The Parliament of the Commonwealth of Australia

INQUIRY INTO INDIGENOUS HEALTH

Discussion Paper

House of Representatives
Standing Committee on Family and Community Affairs

1 September 1999
Canberra

ISBN 0 642 40913 7

Contents

Background

The Committee commenced the Inquiry into Indigenous Health in September 1997. It is a wide ranging inquiry considering issues related to the coordination of service planning and delivery, barriers to access to services and professional education requirements, as well as consideration of the impact on health of a number of other matters such as location, access to transport, opportunities for employment and education and social and cultural factors.

Although the Inquiry commenced some time ago the Committee was unable to complete its work during the Thirty-Eight Parliament, due to the dissolution of the House of Representatives in August 1998. The Committee has been asked by the Minister for Health and Aged Care to complete the Inquiry in the Thirty-Ninth Parliament, reporting on the same terms of reference.

Since the commencement of the Inquiry the Committee has received some ninety eight submissions and has held public hearings in all capital cities and a number of regional centres. The Committee has also visited many Aboriginal communities and health related organisations, particularly in remote and rural areas, to discuss the issues at first hand with the people most affected.

In considering the evidence provided through submissions and public hearings there have been a number of matters on which witnesses have held opposing views. There have also been some inconsistencies between what the Committee has been told should be happening and what it has observed during the course of community consultations.

This discussion paper does not present any detailed analysis of these issues at this stage. It simply attempts to broadly highlight the Committee's impressions and observations in order to allow key stakeholders to respond to perceived inconsistencies or problems before the preparation of the final report. The paper primarily focuses on some of the key areas where the Committee believes there

may be significant impediments to change, and discusses some possible responses, particularly in relation to:

- ⇒ Commonwealth, State and Territory planning and delivery of health and related services, including environmental health services;
- ⇒ Professional education; and
- ⇒ Barriers to achieving good health.

The aim of the discussion paper is to stimulate further debate about the issues, to ensure that any erroneous impressions or conclusions are not pursued, to canvass the possible consequences of certain decisions and to allow the Committee to refine its views in light of comment and feedback.

However, it is important to note that, while the comments on the areas detailed in this paper represent the Committee's current consideration of the issues, it may not reflect the Committee's ultimate position as contained in the final report.

To provide an opportunity for people to respond to the issues and proposals raised in the paper, and to allow those responses to be discussed with both the Committee and other stakeholders at the same time, the Committee will also be holding a number of further public meetings during November and December. Details of the times and places for these meetings can be obtained from the Committee Secretariat.

Barry Wakelin, MP
Chair

Terms of Reference

In view of the unacceptably high morbidity and mortality of Aboriginal and Torres Strait Islander people the House of Representatives Standing Committee on Family and Community Affairs has been asked to report on:

a) ways to achieve effective Commonwealth coordination of the provision of health and related programs to Aboriginal and Torres Strait Islander communities, with particular emphasis on the regulation, planning and delivery of such services;

b) barriers to access to mainstream health services, to explore avenues to improve the capacity and quality of mainstream health service delivery to Aboriginal and Torres Strait Islander people and the development of linkages between Aboriginal and Torres Strait Islander and mainstream services;

c) the need for improved education of medical practitioners, specialists, nurses and health workers, with respect to the health status of Aboriginal and Torres Strait Islander people and its implications for care;

d) the extent to which social and cultural factors, and location, influence health, especially maternal and child health, diet, alcohol and tobacco consumption;

e) the extent to which Aboriginal and Torres Strait Islander health status is affected by educational and employment opportunities, access to transport services and proximity to other community supports, particularly in rural and remote communities; and

f) the extent to which past structures for delivery of health care services have contributed to the poor health status of Aboriginal and Torres Strait Islander people.

Membership of the Committee

Chair	Mr Barry Wakelin MP
Deputy Chair	Ms Annette Ellis MP
Members	Mr Kevin Andrews MP
	Hon Graham Edwards MP
	Mrs Kay Elson MP
	Ms Jill Hall MP
	Mr Harry Jenkins MP *
	Mrs De-Anne Kelly MP
	Dr Brendan Nelson MP
	Mr Peter Nugent MP *
	Mr Harry Quick MP
	Mr Alby Schultz MP

* for Inquiry into Indigenous Health

List of Abbreviations

ABS	Australian Bureau of Statistics
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
AMSANT	Aboriginal Medical Services Alliance of the Northern Territory
ANAO	Australian National Audit Office
ARHP	Aboriginal Rental Housing Program
ATSIC	Aboriginal and Torres Strait Islander Commission
CGC	Commonwealth Grants Commission
CSHA	Commonwealth State Housing Agreements
DHAC	Commonwealth Department of Health and Aged Care
MBS	Medicare Benefits Scheme
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NHMRC	National Health and Medical Research Council
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PBS	Pharmaceutical Benefits Scheme
UPK	Uwankara Palyanku Kanyintjaku

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Introduction

1.1 The 1996 census estimated that the resident Indigenous population in Australia was 386,000 people. Over half of these people live in New South Wales (28.5%) and Queensland (27.2%). Just over a quarter live in Western Australia (14.4%) and the Northern Territory (13.1%).

1.2 The Indigenous population is also young and increasingly urbanised. The percentage of the Indigenous population under 15 years is 40%, compared to 21% for the non-Indigenous population, and the median age of 20 years is some 14 years younger than for the non-Indigenous population.

1.3 Since 1991, the percentage of the Indigenous population living in urban areas (an urban area is defined as a population centre of more than 1000 people) has increased from 67.6% to 72.6%. This compares to 85.9% for the non-Indigenous population.

1.4 However, unlike the non-Indigenous population, a higher proportion of Indigenous people live in smaller urban centres (those with populations between 1000 and 99,999 people). Indigenous people are less likely than the non-Indigenous population to reside in major urban areas.

1.5 Despite the increased urbanisation of the Indigenous population, a much greater proportion of Indigenous people still live in rural and remote areas compared to the non-Indigenous population. This means that there are significant numbers of Indigenous people living in urban, rural and remote locations around the country and that programs need to be accessible to people in all these areas.

Health Status

1.6 The poor health status of Indigenous Australians is acknowledged in the Committee's terms of reference and is well documented. Although the statistics do not need to be exhaustively restated here some of the key facts are discussed below.

1.7 The recent report, by the Australian Institute of Health and Welfare and the Australian Bureau of Statistics, on the Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples indicated, among other things, that:

> "Indigenous peoples continue to suffer a much greater burden of ill-health than do other Australians……The health disadvantage of Indigenous Australians begins early in life and continues throughout the life cycle"[1]

1.8 It has become apparent over the last twenty years that the causes of excess mortality in the Indigenous population have changed, from acute infections to chronic non-communicable diseases and deaths resulting from accident and injury.

1.9 About three out of every four deaths among Indigenous people now result from one of the following:

- diseases of the circulatory system (heart attacks and strokes);
- injury and poisoning (road accidents, suicide and murder);
- respiratory diseases (pneumonia, asthma and emphysema);
- neoplasms (cancers); and
- endocrine, nutritional and metabolic disorders (diabetes).

1.10 The changes are also reflected in changing morbidity patterns, with a reduction in communicable diseases being counterbalanced by an increase in non-communicable diseases, particularly hypertension, ischaemic heart disease and diabetes.

1.11 The impact of these changes has also been fairly general. It has not been restricted to any specific area, and the health of Indigenous Australians in urban areas is as poor as that of Indigenous people in rural or remote areas.

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1 Australian Bureau of Statistics and Australian Institute of Health and Welfare. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. AusInfo. Canberra 1999. pp 4-5.

1.12 Morbidity for Indigenous children, however, arises mostly from infections which are entirely preventable. Given the same level of services and facilities available to the non-Indigenous community, the levels of childhood infections should be no greater.

1.13 Although birth weights are increasing, many infants are still born underweight, especially in remote areas, and infant and childhood malnutrition contribute to growth retardation and predispose children to infectious disease.

1.14 This is particularly relevant in looking at present mortality patterns as there is evidence to suggest low birth weight and growth retardation before birth can contribute to diabetes mellitus, hypertension and heart disease in later life. There is also some evidence linking past infections to increased susceptibility to kidney failure.

1.15 There have been rapid increases, over the past ten years, in the incidence of kidney disease and renal failure. The incidence of renal failure in the Top End is estimated as being some 15 times higher than the Australian aggregate rate.

1.16 Mental health, particularly mental and emotional wellbeing, is also seen as a major problem within the Indigenous community linked to:

> "..the loss of loved ones, childhood trauma, alcohol and drug related misery, violence, ongoing racism, stereotyping and discrimination, and the accumulated loss of two hundred and eleven years of cultural destruction and dispossession."[2]

1.17 This would suggest that current health problems could relate as much to past experiences as to present conditions, presenting major policy challenges.

1.18 Targeted treatment services need to be developed and implemented to address current morbidity and mortality patterns, but this should not be at the expense of neglecting existing primary health care services.

1.19 Appropriate health promotion and prevention programs would also seem to be needed at the same time, to ensure present trends do not continue into the future because of the current health disadvantages experienced by mothers and children.

