The Parliament of the Commonwealth of Australia

Health is Life

Report on the Inquiry into Indigenous Health

House of Representatives
Standing Committee on Family and Community Affairs

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Canberra

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Foreword

In selecting the title for this report the Committee was very mindful of the comments by the National Aboriginal Health Strategy Working Party that:

> In Aboriginal society there is no word, term or expression for 'health' as it is understood in western society. ….The word as it is used in Western society almost defies translation but the nearest translation in an Aboriginal context would probably be a term such as 'life is health is life'. [1]

The continuing poor state of Indigenous health, and the many efforts of successive governments to address the issue, has seemingly left a nation at a loss to know what to do for the best on this issue. The Committee believes that many of the difficulties come down to these differing world views about health, about how it should be defined and about the sorts of services needed for good health.

There is a very significant taxpayer commitment from the Commonwealth Government, which currently spends around $2.3 billion annually on all Indigenous specific programs. Government expenditure on Indigenous health programs alone represents around 2.2 per cent of all recurrent health expenditure, which is roughly in line with the percentage that Indigenous people make up of the Australian population.

The real issue is that the greater degree of difficulty in Indigenous health will require improving different funding models to achieve improved health status for Indigenous Australians over the longer term.

International experiences offer some hope that improvement is possible over the medium and long term, but leadership at a National, State, Territory and

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

community level is essential to developing the many strategies which can overcome the more serious issues.

The problems are difficult but they are not insurmountable. There are practical and effective strategies that can be implemented, which the Report has attempted to highlight. Involvement of the Indigenous community at all levels of the health system is essential for progress to occur.

These sentiments are not new. They have been highlighted in many of the reports into Indigenous health that have been presented over the last twenty years. The failure to effectively resolve these issues to date is a national concern, which needs a more effective focus from all participants.

Progress can only be made in Indigenous health with strong cooperative partnerships between the Indigenous community, the Commonwealth, States and Territories. Goals which allow for an incremental approach can help maintain morale and encourage those most affected.

This is not to say that we can move slowly on this problem but rather, that a cooperative assessment of what is achievable is more likely to achieve results.

Support for strong bottom-up leadership in the Indigenous community, along with more effective administration and relevant education are the key to making the concept of community participation work.

We know that there are no easy answers to the issues of Indigenous health and all participants in the Inquiry acknowledged the long road ahead, but we believe that our Report offers some signposts to the future.

On behalf of the Committee it remains for me to thank all who have assisted in any way in the Inquiry and to encourage all interested people to ensure that the total effort is not diminished by a failure of will on all fronts. May our collective work help create a healthier future for Indigenous Australians.

Barry Wakelin, MP
Chair

Membership of the Committee

Thirty-Ninth Parliament

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Deputy Chair	Ms Annette Ellis MP	
Members	Mr Harry Quick MP	Dr Brendan Nelson MP
	Mrs Kay Elson MP	Mr Kevin Andrews MP
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Thirty-Eighth Parliament

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Mrs Elizabeth Grace MP	Mrs Ricky Johnston MP
Mrs De-Anne Kelly MP	Mr Allan Morris MP
Ms Jenny Macklin MP	Mrs Andrea West MP
Mr Harry Jenkins MP	Mr Lou Lieberman MP

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.

List of abbreviations

ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
ACCHS	Aboriginal Community Controlled Health Services
AHCA	Australian Health Care Agreements
AHW	Aboriginal Health Workers
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Services
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
CDEP	Community Development Employment Projects
CGC	Commonwealth Grants Commission
CSHA	Commonwealth State Housing Agreements
DAA	Department of Aboriginal Affairs
DHAC	Commonwealth Department of Health and Aged Care

FAG	Financial Assistance Grants
FBT	Fringe Benefits Tax
GMA	Guaranteed Minimum Amount
GP	General Practitioner
GST	Goods and Services Tax
HECS	Higher Education Contribution Scheme
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
RACGP	Royal Australian College of General Practitioners
RAMUS	Rural Australian Medical Undergraduate Scholarships
TAFE	Technical and Further Education
UPK	Uwankara Palyanku Kanyintjaku

List of recommendations

1 Introduction

Recommendation 1

The Commonwealth accept it has the major responsibility for the provision of primary health care to Indigenous Australians:

- the Commonwealth must assume responsibility for developing, in collaboration with the States and Territories, an efficient, coordinated and effective mechanism for the delivery of services and programs which impact on the health and well-being of the Indigenous population.

Recommendation 2

Australian Governments continue in their earnest attempts to conclude a meaningful reconciliation with Indigenous Australians.

Recommendation 3

Consistent with international experience Australian Governments must recognise the need to commit adequate resources, including to community controlled primary health care and environmental health services.

Recommendation 4

The Commonwealth take a more active role in the planning, delivery and monitoring of health and related services for Indigenous Australians, if progress is to be made in improving Indigenous health. This role will need to be formalised in agreements with the States, Territories and communities.

Recommendation 5

The Commonwealth establish an independent National Council for Indigenous Health Affairs to stimulate and advise on the coordination of programs across all portfolios and all levels of government in order to improve the health and welfare of Indigenous Australians.

This National Council comprise a panel of experts in all fields that impact on Indigenous health and well-being, including Indigenous representation, and be provided with relevant statutory powers and adequate resources to be effective.

The Council, in conjunction with the Australian Bureau of Statistics and other relevant portfolios establish baseline measures, across all areas which impact on Indigenous health, and against which progress in improving the health of the Indigenous population might be measured over time.

The Council report regularly to the Prime Minister and annually to the Parliament about its activities, and about progress in improving Indigenous health.

Recommendation 6

In recognition of the need for the Commonwealth to play a leadership role in improving the health and well-being of Indigenous Australians the Commonwealth Government, ensures:

- the Minister for Aboriginal and Torres Strait Islander Affairs is given responsibility for oversight of the Commonwealth's efforts across all portfolios, and that, in recognition of the importance of this role, that the Minister also be included as a member of the Cabinet;

- it be a requirement that all new policy proposals to be considered by Cabinet include a statement about the likely impact of that proposal on Indigenous health and well-being;

- such statements are developed by the relevant portfolio, in conjunction with both the Department of Health and Aged Care and the Aboriginal and Torres Strait Islander Commission;

- the Minister for Aboriginal and Torres Strait Islander Affairs reports annually to Parliament on the Government's progress with improving the health and well-being of Indigenous Australians; and

- this issue is included as a standing item for all future meetings of the Council of Australian Governments.

2 Improving the coordination, planning and delivery of health services

Recommendation 7

The Commonwealth ensure that the provisions of the Framework Agreements are incorporated into the next Health Care Agreements to be negotiated with the States and Territories, to ensure that there is a more direct link between:

- the Commonwealth's funding for Indigenous health, both direct and indirect;
- the Commonwealth's national policy role, including the expanded role for the Commonwealth envisaged by the Committee;
- the States and Territories service delivery roles; and
- the role of the community controlled services.

Recommendation 8

In conjunction with the Indigenous community over the next two years, the Commonwealth develop a revised approach to funding primary health care services for Indigenous Australians, based on:

- the use of funds pooling at a regional level, determined by reference to a nominal per person Medicare Benefits Sshedule(MBS)/Pharamceutical Benefits Scheme(PBS) contribution, which takes into account not only the national average costs of MBS/PBS usage by non-Indigenous Australians, but should also be weighted for the higher costs of servicing specific communities and the poorer health status of Indigenous Australians;
- the combination of these funds with an amount from the State or Territory, representing the cost of hospital and other health services; and
- the community to be supported in taking responsibility for these funds and determining the use of the funds pool in delivering services to the community which best meet the health needs of each community.

3 Indigenous health services and community control

Recommendation 9

Over the next twelve months, in conjunction with the National Aboriginal Community Controlled Health Organisation, the Commonwealth Department of Health and Aged Care:

- develop a mechanism for the accreditation of all Indigenous Health Services, including development of arrangements for collection of appropriate data;

- undertake a systematic review of the level of services currently provided by the Aboriginal Medical Services funded through the Department;

- seek independent, professional advice on the overall level of resources required to provide those services to a professional and accredited standard including, where applicable, the higher costs associated with attracting professional staff to work in the area of Indigenous health; and

- ensure that funding commensurate with those needs is provided to accredited services.

Recommendation 10

Where the proposed changes in regional planning arrangements result in community agreement for the Aboriginal Medical Service to undertake additional services, the Aboriginal Medical Service should not be financially disadvantaged in its agreement to undertake additional services.

Recommendation 11

The Commonwealth support increased community control of health services for Indigenous communities. The community has a responsibility to determine the nature of that control. There needs to be flexibility in arrangements to ensure that each community is able to have the services which best meet their needs within a broader accreditation process.

The implementation of this position should be facilitated as part of the revised regional planning process over the next two years.

Recommendation 12

The Commonwealth, States and Territories recognise that the community controlled sector has a legitimate role to play in representing the views of the Indigenous community as they relate to health matters. They should be assisted in every way to actively participate as equal partners in the planning and delivery of health services for Indigenous Australians.

Recommendation 13

The Aboriginal and Torres Strait Islander Commission provide advice to the Minister for Aboriginal and Torres Strait Islander Affairs, within six months, on possible mechanisms to improve the level of management

support provided to Indigenous organisations, including mechanisms to improve the way funding bodies respond when organisations get into financial difficulties.

4 Improving housing and Infrastructure services

Recommendation 14

In the first annual report to Parliament the Minister for Aboriginal and Torres Strait Islander Affairs pay particular attention to the outcome of the recent Australian Bureau of Statistics' Community Housing and Infrastructure Needs Survey. It will report on a strategy to enable the Aboriginal and Torres Strait Islander Commission to address the backlog of need identified in the survey, in conjunction with the States and Territories within the next five years.

Recommendation 15

All future capital infrastructure programs identify an associated and ongoing allowance for the adequate and continued maintenance of the facilities concerned.

Such maintenance programs are wherever possible undertaken by the community concerned and make appropriate provision for differing cultural requirements which might impact on the viability of community infrastructure.

