family and Children's Services
Director, Anthony Burton
Telephone: 8999 2733

Aged, Disability and Community Care
Director, Damien Conley
Telephone: 8999 2831

Community Health

Primary Health and Coordinated Care
Director, Noelene Swanson
Telephone: 8999 2831

NT Aboriginal Hearing Program
Coordinator,
Telephone: 8999 2929
Women’s Health Advisor
Director, Jenne Roberts
Telephone: 8999 2932

Hospital Services

Hospital Services
Acting Director, Allison Grierson
Telephone: 8999 2659

Alice Springs Hospital
General Manager, Joyce Bowden
Telephone: 8922 7276

Katherine Hospital
General Manager, Kathy Stow
Telephone: 8973 9034

Gove Hospital
General Manager, Mark Watson
Telephone: 8987 0302

Royal Darwin Hospital
Executive Director, Steve Muggelton
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Tennant Creek Hospital
General Manager, Ashley Frost
Telephone: 8962 4266

Business and Operational Support

Business Information Management
Director, Stephen Moo
Telephone: 8999 2847

Finance & General Services
Acting Director, Brian Slatter
Telephone: 8999 2808
Information Technology Services  
Director, Ian Allan  
Telephone: 8999 2783

Performance Audit and Adult Guardianship  
Director, John Montz  
Telephone: 8999 2633

Professional Boards  
Director, Geoff Clark  
Telephone: 8999 4194

Workforce Development  
Director, Dr Rosy Warden  
Telephone: 8922 8227

Workforce Relations and Planning  
Director, Steve Marshall  
Telephone: 8999 2920

Legal Services  
Manager, Susan Paltridge  
Telephone: 8999 2810

**Purchasing Division**

Health Development  
Purchasing Director, Steve Guthridge  
Telephone: 8922 7229

Community Health  
Purchasing Director, Jill Macandrew  
Telephone: 8922 7093

Community Services  
Purchasing Director, Bruce March  
Telephone: 8922 7080
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<td>ACAP</td>
<td>Aged Care Assessment Program</td>
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<tr>
<td>ACAT</td>
<td>Aged Care Assessment Teams</td>
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<tr>
<td>AEHW</td>
<td>Aboriginal Environmental Health Worker</td>
</tr>
<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td>AHWCS</td>
<td>Aboriginal Health Worker Career Structure</td>
</tr>
<tr>
<td>AMSANT</td>
<td>Aboriginal Medical Services Alliance Northern Territory</td>
</tr>
<tr>
<td>ASH</td>
<td>Alice Springs Hospital</td>
</tr>
<tr>
<td>ATSIC</td>
<td>Aboriginal and Torres Strait Islander Commission</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Central Australian Mental Health Services</td>
</tr>
<tr>
<td>CASN</td>
<td>Central Australian Service Network</td>
</tr>
<tr>
<td>CDC</td>
<td>Centre for Disease Control</td>
</tr>
<tr>
<td>CSDA</td>
<td>Commonwealth/State Disability Agreement</td>
</tr>
<tr>
<td>DCIS</td>
<td>Department of Corporate and Information Services</td>
</tr>
<tr>
<td>DRG</td>
<td>Diagnostic Related Group</td>
</tr>
<tr>
<td>EHP</td>
<td>Environmental Health Program</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
</tr>
<tr>
<td>FACS</td>
<td>Family and Children's Services</td>
</tr>
<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
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<tr>
<td>GAA</td>
<td>Growth Assessment and Action</td>
</tr>
<tr>
<td>GDH</td>
<td>Gove District Hospital</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IHANT</td>
<td>Indigenous Housing Authority of the Northern Territory</td>
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<tr>
<td>LWA</td>
<td>Living With Alcohol</td>
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<td>NAHS</td>
<td>National Aboriginal Health Strategy</td>
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<td>NGO</td>
<td>Non Government Organisation</td>
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<td>NTU</td>
<td>Northern Territory University</td>
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<td>Office of the Commissioner for Public Employment</td>
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<td>Royal Darwin Hospital</td>
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<td>SAAP</td>
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<td>TESN</td>
<td>Top End Service Network</td>
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<td>TIME</td>
<td>Territory Independence and Mobility Equipment Scheme</td>
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