1.20 The underlying causes of this health disadvantage do not, however, appear easy to identify. The Department of Health and Aged Care submission indicates that:

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2 Submission No 88. p1038

> "there are a number of inter-related factors which impact on poor health among Indigenous people, and its persistence. The relationship between these factors is complex, and current evidence does not allow us to assess the relative importance of one factor over another."[3]

1.21 The submission goes on to suggest that the major factors affecting Indigenous health would include:

- Socioeconomic status;
- Social and cultural factors, including past dispossession and dislocation;
- Access to good quality health care, which can be reduced by barriers such as lack of cultural awareness, location, workforce limitations and financial circumstances;
- Environmental factors; and
- Specific risk factors, such as poor nutrition, alcohol misuse and high levels of tobacco consumption.

1.22 Consistent with this multi-factorial view of the antecedents of ill-health many submissions have stressed the importance of viewing the health needs of Indigenous Australians within an holistic framework, reflected in the NAHS Working Party report, which saw health as:

> "Not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community."[4]

1.23 The Committee supports this view and considers that any response to the health needs of Indigenous Australians needs to involve action across many areas.

Previous Reports

1.24 The continued poor state of Indigenous health over the last twenty years, and the difficulties associated with identifying the underlying causes, has also generated a stream of reports about the problem, most of which have made very similar recommendations.

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3 Submission No 68. p216.

4 National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy*. AGPS Canberra. 1989. px.

1.25 In 1979, a report from the then House of Representatives Standing Committee on Aboriginal Affairs, entitled Aboriginal Health, made a range of recommendations aimed at improving Indigenous health. These included improving the living environment for Aboriginal communities, better health services and a greater involvement of Aboriginals in all stages of the provision of health care services.

1.26 Ten years later, the 1989 Report of the National Aboriginal Health Strategy Working Party described the state of Aboriginal health as the worst of any identifiable group in Australia. This report again strongly advocated Aboriginal community ownership and participation in the provision of health services, as well as promoting the importance of environmental health facilities as being vital to sustain improvements in Aboriginal health and well being.

1.27 In 1991, the Report of the Royal Commission into Aboriginal Deaths in Custody reiterated calls for greater attention to environmental health issues, greater support for the principles of self determination and for the role of Aboriginal Medical Services and for the urgent funding of the National Aboriginal Health Strategy.

1.28 In 1994 an Evaluation of the National Aboriginal Health Strategy found there had been minimal gains in Aboriginal health and that the National Aboriginal Health Strategy had never been effectively implemented.

1.29 These are a just a few of the published reports documenting the status of Indigenous health over the last twenty years. The later reports indicate that, although there have been some improvements in Indigenous health status, the overall health of Indigenous Australians continues to be poorer than that of the general population.

1.30 The Committee does not consider there would be any additional benefit in simply reiterating the recommendations from these reports, most of which are still valid. The challenge for the Committee is therefore, not to develop another series of similar recommendations, but rather, to consider why previous recommendations have not been effective and to identify barriers to achieving change.

1.31 As a first step, one of the cornerstones to achieving any progress would be for all governments to recognise there is no simple solution to the problem. The nature of the health problems experienced by the Indigenous population are not homogeneous. They vary across Australia and have been changing over time. There are also a range of complex inter-related factors which impact to varying degrees on the health of Indigenous Australians.

1.32 An effective response to those problems will require a bipartisan commitment, at all government levels, to an extended period of continued and defined funding.

1.33 To support such a long term commitment, there would also need to be mechanisms developed to report about what has been achieved, rather than about how bad things continue to be. In considering how to measure progress, the Committee believes that it is important to set realistic goals, that are achievable within the allocated timeframe, and not to set up organisations to fail.

1.34 In this regard there would seem to be certain goals which might be achieved within the short term, many of which may initially be related to process as much as to outcomes, such as the level and standard of available primary health care or functioning health hardware, and some will be generational.

1.35 There would also be a continuum of short term, medium and longer term goals that will need to be considered. It is important that the time frame required to make any progress in specific areas is built into reporting arrangements.

2

Health Service Delivery

Commonwealth, State and Territory Roles

2.1 Under current arrangements, the States and Territories are the major providers of health and related services for Indigenous Australians.

2.2 The Commonwealth has only a very small role in direct service delivery, with nearly 80 per cent of all services for Indigenous people being managed by the States and Territories.

2.3 A recent report, Expenditure on Health Services for Aboriginal and Torres Strait Islander People, estimated that in 1995-96, overall government expenditure on health services for Indigenous Australians was around $810m. Although the Commonwealth and States contributed nearly equal amounts, the Commonwealth's contribution was essentially indirect, primarily through the Medicare Agreements and other grants.

2.4 The only Commonwealth monies flowing directly into service provision are the funds it provides for the community controlled health services, which represented only 11 per cent of the total government figure in that year.

2.5 The Commonwealth also provided very little funds from its two largest health programs, Medicare (MBS) and the Pharmaceutical Benefits Scheme (PBS). The report estimated that Commonwealth funding for Indigenous health from the direct Aboriginal health service grants, MBS and PBS payments was still around $100 per person less than other Australians received from the MBS and PBS alone.

2.6 Indigenous people rely much more on publicly funded State and Territory hospital and community health services than other Australians. This pattern of usage is influenced by socioeconomic circumstances and geography. Many Indigenous people live in rural, remote or small urban areas, where private facilities are scarce. Admission to hospital is often the only affordable way of accessing specialist services and transport is a significant problem.

2.7 Additionally, much of the improvement in infant and perinatal mortality over the past twenty years has been achieved through high levels of evacuation and hospitalisation, which also contributes to the current patterns of greater hospital usage and higher costs for servicing remote communities.

2.8 The report on expenditure also found that, despite public impressions to the contrary, the amount of recurrent expenditure for all services and all sources of funds for and by Aboriginal and Torres Strait Islander people was only around eight per cent higher than that for and by other Australians.

2.9 The report did acknowledge that, because of their poor socioeconomic circumstances, health services for Aboriginal and Torres Strait Islander people are generally provided by government. However, taking into account government expenditure alone, the overall level of expenditure per person for the Aboriginal and Torres Strait Islander population is no greater than that provided by government for other Australians in similar socioeconomic circumstances.

2.10 There can be no dispute that the health of Indigenous people is much worse than the non-Indigenous population, even for those in similar socioeconomic circumstances. A higher proportion of Indigenous people also live outside the major metropolitan centres, where the costs of providing services are considerably higher.

2.11 There would consequently seem to be a reasonable argument that the level of expenditure on Aboriginal and Torres Strait Islander health identified in the above report is not excessive and would generally seem to be insufficient to meet the present level of need for health and related services.

2.12 The question of what is the appropriate level of funding is inherent in any discussions about the most appropriate way to deliver health services, but there has been no clear consensus in the information provided to the Committee on what the overall level of funding should be, or the immediate priority for any additional expenditure.

2.13 Given the key role of States and Territories, and since the Commonwealth does not play a major role in service delivery, the Commonwealth's capacity to directly influence the coordination, planning and provision of Indigenous health and related services at the moment is very limited.

2.14 The Commonwealth Department of Health and Aged Care submission points out that the Government's policy acknowledges this, noting that:

> "Improvements in the health of Aboriginal and Torres Strait Islander Australians can only be achieved with the cooperation of the State and Territory Governments."[1]

2.15 To facilitate such cooperation the Commonwealth has developed with each State and Territory a Framework Agreement which provides for:

- National and State/Territory level forums of all stakeholders to provide advice and input to the policy process;
- The introduction of joint health planning processes at the regional level which focus on improving primary health care services and reducing barriers to access;
- Improving access to mainstream services;
- Increasing the level of resources allocated to reflect the level of need; and
- Improving data collection and evaluation mechanisms.

2.16 The WA Branch of the Australian Nursing Federation however, considers that:

> "In our experience, reliance on state health authorities to translate Commonwealth strategies and programs into action does not achieve satisfactory outcomes"[2]

2.17 There are also conflicting views on whether the Framework Agreements have been effective.

2.18 In a review of the Commonwealth Aboriginal and Torres Strait Islander Health Program, in 1998 the Australian National Audit Office (ANAO), noted that:

> "The ANAO considers that the Framework Agreements are 'in principle' agreements, without any detail committing the parties to undertake specific action, provide a level of funding or achieve quantifiable outcomes within an agreed timeframe. Furthermore there is no recourse for DHAC where States and Territories do not

1 Submission No 68 p239.

2 Submission No 19 p549.

> comply with the requirements of the Agreements. The ANAO considers the value of these Agreements as being in clarifying expectations of State and Territory governments."[3]

2.19 Based on the Committee's observations, the regional planning process seems to be working well in some areas and not in others. Whether it is working seems to depend on the level of commitment by State and Territory staff to the process, and their willingness to engage all parties to the Agreements, rather than the specific content of the Agreements.

2.20 Generally, the Committee did not observe that local services, either State or community controlled, were closely involved in the mechanisms established under the Agreements. Nor did they appear to have a very good appreciation of the role of the Agreements and their own part in the process.