Recommendation 16

The Aboriginal and Torres Strait Islander Commission consult with the Department of Education, Training and Youth Affairs, the Australian National Training Authority, and with relevant State and Territory Authorities to develop, within two years:

- innovative approaches to support the training of community members in the basic and ongoing maintenance of community facilities; and
- mechanisms to upgrade that training over time to trade qualifications.

Recommendation 17

In view of the importance of potable water to the health and well-being of Indigenous communities:

- the Aboriginal and Torres Strait Islander Commission provide advice to the Minister for Aboriginal and Torres Strait Islander Affairs, within six months, of the costs of providing adequate water, within three years, to all those communities where water supplies do not meet national standards, including those for which no testing has been undertaken; and

- the Minister's annual report to Parliament provide advice about the Government's plans to address these outstanding needs.

Recommendation 18

The Commonwealth Department of Transport review the current funding arrangements for roads and provide advise to the Minister for Aboriginal and Torres Strait Islander Affairs, within six months, about possible mechanisms to ensure that the responsible authorities are providing an adequate service to Indigenous communities.

Recommendation 19

The Commonwealth Grants Commission report to the Minister for Aboriginal and Torres Strait Islander Affairs on:

- mechanisms to ensure there is a more transparent process for fiscal equalisation relative to the factors related to adjustments for Indigenous citizens as part of the allocation of Goods and Services Tax funding to the States and Territories; and

- ways to improve reporting by States and Territories on the use of those funds for Indigenous citizens.

5 Cultural, educational and employment issues as they relate to health

Recommendation 20

The Commonwealth provide additional resources to ensure that within two years all Indigenous children are able to be monitored for ear disease on a regular basis from birth, and to allow the hearing ability of all Indigenous children to be tested by the age of three years.

That the progress of all health services, including State and Territory health services, in this regard should be monitored and that the services' capacity to undertake these tasks should form part of the criteria for accreditation.

Recommendation 21

Within two years, the Minister for Health and Aged Care and the Minister for Aboriginal and Torres Strait Islander Affairs, in conjunction with other Ministers, develop performance measures for each Commonwealth Department that reflect Indigenous cultural perspectives and are able to highlight the impact on Indigenous health of specific policies and programs.

The Australian Health Ministers Conference develop linkages with other relevant Ministerial Councils to ensure the States and Territories develop

a similar approach to bringing the importance of cultural values and the impact on health and well-being of activities in those non-health areas to the attention of other sectors.

6 Other important health issues

Recommendation 21

The Aboriginal and Torres Strait Islander Commission report to the Minister for Aboriginal and Torres Strait Islander Affairs, within the next six months, on:

- a series of pilot programs to trial alternative innovative strategies to encourage the supply and consumption of fresh fruit, vegetables and meat in remote communities; and
- mechanisms to monitor the new arrangements to ensure that any cost savings are passed on to consumers.

Recommendation 22

The Aboriginal and Torres Strait Islander Commission and other Commonwealth, State, Territory and local government funding bodies, actively support communities interested in the local production of food, by the flexible use of long term program funding, and the provision of appropriate training and support.

Recommendation 23

The Aboriginal and Torres Strait Islander Commission and the Commonwealth Department of Education, Training and Youth Affairs work with the States and Territories to develop within twelve months a national mechanism for training and accreditation of store managers, within twelve months, particularly ensuring that this process encompasses:

- an understanding of health and nutrition;
- an acceptance that the store manager has a key role in educating the community about appropriate food choices and in presenting food in ways to encourage such choices; and
- establishment of community traineeships in store management.

Recommendation 24

The Commonwealth Department of Health and Aged Care ensure that Commonwealth, State and Territory substance misuse programs incorporate:

- early and opportunistic intervention programs by health professionals;
- diversionary and sobering-up shelters, including night patrols;
- detoxification programs; and
- rehabilitation programs, including residential and family rehabilitation, and follow up after care programs.

Recommendation 25

The Commonwealth facilitate innovative models of income support and funding to Indigenous communities which volunteer to participate in such programs. The Commonwealth must increase resources and practical assistance to participating Indigenous communities in consultation and cooperation with the Aboriginal and Torres Strait Islander Commission.

7 Health professional issues

Recommendation 26

The Commonwealth, in conjunction with States, Territories and the community controlled sector, develop within the next two years a national system of training for Aboriginal Health Workers (AHW), which is based on agreed national standards and competencies, and takes into account the varied nature of the roles of AHW. The national system must incorporate a combination of:

- basic local training, based in community controlled organisations and involving practical work within the community;
- block release type training, leading to more advanced qualifications, through accredited training organisations, including the AMS; and
- more formal undergraduate and post-graduate training through TAFE and University.

That the development of a national training system also be supported by the introduction of common classifications for AHW, and an agreed career structure.

Recommendation 27

The Commonwealth in conjunction with the States and Territories ensure funding for health services includes appropriate allowances for the recruitment, ongoing training and retention of all staff, taking into account the nature of the services provided, the location of the service,

the needs of the local communities and the need for basic minimum numbers of staff.

The Minister for Aboriginal and Torres Strait Islander Affairs report to the Parliament within two years on the adequate level of staff determined as required to maintain viable health services, given the needs of the Indigenous community.

Recommendation 28

Over the next five years, the Commonwealth, in conjunction with the States and Territories, develop a program for provision of adequate housing for health service staff, including AHW, in remote areas. This program should be linked to the revised regional funding arrangements recommended by the Committee.

Recommendation 29

Within two years, all undergraduate and post-graduate health science courses should include an effective cross cultural awareness component, as well as dealing in detail with the current health status of Indigenous Australians and the factors which have contributed to their ongoing social and cultural disadvantage.

All continuing medical education courses should also expand on these matters and continue to expose health professionals to cross-cultural learning.

Recommendation 30

The Commonwealth explore further ways to encourage doctors to practice in Indigenous communities, including:

- additional assistance to return to mainstream practice after the completion of a specified period;
- more professional support, in terms of initial training and local orientation before commencing work as well as continuing medical education;
- a greater focus on the use of doctors as a part of a regional team; and
- increased professional recognition for service in Indigenous health.

Recommendation 31

The Commonwealth work with the States and Territories, and nursing professional bodies, to develop within two years an expanded role for nurse practitioners in rural and remote Indigenous communities that will

provide both increased career potential for nurses and better meet the health needs of the community.

Recommendation 32

The Commonwealth ensures that:

- Abstudy / Austudy arrangements are flexible enough to take into account students differing educational experiences and that Indigenous students are not disadvantaged, either in terms of the level of financial support or time required for completion of degrees, because they have taken a different path to learning; and

- the eligibility criteria is amended to ensure that medical students who agree to scholarships from the Commonwealth or State and Territory Health Authorities, in return for an agreed period of work in remote or rural communities, continue to be eligible for the full Abstudy / Austudy allowances.

8 Research and data collection

Recommendation 33

The Commonwealth pursue initiatives to improve the collection of data on Indigenous health as a matter of urgency. Additional resources should be allocated if necessary to support the process, recognising that in many instances it is a State matter, but that additional support from the Commonwealth must be sufficient to encourage the States and Territories to resolve the issue.

Recommendation 34

The ABS be funded to repeat the 1994 National Aboriginal and Torres Strait Islander Survey on a regular basis, to provide an adequate measure of the change in the levels of Indigenous disadvantage over time.

The ABS also develop new mechanisms to record the Indigenous population, which take into account the mobility of community members and which do not rely on single point in time recordings.

Recommendation 35

For the next five years, the Commonwealth ensure the National Health and Medical Research Council allocate at least five per cent of total annual research funding for Indigenous health research. This research should be directly related to the health problems experienced by the Indigenous community and be aimed at either developing strategies to address those problems directly, or to provide evidence which will

support government programs and policies to address the problems. Such research must also be developed and conducted in conjunction with the Indigenous community.

1

Introduction

A way needs to be found of harnessing a national effort for a very complex range of issues in a very complex system of government. In the circumstances only the Commonwealth can provide the necessary leadership and coordination.[1]

1.1 The Committee has found that the planning and delivery of health services for Indigenous Australians is characterised by a general lack of direction and poor coordination.

1.2 With services and programs being delivered by Commonwealth, State, Territory and Local government agencies, there is no clear delineation, or agreement, about which level of government is ultimately responsible for ensuring there are continuing improvements in the health of Australia's Indigenous population.

1.3 There appears to be little, if any, coordination between these diverse Commonwealth / State health programs, other environmental programs or programs provided through other agencies, in areas such as education and employment.

1.4 The adverse health impact of continuing disadvantage in these other areas are as important as the effect of lack of access to adequate health care, and this will be discussed further in Chapters Four and Five.

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1 Professor I Ring. Submission No 96. p1100.

1.5 There is also only a limited amount of program coordination between the various health service providers:

- the Commonwealth focuses mainly on primary care, through Medicare Benefits Schedule (MBS) payments for services provided by private General Practitioners (GPs) and those working in Aboriginal Medical Services (AMS), as well as direct grants to the AMS; and
- the States and Territories focus on acute care, but also provide primary care through hospital outpatients and community health programs, as well as providing support for more specific population programs through the AMS.

1.6 The outcome of these piecemeal funding and coordination arrangements is fragmented policy and programs, across the States, Territories and Commonwealth, which do not result in any consistent approaches, either nationally or even at the local level.

> …we have to look at simplifying the funding mechanisms and also making them more transparent. This crossover between States and Commonwealth is a nightmare for people sitting out there with minimal resources.[2]

1.7 The lack of clear delineation of responsibility for Indigenous health is also an incentive for the parties, particularly the States, to indulge wherever possible in shifting the onus for payment to the other sector.

1.8 The lack of any real efforts to integrate community involvement into the planning and delivery of health and related services has been the biggest barrier to progress.

1.9 The Committee recognises that Indigenous communities are not homogeneous and that levels of services will vary considerably between each community. If services are to be effective there is a need for greater collaboration, to bring together what is happening at different levels as part of a broader national policy or action plan which focuses on the needs of each community.

1.10 The Commonwealth has developed Framework Agreements with each State and Territory, to better define the respective roles and responsibilities of each jurisdiction in Indigenous health matters. There has been some criticism of the effectiveness of these agreements, and they are discussed in more detail in the next Chapter.