2.21 The Committee recognises that the Agreements have not been operating very long and that it will take some time to develop effective working relations between parties. It is also recognised that if the current structural arrangements continue then agreements of this nature are very important. The real test of the sustainability of the Agreements, will be whether additional resources are made available if the planning process identifies unmet needs above existing resources.

2.22 In the recent Budget, the Commonwealth made some additional funding available for new services in those regions where the needs have been identified through a completed planning process. It is difficult to assess the adequacy of this response, given that much of this planning is yet to be properly completed, but it is also likely a significant level of new funding would need to be provided by the States and Territories.

A Role for the Community Controlled Sector

2.23 The other key players in the delivery of health and related services for Indigenous people are the community controlled health services. These services were initially developed because the community considered mainstream services were not responding to their needs.

2.24 The National Aboriginal Community Controlled Health Organisation (NACCHO) submission to the Inquiry states that:

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3 The Auditor-General. *Audit Report No 13. The Aboriginal and Torres Strait Islander Health Program*. Australian National Audit Office. Canberra 1998. p96.

> "Aboriginal community controlled health services are primary health care services initiated by local Aboriginal communities, aiming to deliver holistic and culturally appropriate care."[4]

2.25 As indicated above, these services are primarily funded by the Commonwealth, through direct operational grants which represent about 11% of total government expenditure on Indigenous health services. Some services are also funded by the State or Territory for specific programs.

2.26 Some of the benefits NACCHO consider a properly resourced community controlled health service can deliver include:

- "significantly improved access;
- the full range of primary health care services in one place – with service delivery being integrated and holistic;
- culturally appropriate care;
- value for money as services can be better targeted because they are based on local knowledge;
- the sector represents a major source of education and training for Aboriginal people; and
- a pool of knowledge and expertise about Aboriginal health which enables the sector to not only deliver appropriate care but also to advocate effectively for Aboriginal people in health."[5]

2.27 The Committee was also impressed by the level of information that many of the community controlled services had collected, and was able to access, about the health and well-being of the population they served.

2.28 Despite the numerous reports, some of which were mentioned earlier, recommending increased levels of community involvement, the community controlled services have struggled to achieve funding support and to develop effective working relationships with mainstream services, which often see them as rivals or as duplicating services.

2.29 There are around 100 community controlled services operating around the country which primarily provide primary health care service and occasionally some limited specialist care. They rely on the State or Territory to access hospital and the broader range of specialist services.

2.30 The Framework Agreements provide for the inclusion of the community sector in joint planning arrangements, but do not really address what role that sector should play in the delivery of any new services arising from

4 Submission No 64 p174.

5 Submission No 64 p174.

those processes. The Agreements primarily relate to ways in which mainstream services need to be enhanced.

2.31 While the Committee agrees that this is an important objective, there does not seem to have been any meaningful dialogue arising from earlier reports, about how to ensure a greater level of community participation in the planning and delivery of health services. In particular, there does not appear to be any consensus about what would be the most effective and efficient mix of mainstream and community controlled services.

2.32 For such dialogue to be effective, however, there needs to be a strong community sector, which can participate in any arrangements for the planning and delivery of health services as an equal partner.

2.33 At the present time the capacity of the community controlled sector to participate is generally reliant on direct funding from government, to support bodies such as NACCHO and its State affiliates. This means that any continued role for these organisations is subject to ongoing government approval.

2.34 What should occur is for funding bodies to recognise the rights of funded organisations to professional representation, and to ensure that a component of all grants provides adequately for the costs of such representation. The organisations themselves could then fund their own representative bodies at an appropriate level, which would no longer be dependent on direct government support.

2.35 This would also need to be matched by a recognition of the legitimate role of those bodies to participate equally in any decision processes.

Other Funding Issues

2.36 For many non-Indigenous people, the MBS and PBS programs play a key role in facilitating access to appropriate primary care services. However, this is not the case for people, particularly Indigenous people, in those States and the Northern Territory, where a high proportion of the population live in rural or remote areas.

2.37 Rural and remote areas have difficulty attracting and sustaining private medical providers and the States and Territory argue they are then left with the cost of providing such services through the hospital or community health programs. As such, States with a high urban population receive a greater benefit from Commonwealth funding.

2.38 Even where there are private general practitioners in some of these areas, often they do not bulk bill. The local community controlled health service

is then left to address the needs of both the Indigenous population as well as many of the poorer non-Indigenous people from the area, using a funding base which does not necessarily allow for those additional patients.

2.39 The per capita MBS payments in the NT in 1997-98 was $169.74, compared to $291.80 in WA, $366.87 in NSW and $337.77 nationally.

2.40 Even for those States with a high rural/remote population the figures will be weighted by the larger population centres. Given the isolation of many Indigenous communities, and the very limited use they make of the MBS, it would not be unreasonable to assume that the per capita MBS amount is almost negligible for those areas.

2.41 However, a recent report undertaken by consultants for the Health Insurance Commission found that:

> "..given the current conditions existing within Aboriginal and Torres Strait Islander communities, the Medicare system cannot of itself be expected to serve as an adequate funding mechanism for health care for Aboriginal and Torres Strait Islander peoples unless Medicare were to be radically altered."[6]

2.42 There may therefore be a need to consider alternative arrangements to address this problem, such as cashing out a nominal figure and then directing the funds through more specific grants, possibly in the manner that is currently being tested through the Coordinated Care Trials.

2.43 Any such arrangement would need to ensure that an adequate level of funding is assumed at the start and that appropriate mechanisms are incorporated to allow for population characteristics and growth, co-morbidity, remoteness, cost increases, etc.

General Observations

2.44 As discussed above, Commonwealth funding for Indigenous health services is provided through specific operational grants, general Medicare grants to the States and through the MBS and PBS.

2.45 At the State and Territory level, funding is also delivered through a number of different mechanisms including direct grants, specific programs and general mainstream services.

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6 Keys Young. *Report to the Health Insurance Commission on Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceutical Benefits Scheme.* Sydney 1997. pi.

2.46 However, the majority of funding for Indigenous health services is not specifically targeted. It simply represents that proportion of the general health budget used by Indigenous people. For instance, hospitals are provided with an overall budget, a proportion of which at the end of the period will have been used for services to Indigenous people.

2.47 In addition, Commonwealth, State and Territory health programs are generally inflexible and vertical in nature, relating to identifiable risk factors, specific activities or diseases etc. This is at odds with the nature of Indigenous health problems, which are not limited to a single body part or illness and require a more holistic, or cross program, approach.

2.48 The inflexibility of program guidelines and reporting requirements can also act as a barrier to innovative solutions at the community level. The Committee was advised of one instance in a remote rural community where, in the course of its normal program activities, a bus provided for a youth program had also been able to assist the elderly people living out of town to come and do their shopping and to get children from those areas into school. However, due to difficulties with the youth program funding arrangements the bus was sitting idle and the old people were not able to access proper foods, or the children to attend school on a regular basis, even though the health service would have been happy to supply a driver to complete these tasks.

2.49 Many Commonwealth and State programs are also reviewed or revised every few years, meaning that services are constantly justifying existing expenditure, or arguing for continuation of funding.

2.50 The outcome of these piecemeal funding arrangements is fragmented policy and programs across the States, Territories and the Commonwealth, which do not reflect any sort of consistent policy approach.

2.51 The Committee recognises that neither Indigenous communities nor Indigenous health problems are homogeneous, but there should be some way to bring together what is happening at the different levels of the health system as part of a broader national policy or plan.

2.52 Such an approach may be able to take into account the quantum of funds available for health services, including some additional Commonwealth funding to allow for MBS/PBS shortfalls, and better direct the development of programs to target the differing health needs of urban, rural and remote Aboriginal communities.

2.53 It would need to incorporate a key role for the community controlled sector, both in terms of delivery of comprehensive primary health care services and in the development and monitoring of the national plan.

2.54 Any approach to changing the way services are funded or delivered would also need to focus more on outcomes, rather than on the amounts being spent, or where they are spent.

2.55 A set of national performance indicators has been developed by Australian Health Ministers, but there are almost 60 of these indicators, many of which are not yet able to be fully reported against by most jurisdictions. Development of these indicators is continuing and the Committee supports the use of such national indicators, but considers there should be a smaller set of outcomes against which all jurisdictions have to report.

2.56 Despite the number of indicators there is only one effective indicator relating to community involvement and this would need to be addressed, even in a more simplified set of indicators. It might be useful if the community sector itself was able to report to Ministers on the performance of the health authorities in this regard.

Possible Directions

2.57 There are clearly a range of possible actions that could be considered to address these issues, ranging from support for existing arrangements to a complete change in the way Indigenous health services are funded and delivered.

A. Support for the existing arrangements

2.58 Any alteration to existing funding and delivery arrangements would represent a radical change.

2.59 In addition, the Commonwealth, States and Territories are currently making an effort to work together and to focus on improving outcomes, and a radical overhaul at this stage may simply be counterproductive.

2.60 Nevertheless, there are some actions that could be considered to improve existing arrangements, including:

- Improving the scope of the present Framework Agreements, to better define a more appropriate level of community involvement and to better identify the level of overall funding which will be available across all programs for Indigenous health services;
- Developing a national Indigenous health plan, which would encompass State and Regional planning and link continuing or additional Commonwealth funding to associated outcomes, based on a more

focussed set of performance indicators. The implementation of this plan could be overseen by Health Ministers or a joint Ministerial Committee;

- Addressing the most appropriate mechanisms for distribution of Commonwealth funding including the possible cashing out of nominal MBS / PBS entitlements; and
- Adopting a bipartisan approach to funding which has a longer time frame (ten to fifteen years or more), recognising it will take some time to effect any major changes in health outcomes and to ensure there is some degree of certainty about program planning and delivery.

B. States to assume responsibility

2.61 Alternatively, the Commonwealth could pass all responsibility for direct funding of services to the States and Territories, and concentrate on improving mechanisms to monitor State and Territory efforts, particularly in improving health outcomes.

2.62 The advantage of this approach is that it simplifies funding to some extent, and allows the States and Territories to approach Indigenous health at the local level in a more integrated manner.

2.63 Although there is no guarantee that States and Territories would necessarily direct funding to either the existing community controlled services or to Indigenous primary care services, the loss of national focus and involvement could be compensated by increased attention to outcome reporting.

2.64 The continuing problems with the cultural acceptability of mainstream services could also be monitored through improved outcome reporting.

2.65 However, given the degree of difficulty the community controlled services have experienced in accessing State funding and in gaining acceptance from mainstream providers, it may be that such an approach would ultimately lead to the disenfranchising of the community controlled sector.

2.66 It would also increase difficulties in achieving common service and professional standards across States and may further exacerbate problems experienced by people living on or near the State and Territory borders.

C. Commonwealth assumes responsibility

2.67 The Commonwealth could also assume responsibility for all primary health care services and fund these directly.

2.68 This would have the advantage of allowing a national approach to primary health care but may increase the incentives for cost shifting from the States and Territories.

2.69 It could however, allow the Commonwealth to develop, and consistently implement, minimum standards for the delivery of comprehensive primary health care services, based on the type and health needs of the community involved. These could relate to the scope of services provided, staffing and equipment levels, staff accommodation, clinic structures, patient transport, professional education, etc.

2.70 There may be difficulties involved with ensuring there are continuing and effective working relationships with the hospital and specialist services which would still need to be provided by the States and Territories.

D. A new approach

2.71 An alternative to any of these approaches would be to have an arrangement based on pooling all funds currently allocated to Indigenous health by the Commonwealth, States and Territories.

2.72 To avoid any Commonwealth / State conflict, it would then be necessary to establish a separate agency, at arms length from all parties, which would determine where the funds are to be allocated and be responsible for monitoring expenditure and outcomes.

2.73 This body could also be responsible for developing appropriate standards and would need to involve a high degree of community participation.

2.74 Such a body would require bipartisan support and a long term guarantee of operation. Support from the States and Territories would also be necessary and this may be very difficult because, as indicated above, much of the State funding is intricately tied to mainstream services, such as hospitals.

2.75 If this proved too difficult, it may be still be possible to pursue such an approach, but with funds remaining with the relevant authorities. The agency would simply be responsible for advising what the appropriate level of funding should be, based on concepts of identified need, standards and equity, and on the proportions of funding which would be the responsibility of each jurisdiction.

3

Health Workforce Issues

General Issues

3.1 Improved levels of primary and secondary health care will not alone resolve the problems in Indigenous health, but are essential. Another key factor in the successful delivery of any health care program is adequate staff, both in terms of numbers and skills.

3.2 Staff associated with the delivery of Indigenous health programs include Aboriginal health workers, nurses, general practitioners, specialists, dentists, other allied health professionals and administrators.

3.3 The majority of evidence to the Committee has supported the need for improved training of the non-Indigenous health workforce, in order to ensure that mainstream services can become more responsive to the needs of the Indigenous population.

3.4 The advantage of this approach is that not only do people become more responsive in the delivery of existing programs but are also able to use their understanding in developing new programs, in conjunction with the community, to better meet Indigenous health needs.

3.5 There was also considerable evidence that there are difficulties associated with the recruitment, training and ongoing support provided for all these staff, and that there are inadequate numbers of Indigenous people training to become health workers and health professionals.

3.6 Factors discussed in terms of the difficulties in recruiting and retaining staff included the lack of professional support available in rural and remote areas, inadequate remuneration, lack of appropriate housing in remote areas, lack of family support and lack of cultural knowledge.

3.7 The issues of remuneration cannot be considered in isolation from other funding matters and need to be addressed as part of the overall determination of funding levels required for the delivery of adequate health services to the Indigenous population. However, the allocation of funding for the delivery of adequate health services should include realistic allowances for an appropriate staffing structure.

3.8 The Committee also believes that this funding should be based on a predetermined minimum level of staffing to ensure that appropriate professional and other support is available.

3.9 In some clinics the Committee visited there was only one nurse assigned to the clinic, who was then expected to be on call 24 hours a day. This is obviously unsustainable in the long run, leading to significant staff turnover that might be alleviated by providing sufficient funding for two nurses and adequate relief arrangements.

3.10 A key factor in some of the more successful clinics visited by the Committee would seem to be stability of staffing. In those areas where people had been able to remain for a number of years there was considerably more community acceptance and participation than in those areas where staff changed every six months.

3.11 The Committee recognises that the appropriate level of staff cannot be arbitrarily determined across the board, as it will depend on the nature of the service. For instance the staffing arrangements for clinics associated with a regional medical service, with regular staff rotations, doctors working on a weekly visiting basis and other support arrangements, may be entirely different to a stand alone clinic.

3.12 However, allowances need to be built into funding formulas which take into account a viable staffing structure irrespective of the nature of the service delivery arrangements.

3.13 A major concern expressed to the Committee in terms of recruiting and retaining good staff was the need for appropriate staff housing. In many communities staff are expected to live in small and/or makeshift type accommodation, because the limited funding available to the health system is focussed on service delivery. This is despite the provision of housing in the same community by other government agencies, such as Education, for their staff.

3.14 The Commonwealth has provided some funding for housing of staff employed by community controlled services in remote areas, primarily doctors, but this has been on a fairly ad hoc basis. There would appear to be no systematic program directed at providing housing for all health staff, and the Committee considers that staff housing should be a primary component of any health service funding arrangements.

3.15 In terms of cultural awareness some staff have advised that a lack of understanding about what is required when working in Indigenous health services, and what might be expected in terms of working and living conditions makes people reluctant to apply for such positions. The gap between expectations and reality often also means that staff do not stay in the jobs for very long.

Training Issues

3.16 The lack of exposure to cross-cultural training and to the nature of health problems and service delivery arrangements in Indigenous communities appears to be a fairly common problem in the training of most health professionals.

3.17 The Committee recognises that many health professionals will never work in the area of Indigenous health and that there is an ever increasing number of complex areas for students to cover in the course of their training.

3.18 The Committee also recognises that many of the health and medical schools have already identified this shortcoming and are making efforts to address the issue.

3.19 Nevertheless there would still seem to be a need for further efforts in this area, and a greater emphasis on the health and cultural needs of Indigenous patients at all levels of training, including specialist training. This could include funding support for the placement of trainees with the community controlled medical services, for first hand exposure to cross-cultural service delivery.

3.20 Additionally there would seem to be a good argument for developing a program to allow new staff, particularly doctors, to receive area/culture specific orientation from the local Indigenous health service before commencement of any placement in the health services of a particular region.

3.21 It has also been suggested that a vertically integrated system for the recruitment, education and training of rural and remote health

professionals should be developed, based on the collaboration of governments and training institutions.

Doctors

3.22 Difficulties identified in relation to the role of doctors specifically in Indigenous health related to the capacity of doctors to provide culturally sensitive services and the difficulties in recruiting and retaining doctors in remote and rural areas.

3.23 As indicated above, the difficulties associated with capacity to provide culturally sensitive services are reasonably common to all the health professions. The focus in the past on selecting medical students solely on the basis of academic performance has also made it difficult for people who may be committed to Indigenous health, but who do not have a sufficiently high final result, to gain access to the medical profession.

3.24 Medical schools, such as that at Newcastle University, have recognised this and are now selecting students on the basis of much broader criteria.

3.25 The nature of medical practice in Indigenous health is also different from general medicine and doctors will often see conditions or health problems that are not generally prevalent in the non-Indigenous population. This is true, to varying degrees, for practice in rural, remote or urban areas.

3.26 The Committee has been told that doctors are reluctant to commit time to practice in Indigenous health because of the professional isolation and the lack of recognition of the value of this work for future career advancement. To offset this it may be appropriate for this type of work to entail more specialised training and greater professional status, possibly even through the creation of a new specialty in Indigenous health.

3.27 The Commonwealth has been progressively introducing programs and new arrangements to support doctors in rural and remote areas, including Departments of Rural Health, Divisions of General Practice and the Rural Incentives Program.