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2 Ms P Field. Evidence. p1381.

1.11 It is unlikely that the health of Indigenous Australians will improve significantly until the fragmentation of services, cost shifting and lack of agreement about responsibility for Indigenous health are fully addressed.

1.12 The Committee believes that for this to happen there must be a clear agreement between the States and the Commonwealth, not only about what their respective responsibilities are, but also on how these responsibilities will be acted upon and the level of resources to be committed by all parties.

> Effective coordination can only be achieved if there is collaboration between Indigenous communities, community controlled organisations and government institutions. This can only be achieved if the premises on which coordination are built are shared by all parties. Some of these premises include:
>
> - definitions of health
> - equitable sharing of power and decision-making
> - respect for varying patterns of organisation and planning
> - collaboration in setting performance indicators and evaluation procedures.[3]

Recommendation 1

1.13 **The Commonwealth accept it has the major responsibility for the provision of primary health care to Indigenous Australians:**

- **the Commonwealth must assume responsibility for developing, in collaboration with the States and Territories, an efficient, coordinated and effective mechanism for the delivery of services and programs which impact on the health and well-being of the Indigenous population.**

The Indigenous population

1.14 According to the 1996 Census there are around 386,000 Indigenous Australians, which represents approximately 2 percent of the total Australian population.

1.15 Despite improvements in certain areas, the health and well-being of Indigenous Australians has failed to keep pace with the overall

3 A/Prof A-K Eckermann, Submission No 11. p1.

improvements in the health and well-being of non-Indigenous Australians, so that the level of disadvantage faced by Indigenous Australians has continued to grow over time.

1.16 Even though the Indigenous population is younger, and growing at a faster rate, Indigenous Australians continue to be the most disadvantaged in the country, no matter where they live. This level of ongoing disadvantage is discussed in more detail at Appendix D.

1.17 In general terms, Indigenous Australians are more likely to be unemployed or on lower incomes, less educated, imprisoned or in some form of care, homeless or living in overcrowded or substandard conditions, as well as being unwell or dying earlier compared to the non-Indigenous population.

1.18 The life expectancy of Indigenous Australians is about 18 years less than for other Australians. Their age adjusted mortality is about three times the non-Indigenous rate and much higher for some conditions.

1.19 Over the last twenty years the causes of excess mortality in the Indigenous population have progressed from acute infections to chronic non-communicable diseases and deaths resulting from accident and injury.

1.20 Between 1985 and 1994, there was very little improvement in the mortality experiences of Indigenous Australians, and about three out of every four deaths among Indigenous Australians 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).

1.21 Adult morbidity patterns have changed, with a reduction in communicable diseases being counterbalanced by an increase in non-communicable diseases, particularly hypertension, ischaemic heart disease and the complications of diabetes.

1.22 Morbidity for Indigenous children, however, arises mostly from entirely preventable infections. Indigenous infant mortality rates have been decreasing since the 1970's and birth weights have been increasing, but prematurity and low birth weight is still prevalent, especially in remote areas.

1.23 Malnutrition continues to contribute to growth retardation and predispose children to infectious diseases. This further contributes to premature mortality, as there is evidence to suggest that low birth weight and growth retardation before birth predisposes to diabetes mellitus, hypertension and heart disease in later life.

1.24 There have been rapid increases, over the past ten years, in the incidence of kidney disease and renal failure within the Indigenous population. The complex reasons for this rapid increase are not completely understood.

1.25 It may relate to an increasing number of children now surviving early childhood illnesses, as a result of evacuations and improved health services. These early trauma nonetheless contribute to problems later in life. There is already some evidence linking past infections to increased susceptibility to kidney failure. For example, the incidence of renal failure in far Northern Australia is estimated as being some 15 times higher than the Australian aggregate rate.

1.26 Mental health and emotional well-being, is another major challenge facing the Indigenous community. It is 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.[4]

1.27 The impact of these devastating changes is not limited to any specific geographic or socioeconomic area. While there are some regional differences, for specific conditions, the overall health outcomes for Indigenous Australians in urban areas is as poor as that for Indigenous Australians in rural or remote areas.

1.28 The development of more programs which recognise the underlying levels of disadvantage and are built on an understanding of the impact of the past on Indigenous Australians and their culture are necessary to address this continuing gap.

Experiences in other countries

1.29 The poor health status of Indigenous Australians stands in stark contrast to that of the Indigenous populations of New Zealand, Canada and the United States.

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4 The Royal Australian and New Zealand College of Psychiatrists. Submission No 88. p1038.

> The failure to make significant improvements in the health of Australia's Indigenous population is unique in the developed world and yet there is nothing that is unique in the experience, disease pattern, or circumstances of Aboriginal and Torres Strait Islander people which could reasonably explain the failure to make satisfactory progress.[5]

1.30 The health status of the Indigenous peoples of New Zealand, Canada and the United States is discussed in more detail at Appendix E. It is important to recognise that the improvements in Indigenous mortality achieved in these countries have not necessarily been matched by the same relative levels of improvement in the socioeconomic circumstances of those populations.

1.31 One factor which has been cited as important in these countries has been the commitment to provide adequate resources for appropriate community controlled primary health care, environmental services and encouragement of improved education.

> The 1976 Indian Health Care Improvements Act…was intended to elevate the health status of American Indians and Alaskan Natives to a level equal to that of the general population through a program of authorised higher resource levels in the IHS Budget. Appropriated resources were used to expand health services, build and renovate medical facilities, and to step up construction of safe drinking water and sanitary disposal facilities. It also established programs designed to increase the number of Indian health professionals for Indian needs and to improve health care access for Indian people living in urban areas.[6]

> These international comparative analyses demonstrate that what makes a difference is the attention by national governments to the development of effective, efficient systems of health care. Further the impact of this is strengthened when it is linked to the development of healthy living environments, quality housing and education.[7]

1.32 It is argued that these practical measures have paralleled a philosophical recognition of the status and rights of the Indigenous populations of those countries.

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5 Australian Medical Association and Public Health Association of Australia. Submission No 32. p48.

6 Indian Health Service. *1997 Trends in Indian Health.* p2.

7 Senator the Hon. John Herron, Minister for Aboriginal and Torres Strait Islander Affairs. Bancroft Oration. 1999. p7.

> Treaties, no matter how loosely worded, have appeared to play a significant and useful role in the development of health services, and in social and economic issues, for the Indigenous people of New Zealand, the United States and Canada.[8]

1.33 Concluding a meaningful reconciliation with Indigenous Australians is likely to contribute to a longer term improvement in their health and welfare.

Recommendation 2

1.34 **Australian Governments continue in their earnest attempts to conclude a meaningful reconciliation with Indigenous Australians.**

Recommendation 3

1.35 **Consistent with international experience Australian Governments must recognise the need to commit adequate resources, including to community controlled primary health care and environmental health services.**

Earlier reports

> When innumerable reports on the poor state of Aboriginal health are released there are expressions of shock or surprise and outraged cries for immediate action. However, the report appears to have no real impact and the appalling state of Aboriginal health is soon forgotten until another report is released.
>
> The Hon. P Ruddock, MP. Chairman. House of Representatives Standing Committee on Aboriginal Affairs. 1979

1.36 Despite this, the continuing poor state of Indigenous health in Australia over the last twenty years, and the difficulties associated with isolating the underlying causes, has generated a continuous flow of further reports about the problem. The Committee has identified at least 20 further reports into aspects of Indigenous health which have been undertaken

8 Ring, Ian T. and Firman, David. 'Reducing indigenous mortality in Australia: lessons from other countries.' *Medical Journal of Australia.* 1998; 169: 528-533.

since 1979. A list of some of the major reports, and their key recommendations are outlined at Appendix F.

1.37 Most of the reports have acknowledged that the underlying causes of this failure to improve Indigenous health outcomes in Australia are complex and difficult to quantify. They have made very similar recommendations regarding the need for improved living conditions, increased health services, improved training for health staff and the need to involve the community in the planning and delivery of all services.

1.38 Despite what would appear to have been genuine commitment from all levels of government there has been little effective progress in implementing the key recommendations from these reports.

1.39 Part of the difficulty is the complexity of the issues, acknowledged by the submission from the Department of Health and Aged Care, which indicated:

> …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.[9]

1.40 The Department's submission suggests that the major factors affecting Indigenous health 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.

1.41 The Committee considers that with such a relatively small number of people, many of whom live in identifiable and discreet communities, it should be possible to develop a range of programs which are able to address all these issues.

1.42 In the Committee's view the major difficulty in implementing the key recommendations from these reports has been the lack of any clear

9 Commonwealth Department of Health and Aged Care. Submission No 68. p216.

consensus about which tier of government is responsible for Indigenous health matters, as discussed earlier.

1.43 This is compounded by the lack of coordination between Commonwealth, State and Territory health and related services, and between programs within each of those jurisdictions.

1.44 Even though the Commonwealth provides a considerable proportion of the funds for Indigenous health services, its only direct link to service delivery is through its funding of the Aboriginal Community Controlled Health Services and some payments to individuals, through the MBS and the Pharmaceutical Benefits Scheme (PBS).

1.45 As indicated earlier the Commonwealth relies on specific agreements with the States and Territories to define respective roles and responsibilities and more than 80 per cent of services for Indigenous Australians are delivered through the State and Territory health systems.

1.46 The Committee considers that there are two major prerequisites that will need to be satisfied before there can be any significant improvement in the health and well-being of Indigenous Australians.

1.47 Firstly, the Commonwealth has to adopt a much more central and active role in the coordination, planning, delivery and monitoring of health and related services for Indigenous Australians. Secondly, the Indigenous community has to be allowed to play a far greater role in those same areas.

Recommendation 4

1.48 **The Commonwealth take a more active role in the planning, delivery and monitoring of health and related services for Indigenous Australians, if progress is to be made in improving Indigenous health. This role will need to be formalised in agreements with the States, Territories and communities.**

Commonwealth coordination

1.49 The Committee supports the need for a National Council of Indigenous Health Affairs, to advise on the coordination of the necessary activity across all areas that impact on Indigenous health and well-being, and across all levels of government.