3.28 However, there are problems in attracting all professionals to rural and remote areas and it may be that as well as greater professional recognition and additional financial support, doctors need to be supported as a more generic resource, applicable to a region, rather than just one area.

3.29 This could include a concomitant increase in nurses and nurse practitioners and Aboriginal Health Workers in the area to provide day to day support for the local communities, with the doctor, or preferably

doctors, living in a more central location and providing support through telemedicine as well as regular scheduled and emergency visits.

3.30 It has also been suggested that there would need to be practical and legal recognition of nurse practitioners, as a means of increasing the capacity of remote services to deal with a greater range of issues when no doctors are available. The NSW Government has made some moves in this direction and it would seem necessary for any such arrangements to be applied consistently across all jurisdictions if any changes are to be made in the way Indigenous health services are delivered.

Aboriginal Health Workers

3.31 Aboriginal Health Workers (AHWs) play a variety of essential roles in the delivery of services for Indigenous people in a broad range of services and locations.

3.32 The major issue relating to AHWs raised with the Committee was the lack of a common approach to AHW education and training, status, registration, career and award structures and professional recognition.

3.33 Under the current arrangements there is no consensus on the role of AHWs, which can vary considerably between States and even between types of services within a State. As the submission from the WA Branch of the Australian Nursing Federation notes:

> "There is no question that indigenous health workers have made significant contributions to the health of their communities. The fact however remains that such workers do not receive consistent education programs across the country nor, in spite of the nature of their work is their practice regulated by registration in more than one jurisdiction."[1]

3.34 The Menzies School of Health Research submission pointed out that AHWs are:

> "currently trained to act as cultural brokers, to provide first aid and early management of common conditions and to recognise many health problems that are immediately life threatening. AHW do not have the skills of more highly trained professionals; generally they are not trained to deal with chronic conditions that

1 Submission No 19 p550.

> have serious long-term implications for health, nor to implement preventative programs."[2]

3.35 At a National Aboriginal and Torres Strait Islander Health Workers' Conference in 1997 AHWs also highlighted similar concerns, including:

- Working conditions, including a lack of uniform pay rates and awards, professional recognition and education and training;
- Lack of input into allocation of funds / budgets directed specifically towards Indigenous health;
- The lack of clear definition and role for AHWs; and
- The tension between community expectations of what services AHWs should be providing and the limitations imposed on them by their employers, their colleagues and a general lack of resources.

3.36 Strategies to develop a common approach to the role and treatment of AHWs need to be developed, including the development of a national framework for the training and registration of health workers, linked to appropriate accreditation that will be recognisable and portable.

3.37 In doing so, however, there would need to be some way to recognise regional variations and they would have to be developed in conjunction with the service providers and the community.

3.38 Some efforts have already been made to develop national competencies for AHWs but, as the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) indicated in their submission:

> "AMSANT made a substantial contribution to the debate over health worker competencies only to be frustrated as a national standard was established which does not suit the needs of the Northern Territory"[3]

3.39 There have also been criticisms conveyed to the Committee of the move to institutional based training for AHWs, which does not recognise some of the cultural and educational limitations associated with recruiting and training AHWs for community acceptance.

3.40 Institution based training has been said to take students reluctantly away from their community and they may not return after they complete their training. Conversely they sometimes find it difficult to spend too much time away from home and return before completing their training.

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2 Submission No 39 p651.

3 Submission no 63 p721.

3.41 Another criticism is that the students who might be able to qualify academically for institutional type training may not necessarily be the person the community would choose for that role in a cultural sense. This may then reduce their effectiveness.

3.42 There is limited support at the moment for on the job training of AHWs. Some of the community controlled health services have attempted to develop AHW training with mixed success. They have been able to train a limited number of effective AHWs but have struggled to gain support from the education sector, which has primary responsibility for training.

3.43 Recent changes to educational funding arrangements have meant that there is more scope for such alternative training arrangements, but the organisations have advised that this has also been offset to some extent by a reduction in the additional support that was previously available to Indigenous students under Abstudy.

3.44 Consideration should be given to providing more support to on the job training for AHWs through the community controlled health services and through mainstream services, linked to appropriate funding and support from the education sector. There may also need to be increased financial and other support to ensure Indigenous students in remote areas can participate and are retained.

Indigenous Health Professionals

3.45 It has been suggested that a priority in the area of medical education should be to develop a national training strategy to bring the level of health professionals from the Indigenous population in all disciplines up to the same level as the non-Indigenous population within 15 years.

3.46 To meet this objective it has been proposed that what is needed is a program to identify likely students late in primary school, or early in high school, and to provide funding and other support, including cultural support to encourage these students to continue their training.

3.47 The Committee would support this view but notes that it is necessarily a long term objective that will need to be pursued in conjunction with other initiatives.

3.48 It may also be more effective if training schools are located closer to where the students live.

3.49 Where the Committee would see considerable benefit is in an immediate focus on increasing the skills of existing Indigenous health administrators

as well as increasing the overall numbers of such administrators as quickly as possible.

3.50 The development and delivery of community controlled and / or culturally appropriate services relies heavily on the skills of the service administrators, many of whom have had to learn on the job and have little formal qualifications.

3.51 This is not necessarily a drawback but can sometimes leave them at a disadvantage in dealing with the non-Indigenous bureaucracy, particularly in relation to applying and accounting for the use of funding.

3.52 Additionally, the numbers of skilled administrators is limited. This means that they have little time for further skills development and that most of the responsibility falls to them, again resulting in high staff turnovers and burnout.

4

Environmental Health

Health Hardware

4.1 As noted earlier, there have been numerous reports supporting the need to take into account both the levels of health service provision and the living environment, when considering Indigenous health issues.

4.2 In 1979, the House of Representatives Standing Committee on Aboriginal Affairs noted that:

> "It is universally accepted that the attainment of a satisfactory standard of health in any community depends on the provision of certain basic amenities"[1]

4.3 It has also been suggested that improving the level of infrastructure for Indigenous communities will have a greater long term health benefit than providing more health services.

4.4 The Committee supports the need for improved infrastructure as a priority, and believes that such improvements are necessary for sustained improvements in health outcomes.

4.5 The Committee also believes, however, that this is a complex issue. As indicated in the second Chapter, health problems and community needs

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1 House of Representatives Standing Committee on Aboriginal Affairs. *Aboriginal Health.* AGPS. Canberra. 1979. p37.

vary considerably across the country. Improvements in health status will not only require improvements in infrastructure, but also in the areas of health service delivery, education, training and employment.

4.6 In 1991, ATSIC undertook a national survey of the community housing and infrastructure needs of rural and remote communities, which estimated at that time the cost of providing housing ($1088m), repairing houses ($280m), upgrading internal roads ($155m) and access roads ($192m) would total $1716m nationally.

4.7 The costs of upgrading other infrastructure (such as water, electricity and sewerage) was not estimated, although some estimates were made of the availability of these services in the surveyed communities.

4.8 The difficulty with surveys such as this is that they present a problem of such magnitude it seems insurmountable and makes it difficult to focus on a realistic approach to addressing the problems within existing delivery structures and financing arrangements. The general result is that any response, no matter what amounts are involved, is likely to seem inadequate and be seen as a failure.

4.9 In 1987 Nganampa Health Council in South Australia developed an environmental health review, Uwankara Palyanku Kanyintjaku (UPK) which identified nine healthy living practices important to improving health status:

- Washing people;
- Washing clothes and bedding;
- Removing waste;
- Improving nutrition;
- Reducing crowding;
- Separating dogs and children;
- Controlling dust;
- Temperature control; and
- Reducing trauma.

4.10 These are simple objectives which can be largely managed at the local level, but which require a focus on making sure that existing hardware is working and that any new hardware is robust and can be easily maintained.

4.11 Implementation of this approach in conjunction with long term programs to meet the backlog of needs would provide a better basis for a more effective use of existing and future resources.

4.12 A systematic review of the existing infrastructure would still be required, to see what is working and what is not, but unlike previous surveys it should not simply define the size of the problem, but would need to be linked to progressive funding to deal with problems as they are identified.

4.13 An important corollary is that if health hardware is made to work then there must be continuing programs funded to keep it in good working order. It is not simply a matter of identifying and fixing the immediate problem. Taps need to keep working, toilets keep flushing, roads remain sealed, houses in good order, etc.

4.14 Mechanisms would also need to be developed to ensure that any funding for maintenance is used for that purpose. The Committee was advised of occasions were maintenance funds had been provided, but because they had not been spent by the end of the financial year, they were used for other purposes. This sometimes results from funding arrangements which dictate unexpended funds must be returned, even though there may be legitimate reasons that the funds were not used in time.

4.15 A key to ensuring that the health hardware is working, and continues to do so is the development of appropriate housing guidelines and adequate maintenance and inspection during the construction of housing. This has not always been the case to date.

4.16 As Indigenous services are often located on Crown land, local building requirements are not always applicable or enforceable. There should be a common set of standards applicable to all community infrastructure, which makes allowances for regional variations in design and construction requirements. The use of these standards should be a condition for all building contracts, and there should be appropriate sanctions, linked to regular progress inspections by appropriately trained staff, if the standards are not met.

4.17 To support any ongoing maintenance program there must also be a pool of skilled community members able to undertake the repair and maintenance work. These workers need to be appropriately trained and remunerated to make sure that the community values their day to day work.

4.18 The two primary factors in achieving these healthy living practices would be adequate water supplies and appropriate housing. Arrangements for

the provision of these services, however, vary between States and Territories and even between communities.

Water

4.19 Water is vital to achieving any sustained improvements in health outcomes and in providing people with the capacity to take responsibility for their own health. Clean water has to be able to get into the house and yard and waste water, including sewerage, needs to be able to drain away safely.

4.20 Nevertheless the above mentioned ATSIC study found that in some 34% of communities surveyed, the water supply did not meet the National Health and Medical Research Council's (NHMRC) standards. Additionally only 38% of communities had a qualified person doing regular water testing.

4.21 In this regard, the Committee also found that if water supplies in remote communities were tested by the relevant authorities it was mostly for micro-biological contaminants. Testing for other factors, such as mineral or chemical content, which can also have detrimental effects on health, was irregular and ad hoc. This was often a matter of expediency as there are no easy remedies for such problems, and there are no other sources of water available for these communities. Even where the water was tested regularly the community was often not informed about test findings.

4.22 Water services for Indigenous communities are generally funded by the Commonwealth (ATSIC), or State, Territory and local government.

Housing

4.23 An evaluation of ATSIC's Health Infrastructure priorities program in 1999, reported that:

> "The housing situation in the Indigenous population has improved a little from 1991 to 1996 with less crowding in Indigenous households, and a lesser proportion living in improvised dwellings. The improvement is greater in rural areas than in urban areas, indicating there has been a positive and real impact of the governmental funding focus on housing in rural and remote Indigenous communities. However, although rural

> dwellers continue to need more assistance with housing than their urban counterparts, this evaluation finds there is also a need to provide more assistance to urban dwellers who suffered much more from the reduction in access to State government housing from 1991 to 1996 without the compensation of increased access to community housing available to their rural counterparts." [2]

4.24 There are two Commonwealth funding channels for housing. Through ATSIC and through the Commonwealth State Housing Agreements (CSHA). The CSHA involves the Commonwealth providing funding, which is matched by State and Territory governments under the Aboriginal Rental Housing Program (ARHP), to provide housing but not other infrastructure.

4.25 To improve service planning and delivery and achieve better outcomes the Commonwealth, States and Territories have also been developing Bilateral Agreements in the area of Indigenous housing.

4.26 Under these new arrangements there is a pooling of the dedicated housing funds from ATSIC, the State/Territory share of the ARHP and an additional contribution from the States and Territories. The Agreements then require these funds to be channelled through a newly established Indigenous Housing Authority in each State and Territory, with responsibilities that include:

- Making decisions on Indigenous housing matters;
- Coordinating all Indigenous specific housing funds; and
- Determining responsibility for program management of the joint ARHP and ATSIC funds in each State and Territory.

4.27 This approach is similar to that suggested in the second Chapter as a new approach for the delivery of health services, but it does not encompass all funding allocated to Indigenous housing, only the specifically mentioned programs.

4.28 The Australian National Audit Office has estimated that total government spending on Indigenous housing in 1997-98 was in the order of $250m.

4.29 If annual spending were to be sustained at this level for 10 to 15 years in a systematic program it would go a long way toward addressing the outstanding Indigenous housing needs.

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2 Office of Evaluation and Audit. *Evaluation of the Health Infrastructure Priority Projects Program*. ATSIC. Canberra. 1999. p2.

4.30 Again, this would require long term commitment and assurances and, given the funding involved is both multi-program and multi-jurisdictional, would present a continuing challenge to governments.

4.31 To be effective in meeting the backlog, funds also need to be appropriately apportioned between providing new stock and maintaining existing stock, to ensure that new stock is simply not just replacing old non-viable stock. The focus on capital replacement would decrease significantly over time as the amount of viable stock increased.

4.32 A condition of capital funding under most housing programs is generally that the funded organisations collect rent and maintain the houses. A study by the NT, however, found that many organisations had never been resourced or trained for this purpose.

4.33 Additionally, communities often do not have the resources to pay a costly rent, particularly in view of their low income and the high cost structure in remote areas, and consequently maintenance suffers. It would appear that, at least for some time, there should be an acceptance that the low socio-economic status of Indigenous communities will prevent an effective rental contribution.

4.34 A different approach may be to ensure that sufficient funding for maintenance of key health hardware in the houses is incorporated as part of the overall funding, and that any rent collections are then used for non-urgent maintenance.

4.35 A further complicating factor in maintaining the housing stock is that, because housing is generally in short supply, the ongoing viability of housing is often compromised by the large numbers of people who have to live in those houses. In some communities visited by the Committee it was not uncommon for fifteen to twenty people, and sometimes more, to be living in a basic three bedroom house.

4.36 This overcrowding, often coupled with a lack of knowledge about the proper use and maintenance of facilities, places particular pressure on water, cooking and sewerage systems. It will take some considerable time to address the backlog of need to alleviate the housing shortfall in the short term. Thought would also need to be given to funding houses that are designed to meet the needs of much larger groups of people than would be expected in a normal house of the same size in a non-Indigenous community.

4.37 This may in fact involve a higher unit cost but result in a better long term return if the houses and fittings are able to be sustained for longer periods.

4.38 Another factor which affects the usage of housing in Indigenous communities relates to cultural requirements to vacate a house following the death of a family member. By the time people are able to return to the house it is often no longer habitable, through neglect and / or vandalism.

4.39 Issues related to appropriate design and other cultural factors require close consultation with the community as part of the development of greater community control and ownership.

Other Services

4.40 Another critical health infrastructure issue is the provision and maintenance of roads, both internal roads and access roads to other centres.

4.41 The Committee found that the standard of internal roads in most of the areas visited, both rural and remote was generally poor, particularly in those communities subject to seasonal rains. Most remote communities have a predominance of dirt roads, creating major dust problems and contributing to eye conditions, respiratory problems and skin disorders.

4.42 Occasionally the primary road, or roads, was sealed, but even these few sealed roads were invariably in a poor state of repair.

4.43 In addition, the roads linking the communities to larger population centres were also generally in poor condition and badly maintained, making it difficult to maintain a regular supply service or for medical evacuations, which then had to be undertaken by air at a much greater cost.

4.44 Although the air strips had to assume more importance, because of the state of the roads, many of these were also in poor condition and / or very badly located. In one remote community visited by the Committee the roads were very bad, but the airstrip was unable to be used for night evacuations because of its proximity to nearby hills.

4.45 Responsibility for maintenance of the internal roads generally rests with the local community or council. Their ability to do this properly is limited by funding availability, lack of access to appropriate equipment and few trained people. Funding for this purpose is generally provided through ATSIC or the State / Territory Government.

4.46 Responsibility for access roads generally rests with the State / Territory government, or in some instances, local government.

4.47 Responsibility for air strips is unclear and generally falls to ATSIC or the local community, in the absence of any commitment from other levels of government. For some coastal communities, the provision and maintenance of barge landing sites is also a major area where funding responsibility is not clear.

Observations

Funding and Service Delivery Issues

4.48 Funding for infrastructure, like health, is provided through a range of Commonwealth, State, Territory and local government programs. Unlike health, however, where funding is generally provided through the health portfolios, there are numerous authorities and programs involved for each component of infrastructure services.

4.49 A significant proportion of State or Territory funding for Indigenous infrastructure services comes from either the general Financial Assistance Grants (FAGs) distributed by the Commonwealth, or from revenues raised directly by that State or Territory.

4.50 The Commonwealth Grants Commission (CGC) makes allowance for the additional costs associated with the provision of services in remote areas and in relation to the State/Territory Indigenous population, in determining the distribution of FAGs, but the process does not necessarily require the expenditure of any of the transferred funds for those purposes.

4.51 Even with the introduction of new tax arrangements, there will still be a need for the CGC to apply fiscal and vertical equalisation measures for the distribution of tax revenue.

4.52 A common criticism made to the Committee about the performance of the States and Territories, and even local government, was that all levels of government receive funds from the Commonwealth based on the needs of their Indigenous population, but then do not seem to spend the money on services for those people.

4.53 There would consequently appear to be a need to introduce some degree of transparency about the funds that are distributed on the basis of disability factors associated with the Indigenous or remote populations.

4.54 The way services are delivered through multiple agencies at the Commonwealth, State, Territory and local levels would also appear to

prevent an efficient and coordinated approach to the provision of infrastructure services.

4.55 Some States and Territories are already attempting to address this need for improved coordination. The housing Bilateral Agreements are a positive step in the housing area and Western Australia has developed what it calls the environmental health needs coordinating group which is:

> " a group that is comprised of all the principal Commonwealth and State agencies involved in the delivery of environmental programs to Aboriginal communities, including on the state side, the State Housing Commission, Homeswest, the Health Department of Western Australia, the Aboriginal Affairs Department and others"[3]

4.56 This group has undertaken a single Western Australian Aboriginal environmental health needs survey as a basis for all agencies to prioritise their own programs and to work out how they should work in collaboration with other agencies across Western Australia.