1.50 This National Council must comprise Indigenous and non-Indigenous experts in the fields of health, housing, education, employment, culture, planning, management and administration.

1.51 The primary purpose of the Council must be to gather those people who are most able to contribute to bringing together the community, both Indigenous and non-Indigenous, and governments to focus on improving the health of Indigenous Australians.

1.52 To ensure continuity and consistency the members of the Council should be appointed for at least five years, with an option for a further five year appointment.

1.53 The Council would report regularly to the Prime Minister and annually to the Parliament about progress in improving Indigenous Health, and in particular about any barriers that are identified to achieving further progress.

1.54 The Council's annual report should be added to the schedule of authorities referred to Parliamentary Committees that is tabled by the Speaker at the commencement of each Parliament, to ensure that relevant Committees are in a position to inquire into any aspect of the Council's report.

1.55 The Council must have the power to require information and assistance from other Government departments as necessary. It would also need an appropriate budget.

1.56 The Committee would envisage the role of the Council would include undertaking a complete audit of the factors that impact on the health of Indigenous Australians, in conjunction with the Australian Bureau of Statistics (ABS), to provide baseline information against which progress could then be assessed over time.

1.57 The Council would also be involved in informing the public about government efforts to improve Indigenous health, across all portfolios, and about the underlying problems behind the need for such programs.

1.58 Additionally, the Council would be involved in providing expert advice to government about structural and procedural changes required to improve cross portfolio coordination and communication and about mechanisms to limit duplication between programs.

Recommendation 5

1.59 **The Commonwealth establish an independent National Council for Indigenous Health Affairs to stimulate and advise on the coordination of programs across all portfolios and all levels of government in order to improve the health and welfare of Indigenous Australians.**

This National Council comprise a panel of experts in all fields that impact on Indigenous health and well-being, including Indigenous representation, and be provided with relevant statutory powers and adequate resources to be effective.

The Council, in conjunction with the Australian Bureau of Statistics and other relevant portfolios establish baseline measures, across all areas which impact on Indigenous health, and against which progress in improving the health of the Indigenous population might be measured over time.

The Council report regularly to the Prime Minister and annually to the Parliament about its activities, and about progress in improving Indigenous health.

1.60 In accepting the need for leadership on this matter the Commonwealth also needs to recognise this will require concerted and continued efforts across a range of Commonwealth portfolios for a considerable period.

1.61 Changes in health outcomes will not be achieved in the short term and there will need to be a committed and bipartisan approach. To support a concerted Commonwealth effort, the Committee believes there will need to be senior representation at the highest level to coordinate the Commonwealth Government's efforts.

1.62 The Committee believes that this should be at the most senior Ministerial level and that the Minister for Aboriginal and Torres Strait Islander Affairs should consequently be elevated to Cabinet, with an increased level of responsibility for monitoring and coordinating Commonwealth initiatives impacting on Indigenous health across all programs.

1.63 The Committee is not proposing any changes in the current portfolio arrangements for specific programs. The Minister for Aboriginal and Torres Strait Islander Affairs would not assume responsibility for any programs currently delivered through other portfolios, but would instead be responsible for ensuring that all those portfolios work closer together, to improve Indigenous health outcomes.

1.64 Government decisions are principally made at the national level, with little scope for Indigenous input. These decisions are generally very sensible for the non-Indigenous community but can often have unintended consequences for Indigenous Australians.

1.65 For example remote communities had to be granted exemption to recent changes to excise arrangements for aviation fuel, after a government decision which would have meant that efforts to limit the impact of petrol sniffing would have had to be abandoned, because of increased costs. Proposed changes to Social Security paydays could also significantly limit the effectiveness of the efforts of some communities to limit alcohol sales on current pension pay days.

1.66 The Minister must be able to ensure that all portfolio initiatives identify the likely impact on the Indigenous community, even if it initially seems remote or unlikely there would be any impact.

1.67 To assist the Minister in assessing such proposals the Committee believes that all portfolios should be required to explain to Cabinet the impact of any new policy proposals on the health and well-being of Indigenous Australians.

1.68 The Committee also believes that the Minister for Aboriginal and Torres Strait Islander Affairs should report to Parliament on an annual basis, on the progress of Government actions across all portfolios to improve Indigenous health and well-being.

1.69 The report would provide a benchmark against which to monitor improvements in disparities between Indigenous and non-Indigenous Australians in health, education and employment, but should not just be a reiteration of budget amounts and other statistics. The report should obviously include expenditure information, but must focus on achievements against short and long term goals and on the changing priorities as progress is being made against those goals.

1.70 To support the Commonwealth commitment the States should also be encouraged to provide similar reports to their own Parliaments and the issue should become a standing item on the agenda for the Council of Australian Government meetings, to ensure there is a concerted and focussed effort.

1.71 Commonwealth leadership in this area will only have an impact if there is long term bipartisan support for the process. If the matter is reviewed every time there is a change of government, there will only be limited progress.

1.72 The Indigenous community needs to be assured that this matter is a high priority for government, irrespective of which party is in Government.

Recommendation 6

1.73 **In recognition of the need for the Commonwealth to play a leadership role in improving the health and well-being of Indigenous Australians the Commonwealth Government, ensures:**

- **the Minister for Aboriginal and Torres Strait Islander Affairs is given responsibility for oversight of the Commonwealth's efforts across all portfolios, and that, in recognition of the importance of this role, that the Minister also be included as a member of the Cabinet;**
- **it be a requirement that all new policy proposals to be considered by Cabinet include a statement about the likely impact of that proposal on Indigenous health and well-being;**
- **such statements are developed by the relevant portfolio, in conjunction with both the Department of Health and Aged Care and the Aboriginal and Torres Strait Islander Commission;**
- **the Minister for Aboriginal and Torres Strait Islander Affairs reports annually to Parliament on the Government's progress with improving the health and well-being of Indigenous Australians; and**
- **this issue is included as a standing item for all future meetings of the Council of Australian Governments.**

Community control

1.74 In order for the Commonwealth to play a greater role in ensuring all levels of government are maximising their efforts to improve Indigenous welfare, the key to achieving progress is making sure that the Indigenous community plays an active and effective role in the planning and delivery of services for their own community.

1.75 As indicated earlier, when discussing the overseas experiences, this means that the community controlled services need to be adequately resourced to both provide an appropriate level of care to their community, as well as to participate as equal partners with the States, Territories and the Commonwealth in overall planning and monitoring of services.

1.76 The Committee is proposing that a new funding approach be developed which provides for a pooling of Commonwealth, State, Territory and community funds at the regional level, and that the community play the primary role in determining the allocation and use of these funds.

1.77 It is proposed that additional Commonwealth funding be allocated over the next four years to support this approach. This is based on the understanding that current MBS/PBS arrangements do not suit much of the Indigenous population and that the States and Territories are currently meeting costs of providing services which would normally be met by the Commonwealth for the non-Indigenous population.

> I believe that, at the least, a very defensible case can be made for an increase of about 27% in total expenditures on Aboriginal health…$245m currently.[10]

Other important issues

1.78 In considering the development of new services the Committee believes that there has to be increased focus on improving the coordination of health services with other sectors, particularly the provision of education as well as the development of programs to significantly enhance employment opportunities.

1.79 It is important to consider the impact of the living environment on health and well-being and it may be that improvements in the area of environmental health could have a greater impact than the same level of improvement in health services. There needs to be a much greater focus on meeting the backlog of need in terms of housing and other infrastructure, particularly potable water.

1.80 In providing additional facilities, especially housing, greater emphasis needs to be given to the adequate and ongoing maintenance of those facilities, which can then be linked to training and employment opportunities for the local community.

1.81 The health workforce should reflect the skills and disciplines that are necessary to deliver services and improve health.

1.82 The Committee recognises there are many specific health problems facing the Indigenous community, such as mental health, dental health, skin diseases, infectious diseases, eye disease, cardiovascular disease, etc. The

10 Prof J Deeble. *How much is needed? A needs based funding formula for Aboriginal and Torres Strait Islander Health*. March 2000. p2.

Committee acknowledges the need to address these issues in an holistic fashion, rather than a piecemeal approach but there are three issues which the Committee feels strongly need to be addressed as priorities. These are nutrition, hearing loss and the misuse of alcohol and other substances.

1.83 Nutrition and ante natal care are critical foundations to future health and well-being. If mothers are malnourished then their babies will be born underweight and prone to considerable health problems. Malnourished children experience learning difficulties, subsequent unemployment problems and considerable health problems in later life.

1.84 Similarly, the ongoing impact of alcohol and other substance misuse on many Indigenous communities is considerable.

> As Indigenous people, we know that drugs and alcohol are devastating and killing our families and communities – we don't need a history lesson to tell us that[11]

1.85 These issues are all discussed in more detail in the following Chapters.

11 Barbara Flick. *Drugs of Opulence and Drugs of Dispossession.* Aboriginal and Islander Health Worker Journal. Vol. 22 no. 4 July / August 1998. p7.

2

Improving the coordination, planning and delivery of health services

Aboriginal people often feel that the motivation for government action in Aboriginal Health comes as a response to intermittent political pressure, rather than from a commitment to effective long-term solutions for future generations.[1]

Current arrangements for planning and delivery of health and related services

2.1 Arrangements for the delivery of health and related services for Indigenous Australians, as for all Australians, reflect the Federal structure of government, and involve all three tiers of government.

2.2 This means that the Commonwealth has a broad policy and financial role, States and Territories are largely responsible for the delivery of public sector health services and Local government mainly focuses on environmental health in conjunction with community or Land Councils.

> This split reflects largely the respective constitutional roles, revenue collection powers being vested mainly in the Commonwealth and the provision of health services with the States.[2]

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1 National Aboriginal Health Strategy Working Party. Op cit. pxi.

2 Mooney, G. Jan, S. and Wiseman, V. 'Economic issues in Aboriginal health care.' in *Economics and Australian Health Policy*. p251.

2.3 The Commonwealth heavily subsidises private medical services and pharmaceuticals, through the MBS and PBS, in addition to providing financial incentives to purchase private health insurance. However, Indigenous Australians receive limited benefits from these latter arrangements.