4.57 The Committee considers that for this approach to work effectively, funding should be linked to the achievement of specific overall objectives, related to the communities needs, rather than being determined on an agency basis, and then allocated according to the agency's views of the priority areas in that portfolio.

Training Issues

4.58 Development of effective infrastructure management is also a community development issue and as such is necessarily time consuming and limited to a small pool of skilled people. Efforts need to be targeted at increasing the pool of people who can manage these programs, as well as a pool of people able to undertake maintenance.

4.59 It has been suggested that to increase training opportunities, approval of infrastructure projects should be based on incorporating some aspect of local training, but this can present difficulties.

4.60 Trade qualifications require a number of years training which cannot be sustained by intermittent short term projects. Additionally, the infrastructure needs of many communities are longstanding and immediate, and they have difficulties balancing the opportunity of getting badly required facilities against a longer term training benefit.

3 Evidence. p228

4.61 Training needs to be treated as a separate and important issue that might be linked on occasion to specific projects, but is not dependent on those projects.

4.62 A possible solution to this may be a national training program about maintenance skills that is not at the trade level, but which is formal and accredited and could be extended with subsequent training to trade qualifications. Existing trade programs should continue to be supported and expanded where possible.

4.63 The Army has also been involved in some remote communities in the provision of infrastructure services. This program appears to have had some benefits and the communities visited by the Committee that had been involved were generally very supportive of the work of the Army. The Army has provided upgraded facilities as well as some health assistance to clinics along with some degree of training in ongoing maintenance.

4.64 It may be that this program is not viable in the long term, given the Army's normal role and responsibilities, and that it may be difficult for the Army to commit five years or more into the future. However, the concept of targeting priority areas with a concerted but planned attack, based on community consultation, may be worth further consideration.

Possible Directions

4.65 The key to improving the overall level of infrastructure in Indigenous communities, particularly housing, would again seem to be some mechanism to guarantee long term funding.

4.66 Secondary to this would be the need to develop an across portfolio approach, which pooled the available funds, from all levels of government and then allowed the community to focus on developing a prioritised program of upgrade and maintenance, as well as linking to a separate training program.

4.67 Priority also needs to be given to ensuring that health hardware is repaired and maintained and that the provision of infrastructure focuses on achieving healthy living practices.

4.68 An interim step would be to develop a portfolio by portfolio approach, similar to that being undertaken through the Bilateral Agreements on housing.

4.69 A further key to the success of any new initiatives would appear to be greater local involvement in the design, construction and maintenance of housing and other infrastructure, to increase the sense of ownership of those facilities.

4.70 This could be associated with the development of a more appropriate role for environmental health workers, based on improving their skills, remuneration and status within the community. It may be appropriate to consider linking the environmental health workers to the health sector rather than the council. This may improve their career structure as well as creating a closer link in people's minds between their work and health outcomes.

4.71 In terms of transparency of funding, a recent amendment to the CGC Act has provided for the CGC to develop measures of relative disadvantage that could be used to target resources for Indigenous communities more effectively to the areas of greatest need.

4.72 This will only generally apply to Commonwealth programs at this stage, but it may be that the CGC should extend this process to encompass the development of a general measure of disadvantage which can be used as the basis for further fiscal and vertical equalisation.

4.73 States and Territories might then be required to report on the usage of funds for this purpose and outcomes in meeting communities' needs.

5

Other Barriers to Good Health

5.1 In addition to the need for a safe and healthy living environment and adequate health care services there are a number of other factors noted by the Committee that require attention before any long term improvements in health and well being will be achieved for Indigenous people.

5.2 These include:

- Improved diet;
- Access to adequate transport; and
- More culturally responsive services.

Nutrition

5.3 The move from traditional lifestyles to fixed settlements and a more sedentary lifestyle, coupled with poor diet, has contributed significantly to the poor health of the Indigenous population.

5.4 The problems associated with low birth-weights, childhood malnutrition and other infections in infancy has already been discussed. The prevalence of diets high in sugar, salt and fats then persist right throughout adulthood for most Indigenous people.

5.5 These factors are thought to contribute at least in part to the rising levels of non-insulin dependent diabetes in Indigenous communities.

5.6 However, accessing good healthy foods is not straightforward. The low incomes of most of the Indigenous population means that a significant proportion of any budget must be spent on the necessities of life, ie. food, shelter and clothing.

5.7 As a consequence, people tend to try and buy food which is cheap and filling, rather than healthy and nutritious.

5.8 Many people also live in rural and remote areas where the costs of transporting food and other goods is generally very high, primarily because of the distances involved, and because there is no effective competition for delivery of services. The high costs of transport and the state of the roads also means that in many instances delivery of supplies is only undertaken on a weekly or fortnightly basis, which makes it difficult to maintain a stock of good quality fresh fruit, vegetables and meats.

5.9 Some communities have attempted to resolve the cost issue by cross subsidising healthy food with other less-essential store items. The disadvantage of this is that people may not buy any other items, making the store financially unviable in the long run.

5.10 It would therefore appear that there is a necessity to address this issue from both a demand and a supply side.

5.11 On the supply side there may be scope to apply some form of freight equalisation, similar to that applying in Tasmania, for remote Indigenous communities. The challenge would be to ensure that the benefit of the subsidy was passed through to the consumer and did not simply further enrich the freight companies.

5.12 On the demand side there is a need for more community initiatives, linked to the health service, to educate people about the benefits of healthy food and about how to identify and to prepare such food. There were a number of valuable initiatives being instituted in the communities visited by the Committee.

5.13 In one instance, the local women had developed a recipe book, using as the ingredients the types of healthy food that were generally on special in the store. In another instance, the store had developed a colour coded system to indicate healthy food.

5.14 A number of stores were also involved in providing some form of meal for school children, but this was out of store profits, which then meant that the overall costs of food was kept high.

5.15 A balance between store profitability and healthy shopping is difficult to maintain, particularly in communities which have had little experience in making such decisions. In general these communities rely heavily on non-

Indigenous store managers, yet there is no requirement for such managers to have any formal qualifications or understanding of health issues.

5.16 As well as addressing the costs and demand issues a national process for registration and accreditation of store managers, such as that suggested earlier for Aboriginal Health Workers, should be considered.

5.17 Although the supply problems mentioned above may not be as significant in the metropolitan or smaller urban centres, nutrition is still a major issue, as many people in these areas are on low incomes and have limited access to transport.

Transport Issues

5.18 The first transport issue relates to the high costs of getting supplies and equipment to rural and remote communities, as mentioned above.

5.19 A more general issue is that there are few people in these communities with access to private transport, resulting in considerable difficulties in accessing health services, particularly hospital and specialist services. Even for those with private transport, the state of the roads, as mentioned in the previous Chapter, complicates getting people to and from hospital.

5.20 A survey by the Australian Bureau of Statistics in 1994 found that for more than 23% of Indigenous people an Aboriginal Medical Service was more than 100km away, that half the people living in rural areas had to travel more than 50kms to a hospital and in the NT over half the Indigenous people had to travel more than 100 km to get to a hospital.

5.21 In those few rural communities where there is some form of public transport, the timetables are often such that an overnight stay is necessary, making it a major expense for people.

5.22 In an emergency, the health service can often arrange an air or ambulance evacuation but a complicating factor can be the Federal nature of the health system. While the traditional lands of many Indigenous communities straddle State and Territory borders, the health system still operates inside those borders.

5.23 The Committee was informed of instances where people had been injured in WA, near the NT/WA border, and even though they were closer to Darwin, they were sent to Perth for treatment. Other instances were quoted where people were admitted to Alice Springs hospital and were sent to Adelaide for further treatment. They then had difficulties in finding their way home.

5.24 Even within some States there were problems. For instance in the Kimberley region, the Committee was advised that Derby was considered to be the regional centre for health purposes, but to get there from Kununurra patients had to travel through Broome, which was both difficult and more expensive.

5.25 The schemes operated by the States and Territories to assist with patient transport were also generally criticised as being insufficient. They do not take enough account of the needs of Indigenous patients, particularly the need for the elderly or very young mothers to have additional escorts.

Cultural Awareness and Racism

5.26 The lack of cultural awareness of many hospital and other health staff means that a lot of Indigenous people find these services alienating and uncomfortable. As a consequence people tend to delay seeking treatment until the last minute.

5.27 The need for health professionals to be made more aware of cultural issues, such as family relationships and responsibilities has been discussed in Chapter three.

5.28 The Committee was advised, however, that there is still a degree of covert racism existing in the health system, linked to stereotyping of Indigenous people as lazy, irresponsible and a drain on public resources. This may be linked to an institutionalised bias which will require structural changes as well as cross-cultural training.

5.29 The high turnover of staff in health services means that the importance of ensuring that people receive cross-cultural training as an inherent part of their basic training is very important. This would help to ensure that people are not then influenced by existing workplace attitudes and practices.