2.4 The States' responsibilities include public medical and psychiatric hospitals and public health programs, as well as the regulation of health workers in the public and private sectors.

2.5 Additionally, there is private sector involvement in health services, operating with direct and indirect government subsidies from both Commonwealth and State sources. The use of these facilities by Indigenous Australians is limited.

2.6 Community Controlled Aboriginal Medical Services (AMS) play a major role in providing primary health care to Indigenous Australians. These are autonomous non-government organisations, primarily funded by the Commonwealth, but with some additional financial support for specific programs from the States and Territories.

2.7 Commonwealth funding for Indigenous health services includes grants to the AMS, general Health Care grants to the States and Territories and payments to individuals through the MBS and PBS.

2.8 State and Territory funding is delivered through a number of different mechanisms including direct grants to AMS, specific Indigenous health programs and general mainstream health services.

Access to Medicare Benefits and the PBS

2.9 Access to primary health care for non-Indigenous Australians is funded primarily through the MBS and PBS. In contrast, Indigenous Australians have more limited access to services funded by MBS and PBS, particularly those living in rural and remote areas.

2.10 A report on research undertaken for the Health Insurance Commission, and entitled 'Market Research into Aboriginal and Torres Strait Islander Access to Medicare and the Pharmaceuticals Benefits Scheme', found that Indigenous Australians universally face considerable barriers which impede their full access to both the MBS and the PBS:

- it is estimated that only 15 per cent of Indigenous Australians in urban areas and 38 per cent of Indigenous Australians in more remote areas have an effective Medicare number or card. This includes a significant

number of people who have never been enrolled, or whose enrolment has expired;

- administrative barriers include providing acceptable forms of identification as required by Medicare.

2.11 The 1997 decision by government to allow the AMS to access the MBS has improved the financial viability of AMS but has not significantly improved access to primary health care for Indigenous Australians.

2.12 The problems with attraction and retention of medical practitioners in rural and remote areas is compounded for Indigenous communities.

2.13 State and Territory governments with significant and dispersed rural and remote populations argue that they are left to meet the cost of providing such medical services, through public hospitals or public health programs, because there are no private doctors available.

2.14 Bulk billing is not a common practice in most rural and remote areas and the local community controlled health service or hospital generally provides these services.

2.15 As such, these States and Territories consider they are significantly disadvantaged, compared to States with a more urbanised population who receive a higher per capita share of MBS and PBS payments.

2.16 This discrepancy is highlighted when it is considered that in 1997-98 per capita MBS payments varied from $169.74 in the NT to $291.80 in WA, $366.87 in NSW and $337.77 nationally.

2.17 Even for those States with a high rural or remote population these figures will mostly reflect access to doctors and other medical services in the larger population centres. Given the isolation of many Indigenous communities, and the very limited use they make of the MBS, it is clear that the per capita MBS amount would be almost negligible for those areas.

2.18 The report undertaken by Keys Young 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.[3]

3 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.

Funding

2.19 A report commissioned by the Commonwealth, and entitled '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 $810 million.

2.20 The Commonwealth and the States and Territories provided roughly half of this amount each.

2.21 While the Commonwealth and States contributed nearly equal amounts, the Commonwealth's contribution was essentially indirect, primarily through the Australian Health Care Agreements and other grants. The main Commonwealth monies flowing directly into service provision are the funds it provides for the operation of the community controlled health services.

2.22 This amounted to around $90 million in 1995-96, which represented only 11 per cent of the total government figure in that year. Additionally the Commonwealth provided some $42 million direct to Indigenous clients through the MBS and PBS.

2.23 This report also provided considerable information to counter the perennial misconception in the area of Indigenous health, that excessive amounts of money are wasted on Indigenous health programs with little improvement in health status to show for the expenditure.

2.24 What the report has clearly demonstrated is that, despite being significantly sicker than the non-Indigenous population:

- Commonwealth funding for Indigenous health, from both direct grants and the MBS / PBS, is around $100 per person less than other Australians received from the MBS and PBS alone; and
- the total amount of recurrent expenditure, for all services and from all sources of funds for and by Indigenous Australians was only $2,320 per person, which was only 8 per cent higher than that for and by other Australians, as illustrated in the following table.

Estimated government and private expenditures for and by Indigenous and non-Indigenous people, total and per person, 1995-96

	Indigenous			***Per person***	*non-Indigenous*			***Per person***	*Ratio Indig/ Other*
Source	*Govt. $m*	*Private $m*	*Total $m*	***$***	*Govt. $m*	*Private $m*	*Total $m*	***$***	
Subsidised Services									
Public Hospitals									
-inpatients	340	4	344	**939**	8222	948	9170	515	1.82
-outpatients	98	-	98	**267**	2129	-	2129	120	2.23
Mental Institutions	10	-	10	**27**	399	-	399	22	1.23
Nursing Homes	16	4	20	**49**	2065	672	2737	154	0.35
Community Health	199		199	**543**	1438	5	1443	81	6.70
Patient transport	35	1	36	**98**	295	264	559	31	3.16
Public health	26	-	26	**71**	489	-	489	27	2.63
Medicare and other medical	32	2	34	**93**	6523	1374	7870	442	0.22
PBS drugs and appliances	10	3	13	**35**	2366	483	2879	162	0.20
Administration and research	43	1	44	**120**	1295	620	1915	107	1.12
Other Services									
Private hospitals	-	5	5	**13**	258	2858	3116	175	0.07
Dental and other professionals	1	11	12	**32**	296	3108	3404	191	0.17
Non prescribed medicines		12	12	**33**	-	2440	2440	137	0.24
Total	810	43	853	**2320**	25775	12775	38550	2163	1.08

Source Expenditures on Health Services for Aboriginal and Torres Strait Islander People. J.Deeble, C. Mathers, L. Smith, J, Goss, R. Webb and V. Smith. May 1998

2.25 For many non-Indigenous Australians these figures include a certain amount of private spending on their own health, and the report acknowledged that Indigenous Australians rely much more heavily on publicly funded State and Territory hospital and community health services than other Australians. This is shown in the following table, which indicates public expenditure was around one and half times higher for Indigenous Australians.

Gross expenditures per person, Indigenous and non-Indigenous people, through publicly subsidised programs 1995-96, by program.

	Indigenous	*non-Indigenous*	*Ratio Indigenous/other*
Delivery	$	$	
through State and local government	1763	806	2.20:1
through Medicare/PBS	128	535	0.24:1
through Aboriginal health organisations & other Commonwealth programs	344	213	1.62:1
Total	**2235**	**1554**	**1.44:1**

Source Expenditures on Health Services for Aboriginal and Torres Strait Islander People. J.Deeble, C. Mathers, L. Smith, J, Goss, R. Webb and V. Smith. May 1998

2.26 Since 1995-96 the Government has also introduced a private health insurance rebate for eligible persons. It is estimated that there are around 5.7 million people eligible for the rebate at a total cost of some $2 billion.

2.27 While the above figures relate to the earlier period, this additional government expenditure would increase average expenditure per person by some $120.

2.28 As only a very small proportion of the Indigenous population would hold Private Health Insurance, very few Indigenous people would be eligible for the rebate so it could be assumed that this benefit would accrue primarily to the non-Indigenous population.

2.29 This would reduce the differential between government expenditure for Indigenous and non-Indigenous Australians from 44 per cent to around 35 per cent.

2.30 This pattern of high usage of public health services is influenced by socioeconomic circumstances and geography. Many Indigenous Australians 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. Lack of transport is another significant problem.

2.31 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 public hospital usage by Indigenous Australians.

2.32 Even after taking into account government spending alone, the overall level of expenditure per person for the Indigenous population is no

greater than that provided by government for other Australians in similar socioeconomic circumstances.

2.33 One of the difficulties in identifying this funding is that 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 Australians.

2.34 For instance, hospitals are provided with an overall budget, a proportion of which at the end of any period will have been used for services to Indigenous Australians, depending on the availability of beds and the nature of the treatment.

> Whether the states can provide any specific program for Indigenous people within those mainstream services is the big question. It may be able to do so in remote areas but it may find it administratively impossible to do so in anything other than remote areas because it will not be able to identify an particular program that it can administer through the mainstream hospital services in the larger areas. Those services are just swamped by the big one[4]

2.35 In a sense then, a large proportion of the services provided to Indigenous Australians are simply reactive. They tend to represent the application of general non-specific services that are not necessarily designed in any way to meet the special health and or cultural needs of Indigenous patients.

2.36 In addition, Commonwealth, State and Territory health programs are commonly vertical and inflexible, relating to identifiable risk factors, specific activities or diseases etc. It is therefore difficult for funds allocated to individual programs to be used for any other purpose, which might better meet the needs of the local Indigenous community.

2.37 These approaches are 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, and cross program approach.

2.38 The inflexibility of program guidelines and reporting requirements can also act as a barrier to innovative solutions at the community level.

2.39 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 been able to assist the elderly people living out of town to come and do their shopping and to transport children from those areas to 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

4 Professor J Deeble. Evidence. p1377.

regular basis, even though the health service would have been happy to supply a driver to complete these tasks.

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

2.41 These problems are then compounded by the general lack of coordination between programs and jurisdictions, and the incentives for cost shifting, discussed in the previous Chapter.

2.42 In 1996 David Scrimgeour and Komla Tsey, from the Menzies School of Health Research, noted these and other problems with current arrangements:

- As the development of the community controlled services necessarily involves a degree of transfer of resources from the state and territory providers to the Aboriginal community sector, there is a tendency within some state and territory providers to perceive the policy to be diametrically opposed to their interests;
- There is a tendency towards cost-shifting between different levels of government, and also towards duplication of services, as there is no clear delineation of responsibilities between the different bodies;
- There is no definitive policy on how communities should be given greater control of health services or how services are to be provided to communities that do not have their own health services;
- Because Aboriginal community controlled services provide only primary health care, there is no self determination in the secondary and tertiary sectors; and
- There is an unequal distribution of services to Aboriginal people, as some communities have their own services while others do not, and the diversity of funding bodies results in different levels of funding. [5]

Commonwealth coordination

2.43 Apart from payments to individuals through the MBS, the majority of Commonwealth funding for mainstream health services is currently provided directly to the States and Territories on the basis of arrangements defined by the Australian Health Care Agreements (AHCA).

5 Tsey, K. and Scrimgeour, D. *The funder-purchaser provider model and Aboriginal health care provision.* Australian and New Zealand Journal of Public Health. 1996. Vol 20 No 6. p661.

2.44 Under these five year agreements the Commonwealth provides grants to the States and Territories, primarily for acute services. The agreements set out a number of conditions and performance indicators, but are essentially block grants which allow the States and Territories considerable flexibility for resource allocation.

2.45 Although the Health Care Agreements make some allowances for the impact of the population of each State or Territory (weighted by age and sex), there are no specific allowances made for the costs of meeting the health needs of their Indigenous citizens.

2.46 The AHCA include detailed funding arrangements and specific reporting requirements relative to the provision of acute care services by the States and Territories and have defined the Commonwealth's role as:

- contributing to the cost of State funded health services for eligible persons;
- funding and developing policy in relation to health services for which the Commonwealth has direct responsibility; and
- working collaboratively with all States and Territories to develop and coordinate national health policy.

2.47 The national interest is defined as encompassing those objectives, programs and policy parameters which:

- should be consistent across Australia for reasons of efficiency, effectiveness and equity;
- have implications for wider national social and economic objectives; or
- have implications for international relations.

2.48 The Agreements currently include provision for the Commonwealth and States to share responsibility on the National Mental Health Plan, the National Palliative Care Strategy and the Casemix Program.

2.49 The ongoing disparity between the health and well-being of Indigenous and non-Indigenous Australians clearly falls within what would be defined as the national interest.

Coordinating Indigenous health services

2.50 The need for specific agreements with the States and Territories about what will be provided in the health area, is related to the fact that constitutionally the States and Territories are responsible for providing the bulk of health services as well as the health infrastructure.

2.51 As the Commonwealth's involvement is essentially indirect, their capacity to directly influence the coordination, planning and provision of Indigenous health and related services on a day to day basis is limited to whatever arrangements can be agreed with the States and Territories.

2.52 The Commonwealth Department of Health and Aged Care submission points out that current Government 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.[6]

2.53 To facilitate such cooperation, and because the AHCA do not relate specifically to Indigenous health matters, the Commonwealth has developed with each State and Territory an additional agreement, known as the Framework Agreement on Indigenous health that 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.

2.54 The Commonwealth has included a clause in the Australian Health Care Agreements, stipulating that those Agreements are to be implemented consistent with the principles outlined in the Framework Agreements. The Committee believes that while the Commonwealth has tried to ensure some consistency in its arrangements with the States and Territories it has failed to ensure real compliance.

2.55 The WA Branch of the Australian Nursing Federation considers that:

> In our experience, reliance on state health authorities to translate Commonwealth strategies and programs into action does not achieve satisfactory outcomes[7]

2.56 The first of the Framework Agreements was signed in 1996, but their effectiveness is questionable.

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6 Department of Health and Aged Care. Submission No 68. p239.

7 Australian Nursing Federation, WA Branch. Submission No 19. p549.

> What we would say is that it is difficult, that at the moment the framework agreement operates as a sort of gentleman's agreement, really, that there are no sanctions and that we do not have any way of enforcing the commitments that are made in that, and that is a problem.[8]

2.57 In a 1998 review of the Commonwealth Aboriginal and Torres Strait Islander Health Program, 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 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.[9]

2.58 A key aspect of the Framework Agreements is the focus on regional planning, but, based on the Committee's observations, the process appears to be working well in some areas and not in others. This 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.

> In the first instance I think the fact that the regional planning exercise is done at the local level has given people an opportunity to actually sit down to talk, sometimes for the first time. The personal relationships that have started to emerge between key Aboriginal health leaders and leaders of health systems within their regions has a fairly significant impact: it opens the door, starts the dialogue and starts the ball rolling.[10]

2.59 Generally, the Committee did not observe that local health 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.

2.60 The Committee recognises that if the current structural arrangements continue, then agreements of this nature are of paramount importance.

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8 Ms H. Maher. Evidence. p1086.

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

10 Mr S Houston. Evidence. p1025.

2.61 The Framework Agreements do provide for the inclusion of the community sector in joint planning arrangements, but they do not really address what role that sector should play in the delivery of any new services arising from those processes. The Agreements primarily relate to ways in which mainstream services need to be enhanced to meet the needs of Indigenous Australians.

2.62 The Committee believes there has been little meaningful dialogue arising from earlier reports, (see Appendix F), 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.

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

2.64 The States and Territories have indicated a willingness to renegotiate the Framework Agreements, which will shortly expire, but the Committee believes it is the AHCA that should provide the overall framework for Indigenous health services.

2.65 It is important for the new Agreements to be much more explicit about the role to be played by the community controlled sector.

Recommendation 7

2.66 **The Commonwealth ensure that the provisions of the Framework Agreements are incorporated into the next Health Care Agreements to be negotiated with the States and Territories, to ensure that there is a more direct link between:**

- **the Commonwealth's funding for Indigenous health, both direct and indirect;**
- **the Commonwealth's national policy role, including the expanded role for the Commonwealth envisaged by the Committee;**
- **the States and Territories service delivery roles; and**
- **the role of the community controlled services.**

Revised funding arrangements

2.67 The Committee believes an approach is needed to service planning and delivery that will:

- provide an adequate level of funding that can be linked to an improved regional planning process; and
- place the responsibility on the community itself to identify short and long term goals and to work as an equal partner with the mainstream health services in determining how best to meet those needs with the available resources.

2.68 The focus needs to be on the development of local needs based approaches, that can then feed into a broader national analysis of overall relative need.

2.69 There needs to be a requirement for the States and Territories to report in detail on the use of funds, both to justify additional Commonwealth funding and to satisfy the Indigenous community that funds are being used effectively.

2.70 Regional managers of State and Territory health services must have Indigenous health as one of their major health priorities. The proposed changes to the AHCA should entrench this at the State level, but it should be possible to encourage participation at the regional level by including measures of performance in this area in manager's agreements and contracts.

> We have to find ways of holding general managers accountable for their performance against values or standards relating to Aboriginal Health.[11]
>
> I think Queensland Health have to educate their district managers.[12]
>
> They need, in my view, to ensure that the service agreements they have with the district managers and people like that embody targets and things like that which are clearly about focussing on and improving Aboriginal health outcomes. We do not know if they do that, because we never get to see that sort of information.[13]

11 Mr S Houston. Evidence. p1031.

12 Mrs M McMahon. Evidence. p1301.

13 Mr L Collins. Evidence. p1302.

2.71 As a corollary there needs to be mechanisms to ensure that the community controlled sector is able to report to the community on similar terms to the State and Territory health services.

Determining revised funding levels

2.72 As a recognition of problems with the current funding arrangements, the Commonwealth, States and Territories have been trialing a new approach in a number of Indigenous communities, to test different service delivery and funding arrangements. This involves developing a pool of funds that can be used for any client need and can be directed irrespective of program or institutional boundaries.

2.73 Under the trials each of the jurisdictions involved contributes an amount to the funds pool, based on an estimate of what would have been available to the community had there not been a trial.

2.74 The Commonwealth contributions from MBS are estimated on the basis of the population in the area and the national average annual benefit. The PBS contributions are cashed out at a rate which assumes 80 per cent of the population are health care card users and 20 per cent use the PBS at the national average. This works out at approximately four times the average rate at which Indigenous Australians currently use MBS and PBS resources.

2.75 The other two major contributors to the funding pool are State health services and Home and Community Care (HACC) services.

2.76 The contributions to the pool for hospital services are based on estimates of utilisation and average costs and the amount for other health services is based on historical or other estimates. The HACC contributions are based on estimates of utilisation or some capitation rate based on the community demographics.

2.77 This pool of funds, which is no longer constrained by the specific rules of the programs of origin, can then be used by the community for service substitution and to address the health priorities that the community itself considers to be the most pressing.

2.78 The advantage of the trials is that there is much more intensive community involvement, both through consultation prior to the commencement of the trial and in the decision making on health services delivery during the course of the trial.

2.79 The trials are still being evaluated, but the Committee was impressed by the impact that this approach had on the level of community involvement and commitment in those areas where the trials were being undertaken.

2.80 On the Tiwi Islands north of Darwin the community has embraced the opportunity enthusiastically and the health board has developed a range of local initiatives. However, it has not been without problems.

2.81 The trial took a considerable amount of time to get off the ground and there were initial disagreements about the level of funds used to calculate the cash-out figures for the Island. Then, because the trial was slow to start, the community was advised funding would cease at the end of the allotted period, irrespective of the amount of time the trial had been running.

2.82 This proved to be a result of communication problems. Funding arrangements are to continue while the operation of the trail is evaluated. The Committee believes that for such innovative programs to work successfully there needs to be clearer agreements on the roles and responsibilities of the respective parties and on expected outcomes.

2.83 The Committee believes that a similar approach should be introduced for all regions in order to support the current regional planning processes. The level of funding should be determined on a similar basis to the existing trials, recognising that there are some differences in the way all of the current trials have been funded.

2.84 There is a need to address the relative costs of providing services which the Committee believes should be based on some measure which takes into account issues such as remoteness, age and sex profiles, existing infrastructure and other relevant factors.

> One of the things that has become clear in the Medicare access model has been the assumption that a dollars worth of MBS service in Perth is worth the same in the bush is an absolute nonsense. The cost of getting the practitioners to the location is exorbitant.[14]

2.85 The Committee highlights the need for flexibility in recognising the non-homogeneous nature of Indigenous communities and the differing health needs of those communities as well as the capacity of existing service providers and communities to benefit from new services.

2.86 Any approach based on some form of capitation as recommended here would need to recognise the difficulties, discussed in Chapter Eight, of estimating existing Indigenous populations. Funding estimates would

14 Mr S Houston. Evidence. p1047.

need to be based on local information and to make some additional allowance for the problems with the mobility of Indigenous communities.

2.87 This approach will require additional Commonwealth funding, but as indicated previously, there is already a considerable shortfall in many areas because of the lack of equitable access to MBS funding.