5.30 Addressing these problems will take some time, but raising the profile of the community controlled services, coupled with improved training of health professionals should go some way to helping to resolve the issue.

6

Other Issues

Collection of Data

6.1 Accurate data on the health status of the Indigenous population is essential for developing, monitoring and evaluating health programs. The types of information necessary include not only the numbers of people who may have a particular condition or characteristic, but also the overall population level.

6.2 The source of information about the Indigenous population is the National Census and although the same question about Indigenous status has been used in the last four censuses, it is apparent that not all people have answered the question consistently over time.

6.3 The increases between these censuses (42% 1981-86, 17% 1986-91, 33% 1991-96) are much larger than would be expected from natural increases in population.

6.4 The Committee was also consistently advised, during community consultations, that ABS estimates of the local population understate the numbers of Indigenous people in the area. The volatility in the numbers of people who are prepared to identify themselves as Indigenous on census form is also highlighted by the fact that although there were more than 350,000 people who did identify as being Indigenous more than 500,000 people failed to answer the question at all.

6.5 This has two major implications.

6.6 First, if administrative allocations of funding are based on population numbers then services will be under resourced. On the other hand, if the death and illness statistics are not subject to the same discrete increase as the population data, then mortality and morbidity rates may actually appear to be decreasing.

6.7 However, given that the coverage and timeliness of data collected through the health system is also very poor it is difficult to draw any conclusions, other than agree with the likelihood that many services are under resourced.

6.8 The key to improving the accuracy of administrative data collections is to ensure that Indigenous people are accurately identified.

6.9 The 1999 AIHW / ABS Report on the Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples discusses a number of areas of difficulty in producing high quality statistics on Indigenous health, including:

- The need for standard methods and procedures for identifying Indigenous people;
- The changing propensity for Indigenous people to identify themselves, which has a major impact on the ability to estimate the size of the Indigenous population;
- The completeness with which Indigenous people are recorded as such in government administrative data collections;
- The validity and reliability of self reported data relating to Indigenous peoples' health recorded from individual and household surveys; and
- Changes over time in the availability and quality of data, which makes the assessment of trends extremely difficult and potentially misleading.

6.10 In the Report of the National Aboriginal Health Strategy Working Party, it was noted that :

> "Communities have often had good reason to see the process of monitoring and evaluation as a means by which government might gather information about a community without the community's consent and / or the means by which government might coerce a community into adopting standards it might otherwise wish to reject."[1]

1 National Aboriginal Health Strategy Working Party. *A National Aboriginal Health Strategy.* Canberra. 1989. p218.

6.11 The Committee understands that there are a number of initiatives under way to improve the level of data collection, across the area of Indigenous affairs, which may have some impact on health data, including:

- The development and implementation of a National Aboriginal and Torres Strait Islander Health Information Plan;
- The Agreement, already mentioned, by Health Ministers on performance indicators for Indigenous health;
- The development of a draft National Indigenous Housing Agreement; and
- Collaborative work under way to improve the identification of Indigenous people in administrative data sets.

6.12 The Committee strongly supports the need for significant improvements in the collection of information about Indigenous health. However, it is unlikely any major improvements can be achieved unless there is support by the Indigenous community and that the value of the approaches being proposed can be demonstrated.

Alcohol and Other Substance Misuse

6.13 A number of studies and surveys have shown that there are fewer Indigenous Australians who drink alcohol than non-Indigenous Australians. However, these studies have also shown that, for those Indigenous people who do consume alcohol, the proportion of hazardous consumption is substantially higher than for the non-Indigenous population.

6.14 The 1994 National Aboriginal and Torres Strait Islander Survey found that:

> "Nationally, alcohol was seen as one of the main health problems in their local area by about 58% of Indigenous Australians over the age of 12 years. Drugs and diabetes were the next most commonly reported problems."[2]

6.15 Even when considered at the State, regional or local level the majority of people saw alcohol as the most common health problem.

6.16 Alcohol consumption has been linked to many health conditions, such as cirrhosis of the liver, stroke and suicide. Alcohol has also played a

2 Australian Bureau of Statistics. *Health of Indigenous Australians. Report on the 1994 National Aboriginal and Torres Strait Islander Survey*. AGPS. Canberra. 1996. p2

significant role in the high rates of injury amongst the Indigenous community, particularly in relation to road accidents and intentional injury, including domestic violence.

6.17 The recent AIHW / ABS Report on the Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples notes that there may be a range of factors associated with drinking at harmful levels:

> "An analysis of Indigenous drinkers aged 18 years and over in the National Health Survey showed that those in the high risk category were less likely than low risk drinkers to have a higher educational degree and more likely to have left school before the age of 15, to be unemployed or not in the labour force, to earn the majority of income through government pensions, to earn less than $10,000 per annum and to come from a household where English was not usually spoken at home."[3]

6.18 The Royal Australian and New Zealand College of Psychiatrists have also indicated that the abuse of substances arises from a combination of biological, psychological and social causes, many of which relate to mental health:

> "Alienation, despair, depression, anxiety and psychosis all contribute to the use of substances in an attempt to escape or temporarily relieve symptoms. A social milieu of unemployment and mainstream hostility makes the abuse of substances in a community worse and there is a powerful feedback loop through which the abuse of substances creates more misery for the abuser and for family and friends."[4]

6.19 Petrol sniffing is an additional problem in many remote communities, especially in Central Australia and the Top End, and the use of other illicit drugs, such as marijuana and heroin would appear to be increasing.

6.20 As with the health sector itself services are provided through a range of Commonwealth, State and Territory funded programs. The majority of treatment programs are of a residential rehabilitation nature and there are about 60 community controlled services around Australia, based on a variety of treatment models, which are funded by the Commonwealth.

6.21 Funds for the staffing of these services mainly comes from the Department of Heath and Aged Care, and the funds for client accommodation from Aboriginal Hostels.

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3 Australian Bureau of Statistics and Australian Institute of Health and Welfare. *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples.* Ausinfo. Canberra. 1999. p55.

4 Submission No 88. p1038

6.22 There are also some State and Territory mainstream treatment services, but generally Indigenous people seem reluctant to use these services, which they see as culturally inappropriate and mainly for non-Indigenous people.

6.23 In the broader sense there have also been a range of other initiatives used by services and communities to address the problems associated with substance misuse.

6.24 On the supply side these have included:

- Restricting the sale of alcohol, either completely as in dry communities, or on a restricted hours of trading basis, as has been trialed in some major towns such as Tennant Creek;
- Developing canteens as restricted areas, where the sale and consumption of alcohol can be controlled by the community;
- Introducing night patrols, and sobering up shelters, to try and keep people out of jail; and
- Replacing petrol with Avgas.

6.25 In some communities visited by the Committee the operation of the canteen was a major concern to sections of the community, because it contributed to domestic violence and neglect of children by some parents. In one community the canteen was located directly opposite the school, which was seen by many in that community as providing a bad example for the children.

6.26 However, in many instances the canteen is also the major mechanism for generating community profits. Canteens are operated as a community cooperative and the profits are often used to support additional community activities like upgrading facilities or supporting sporting teams.

6.27 On the demand side there have also been a range of initiatives, including:

- Health promotion and education campaigns, using sporting or music stars, such as Yothu Yindi, particularly through Indigenous media organisations; and
- Developing diversionary activities in the areas of sport and recreation, including culture camps and youth drop in centres.

6.28 The difficulties with all these approaches has been that they seem to be fragmented across different sectors, with little coordination between providers or other programs.

6.29 There also seems to be little monitoring or evaluation of the effectiveness of respective programs and activities in addressing the overall issues. The Committee recognises that the nature of the problems, and differences between individuals, will require a range of treatment methodologies and programs. However, there would still appear to be a need for some common standards across services and programs, as well as appropriate mechanisms to monitor their ongoing operations and to assess their effectiveness.

6.30 Health promotion and prevention programs are generally provided through the health sector, treatment services are provided through specialised stand alone services and other activities like accommodation, sport activities or night patrols by a range of other agencies.

6.31 There needs to be a national framework for substance misuse programs, which clearly identifies the roles and responsibilities of each sector and provides mechanisms for improved coordination and monitoring between sectors.

6.32 The aim of the plan should be to ensure that the role of the community controlled services is strengthened and supported by improved linkages to other complementary programs and activities, particularly in the health sector. The services should also be supported in developing appropriate service standards to ensure ongoing quality improvement.

6.33 As the Central Australian Aboriginal Congress points out in their submission:

> "There is no one simple solution to this problem amongst our people. Instead, whatever assists our people to have greater control over our own lives, will be contributing to the struggle against substance misuse."[5]

6.34 The social and cultural influences on the misuse of substances are complex and it is unlikely that any one activity will resolve the problems in the short, or even the medium term.

6.35 Substance abuse needs to be seen as both a major problem requiring continuing and improved services and targeted programs, as well as part of the broader health disadvantage of Indigenous Australians which will require action and support from all sectors.

5 Submission No 27. p610.