2.88 Indigenous Australians are disadvantaged, not only in terms of their health status, but in terms of the other amenities that are taken for granted by non-Indigenous Australians, such as adequate housing, water, sewerage and access to education and employment opportunities.

2.89 At the moment the Commonwealth and the States and Territories spend around $400 million per annum respectively on health services for Indigenous Australians. It is difficult to estimate how much additional funding will be required without completing the regional planning and an assessment of relative need. The Committee does not believe that any significant progress can be made in the absence of increased funding from the Commonwealth.

2.90 A recent analysis, undertaken on behalf of the Australian Medical Association by Professor John Deeble, has estimated that, if using a needs based approach to Indigenous health funding, a further $250 million per annum would be required to address the current unmet need. Professor Deeble based his estimates of relative need on the current differences in mortality between Indigenous and non-Indigenous Australians.

2.91 The Committee is not in a position to provide a better estimate but does not consider this sort of amount unreasonable, given the very poor health of Indigenous Australians.

2.92 Whatever the amount of additional identified Commonwealth funding it should be progressively allocated over the next four years, to allow the new arrangements to be developed properly, particularly the proposed increased role for local communities.

2.93 Under the new arrangements being proposed, the Committee believes that States and Territories should be able to identify considerable savings for re-allocation by reducing duplications and better of use of existing resources.

2.94 The Committee expects the States and Territories would also allocate additional funds commensurate with their responsibilities. This should not be a prerequisite for the distribution of additional Commonwealth funds related to the MBS shortfall identified by the Committee.

Recommendation 8

2.95 **In conjunction with the Indigenous community over the next two years, the Commonwealth develop a revised approach to funding primary health care services for Indigenous Australians, based on:**

- **the use of funds pooling at a regional level, determined by reference to a nominal per person Medicare Benefits Sshedule(MBS)/Pharamceutical Benefits Scheme(PBS) contribution, which takes into account not only the national average costs of MBS/PBS usage by non-Indigenous Australians, but should also be weighted for the higher costs of servicing specific communities and the poorer health status of Indigenous Australians;**
- **the combination of these funds with an amount from the State or Territory, representing the cost of hospital and other health services; and**
- **the community to be supported in taking responsibility for these funds and determining the use of the funds pool in delivering services to the community which best meet the health needs of each community.**

3

Indigenous health services and community control

We also have a belief that health is achievable only when the people who suffer the greatest disadvantage have ownership and control of the process and the programs that are directly related to it.[1]

Health services for Indigenous Australians

3.1 While the States play the major role in delivering health services for Indigenous Australians, with varying proportions of their funds going to hospital services and other programs, the other key players in the delivery of health and related services for Indigenous Australians are the Aboriginal Medical Services (AMS).

3.2 These services were developed because the communities considered mainstream services were not responding to their needs.

3.3 The National Aboriginal Community Controlled Health Organisation (NACCHO) submission to the Inquiry points out that:

> Aboriginal community controlled health services are primary health care services initiated by local Aboriginal communities, aiming to deliver holistic and culturally appropriate care.[2]

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1 Mr William Tilmouth. Evidence. p470.

2 National Aboriginal Community Controlled Health Organisation. Submission No 64. p174.

3.4 There are more than 100 AMS operating around the country, mainly providing primary health care services and occasionally some access to specialist care.

3.5 These services range from major regional organisations, providing health services across a wide area, to small local organisations with few staff. A map indicating the location of those AMS funded by the Commonwealth is shown at Figure one.

3.6 As can be seen from this map, the AMS are distributed fairly unevenly across the States and Territories. This reflects the largely historical, and generally unplanned nature of the decisions to fund each of the individual services.

3.7 The level and nature of the funding provided to many of these services, reflects both the capacity of the service to agitate for funds, as well as sometimes a need to compensate for State and Territory decisions to focus their funding on areas without Commonwealth funded AMS.

3.8 The current funding model presently used by the Commonwealth for existing AMS does not necessarily reflect a direct relationship to the specific health needs of the individual communities being served.

3.9 Responsibility for funding of these services was initially a matter for the then Department of Health. This responsibility was subsequently transferred to the Department of Aboriginal Affairs (DAA) in 1984 and to ATSIC, following its establishment in 1990. At the time of the transfer to DAA there were about thirty AMS funded by the Commonwealth and then about another thirty were established by DAA and ATSIC.

3.10 Responsibility for funding these services was then transferred back to the Department of Health and Aged Care in 1995 and additional services have since been established on the basis of funding provided through that Department.

3.11 This means that while certain communities do have access to a community controlled health service, the majority of Indigenous Australians still rely on the State or Territory for their primary and secondary care, with nearly 80 per cent of all services for Indigenous Australians being managed by the States and Territories.

Figure One.

3.12 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;
- 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.[3]

3.13 The effectiveness of community controlled services, as with all services, is dependent on the level of available resources. Despite numerous reports recommending increased levels of community involvement, some of which were mentioned earlier, the community controlled services have struggled to achieve funding support and to develop effective working relationships with mainstream services.

3.14 Many of the services visited by the Committee were stretching their existing resources to the limit. In one instance the Committee was impressed by the dental facilities at a medical service, only to find that the organisation was unable to use these facilities because of the lack of sufficient funding to employ a dentist.

3.15 The Committee was informed about other communities where there was no ambulance and the general service vehicles often had to be used to transport seriously injured patients over long distances. These problems were often compounded by the nature of the access roads, which as discussed in the next chapter are generally in very poor condition.

3.16 These problems are symptomatic of the confused nature of the funding process, where decisions about capital funding can be made without reference to an analysis of need or consideration of the long term impact on operating costs.

3.17 Owing to the limited available resources many of the community controlled services also maximise their capacity to pay professional staff by utilising the concessions currently available under the Fringe Benefits Tax (FBT) arrangements to the fullest.

3 National Aboriginal Community Controlled Health Service. Op cit. p174.

3.18 These services have expressed concern that they will be significantly disadvantaged by the changes to the FBT arrangements which are to be introduced as part of the Government's new tax system.

3.19 The AMS have argued that they face greater difficulty in recruiting skilled staff due to the high demands of working in Indigenous health and the generally low remuneration available compared with other areas of health practice. This means that they often have to provide a higher salary or increased level of benefits, to compete with hospitals and private practice for skilled health professionals.

3.20 The Government has announced a number of concessions relating to the changed FBT arrangements for charities and certain other non-profit organisations. The FBT capping measures applying to these organisations will be increased to $30,000 of grossed up taxable value per employee from 1 April 2000, and any housing benefits provided by employers located at least 100 kms from a population centre of 130,000 people or more will be exempt from the FBT.

3.21 The AMS do not believe this is sufficient to cover the higher benefits they need to offer in order to attract staff. The Government has acknowledged these concerns, asking the Minister for Health and Aged Care to consult with ATSIC and report on these issues before 1 April 2001.

3.22 The Committee supports the need to review the capacity of the AMS to attract appropriate staff under the new tax arrangements by ensuring that the AMS are provided with a realistic level of resources, sufficient to meet all their staffing and clinical needs.

3.23 One of the other difficulties in assessing the impact of funding problems is that many of these services are not subject to any form of external accreditation, such as that applying to public hospitals and community health services. This means that there is no independent assessment of the efficiency of the organisation in using the available funds, or of the longer term impact on service standards of any funding shortfalls.

3.24 This is not to say that the standard of services provided by the AMS are in any way deficient. The Committee was very impressed by the professionalism and level of services provided by most of the organisations visited, and many services already undertake a regular review of standards and procedures. However, the lack of a consistent and independent review of services, means that there is very little information available to assess the gap between what funding is provided and the level of services that the organisation is trying to deliver.

3.25 The development of any accreditation process for these services needs to take into account the impact of community control on the way services are

developed and delivered and ensure that the community has a clear and valid role in the accreditation process.

3.26 It would be appropriate to ensure that such a process is not only applied to the AMS, but would be relevant to those State and Territory hospital and community health services provided for Indigenous patients and communities.

Recommendation 9

3.27 **Over the next twelve months, in conjunction with the National Aboriginal Community Controlled Health Organisation, the Commonwealth Department of Health and Aged Care:**

- **develop a mechanism for the accreditation of all Indigenous Health Services, including development of arrangements for collection of appropriate data;**
- **undertake a systematic review of the level of services currently provided by the Aboriginal Medical Services funded through the Department;**
- **seek independent, professional advice on the overall level of resources required to provide those services to a professional and accredited standard including, where applicable, the higher costs associated with attracting professional staff to work in the area of Indigenous health; and**
- **ensure that funding commensurate with those needs is provided to accredited services.**

Recommendation 10

3.28 **Where the proposed changes in regional planning arrangements result in community agreement for the Aboriginal Medical Service to undertake additional services, the Aboriginal Medical Service should not be financially disadvantaged in its agreement to undertake additional services.**

Community control

3.29 The key to achieving an effective regional approach is engaging the Indigenous community. Without their participation and cooperation no approach will work.

3.30 However, community control has a variety of meanings and the different interpretations of this seems to be one of the factors separating the services.

> For people involved in health service delivery to Aboriginal people…community control is a 'buzz phrase'; it is the kind of term that everybody appears to believe is a 'good thing', it is an obligatory term to put in any submission for funding for Aboriginal projects; and appears in the policy of all agencies involved in health care. Like many other hackneyed phrases, it can be overused to the extent that it can mean all things to all people.[4]

3.31 Scrimgoeur has argued that:

> …there are significant complexities involved in achieving effective community participation, let alone control. In remote communities, community control of health care has even greater problems and obstacles to its realisation. These problems include:
>
> - One of the main reasons that Aboriginal community controlled services were established in towns and cities was as an alternative to mainstream health services, which for various reasons were not accessible or appropriate for Aboriginal people. In remote communities, there is usually only one health service available, so a community controlled health service is not an alternative to mainstream services…the question of who is meant to be controlling the service may not have much impact on the appropriateness of the service. Other factors such as the quality of non-Aboriginal staff employed may be more important.
> - Towns and cities consist largely of non-Aboriginal spaces, in which many Aboriginal people feel alienated. In this environment, Aboriginal people are entitled to their own spaces for the delivery of services such as health care, where they feel comfortable and with more control over their own affairs.
> - Given the relatively small size of most remote communities, there are considerable diseconomies of scale involved in establishing separate community-based health services.

4 Dr D Scrimgeour. Op cit. p1.

- Most people living in remote Aboriginal communities do not have the level of education required to tackle the managerial tasks required to run a health service. A remote community controlled health service usually has to employ (usually non-Aboriginal) administrative staff from outside the community.
- Contemporary remote Aboriginal communities are expected to make decisions about a large range of aspects of community life, having to also make decisions about the day to day running of the health service may be an unnecessary burden.
- There is evidence from anthropological work that people living in remote Aboriginal communities regard biomedical services as part of the non-Aboriginal domain, and as a result are happy for this to be managed by non-Aboriginal people as long as there is some degree of accountability.[5]

3.32 In the past the development of the AMS has tended to be based on an adversarial approach. AMS competed with mainstream services for resources, creating a degree of tension due to the premise that they were being developed because the mainstream services were unable to provide an adequate service.

> There are constant contradictions about where power is. When the Aboriginal community attempts to organise itself to have power, the community development professionals and a lot of the health professionals dive under that and say, 'They do not represent the community we go down to the least organised part of Aboriginal society and we will work with them'. [6]

3.33 At the moment the Aboriginal Community Controlled Health Services are involved in the regional planning process in each State and Territory, through the Framework Agreements. The level of this involvement varies from State to State.

3.34 In the Northern Territory for instance, the Government was initially reluctant to sign the Agreement, as it did not consider the community controlled organisation sufficiently representative, as these services only operated in a limited number of areas in the Northern Territory.

> The criticism that such organisations are 'not representative' is related to a confusion between descriptive and substantive representation. ACCHSs have been able to produce skilful and articulate political players, with an increasing knowledge of the health system and public health issues, who have organisational

5 Ibid. p83.

6 Dr B Bartlett. Evidence. p1080.

> backing, and who are hence able to operate as effective representatives of the interests of Aboriginal people [7]

3.35 One of the disadvantages of the proposed changes to Commonwealth State Agreements, is that while the community sector is a signatory to the Framework Agreements, it is not a signatory to the AHCA.

3.36 Given that the Committee is proposing that the AHCA now formalise the relationship between the Commonwealth and mainstream services, and that this should make it clear to all parties the importance of this issue, it would be entirely appropriate for the community sector to also become a signatory to the revised AHCA.

3.37 The proposed funding arrangements include a key role for the community sector in the planning and delivery of regional health services and this role needs to be formalised to ensure that all parties are committed to the effectiveness of the arrangements. There needs to be adequate funding support provided to the community sector to ensure that they are able to participate in the regional planning as equal partners. These matters should be formalised as part of the funding arrangements under the AHCA.

3.38 The Agreements need to ensure that it is the community which has primary responsibility for determining the best mechanism for the provision of services, and that the community is given the opportunity to accept this responsibility.

3.39 It is important that the service models available to the community are flexible enough to meet the differing needs of communities across the country.

> The actuality of community control does have many faces, if you like. There have been periods when individual communities have looked at taking over a service themselves. They have gone into it, investigated it and thought about it and, at the end of the day, they have decided 'Well, what happens, if somebody goes off sick? We can't replace them, but we can insist you do. Therefore, we'll decide our providers should be THS. That is community control too.[8]

Recommendation 11

3.40 **The Commonwealth support increased community control of health**

7 Dr D Scrimgeour. Op cit. p90.

8 Ms C Rae. Evidence. p1152.

services for Indigenous communities. The community has a responsibility to determine the nature of that control. There needs to be flexibility in arrangements to ensure that each community is able to have the services which best meet their needs within a broader accreditation process.

The implementation of this position should be facilitated as part of the revised regional planning process over the next two years.

Recommendation 12

3.41 **The Commonwealth, States and Territories recognise that the community controlled sector has a legitimate role to play in representing the views of the Indigenous community as they relate to health matters. They should be assisted in every way to actively participate as equal partners in the planning and delivery of health services for Indigenous Australians.**

Building community capacity

> The important thing about community control is that the community has the capacity to do it. It is no good just suddenly hurling a whole bunch of money into a community and saying 'You have community control now. Off you go and do what you like,' when people do no necessarily have the skills in the community to do that.[9]

3.42 It is not simply enough to say that the community should be allowed to determine the nature of their health services, if they do not have the capacity to do so.

3.43 Frequently communities rely on outside professional advice and expertise. When these people leave, services deteriorate until such time as another person can be found.

> That does not mean to say there are not also issues of local control; there are some things that are best controlled locally in the community. If everything has to be controlled locally in the community, then it all tends to fall apart, or it depends on a

9 Mr J Gallacher. Evidence. p1140.

> competent whitefella being there, or on a particularly strong local Aboriginal leader.[10]

3.44 There needs to be a commitment to developing mechanisms which work within Indigenous autonomy, but which provide the tools to develop such autonomy, without developing a dependence.

> What I have seen in the 17 or 18 years that I have been here working with Aboriginal people primarily in East Arnhem Land is a deskilling of a community. A community that used to build all their own houses now has contractors build them. A community that used to do all their own book-keeping now has whitefellas do most of it. This is a community that where the mechanics, that ran their own resource centres, that did so many things. Essentially because of financial constraints and because of our desire to do things for people, we deskilled a community.[11]

3.45 There needs to be an agreed long term strategy, with appropriate resources, to move to community control.

> There were an enormous number of Aboriginal people working terribly hard in the communities, putting things right and struggling with things. What is very important is that they get adequate respect and support, particularly from government organisations and government. This is where the flavour of a government, the relationship a government has with the Aboriginal community is very important.[12]

3.46 In the context of community control, communities need to be allowed to learn from their mistakes.

> I believe that we, the Tiwi people, have taken 20 years, and our capacity building has been mainly through the development of people that have an interest in our island. We have had a lot of learning experiences and most of them were through mistakes. I think you would agree that each mistake we make has made the Tiwi people stronger in regard to controlling our land.[13]

3.47 Indigenous communities easily attract criticism for financial mismanagement, but the Committee found that they have considerable difficulty in accessing the administrative support they need to address these problems.

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10 Dr B Bartlett. Evidence. p1091.

11 Mr S McMillan. Evidence. p1170.

12 Dr N Phillips. Evidence. p1355.

13 Mr M Puruntatameri. Evidence. p1144.

3.48 For instance, if the community store has financial problems, there should be mechanisms to provide support and expertise to ensure that the problem is not compounded.

3.49 The Commonwealth Department of Health and Aged Care has made limited funding available for management support of services that are having difficulties. The Committee recognises that when organisations are in difficulty the Department, as the funding body, has responsibilities to ensure that further funds are not jeopardised.

3.50 There needs to be a way to balance the requirements associated with accountability, against developing a core of commercial and management expertise in funded organisations and communities.

Recommendation 13

3.51 **The Aboriginal and Torres Strait Islander Commission provide advice to the Minister for Aboriginal and Torres Strait Islander Affairs, within six months, on possible mechanisms to improve the level of management support provided to Indigenous organisations, including mechanisms to improve the way funding bodies respond when organisations get into financial difficulties.**

4

Improving housing and Infrastructure services

One of the major paradoxes of the Australian health care system is that when an Aboriginal is seriously ill or injured, no amount of money is spared in aerial transport to and care in a tertiary care teaching hospital. This may occur from communities where money cannot be found to provide a ready source of running water and adequate sewerage.[1]

Other health related services

4.1 As discussed earlier, there have been numerous reports on Indigenous health which have cautioned against focusing solely on health services, and have highlighted the need to give equal consideration to the impact of the living environment, when considering Indigenous health matters.

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[2]

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1 Kamien, M. Aboriginal Health An Overview. *Current Affairs Bulletin*. 1993. pp11-17.

2 House of Representatives Standing Committee on Aboriginal Affairs. Op cit. p37.

4.3 It has been suggested that improving the standard and availability of infrastructure for Indigenous communities may have a greater long term health benefit than simply providing more health services.

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

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

4.6 As well as there being a considerable backlog of need, the standard of existing housing and infrastructure in many remote, rural, and even some urban communities, from the Committee's observations, is well below the standards generally applying in most non-Aboriginal communities.

4.7 During the course of the Inquiry the Committee visited many communities, and found that, with a few exceptions:

- a significant proportion of the housing stock was in poor repair, with people sometimes living in rough shelters, directly beside the shells of uninhabitable houses;
- roads connecting communities to other centres were generally basic and poorly maintained. They were often simply dirt tracks. Even the few sealed roads seen by the Committee were generally in poor repair;
- water services were of mixed standards and effectiveness, but often inadequate with poor pressure and intermittent supply;
- sewerage systems were of similar standard, and in some communities visited were considered to be a source of illness, rather than any benefit to the community; and
- waste disposal was problematic. In one rural community the local town rubbish tip had been moved so that it was now sited above and beside the Indigenous community housing area. In another remote community the rubbish tip was just on the outskirts of town so that rubbish was simply blown back around the town.

4.8 Although there are significant problems with infrastructure in urban areas, the problems observed by the Committee were most prevalent in rural and remote communities.

4.9 A 1999 evaluation of ATSIC's Health Infrastructure Priorities Program, by the ANAO, reporting on progress with housing stock noted these problems in urban areas:

> 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. [3]

4.10 Again, while the Committee believes there are arguments for additional funding in these areas, many of the problems facing these communities are related to the lack of coordination between government authorities, local councils and local communities, as well as an inadequate focus on maintaining key services to an acceptable level.

Focus on sustainable services

4.11 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;

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

- temperature control; and
- reducing trauma.

4.12 These objectives all seem to be relatively straight forward and easy to understand from a mainstream perspective. They should be able to be managed at the local level, with appropriate support, and they focus on the more important aspects of the whole living environment.

4.13 However, these simple practices could not be achieved by most households involved in the study at the time. Many remote communities are still unable to achieve all these healthy practices, because they do not have the working hardware.

4.14 The emphasis in the infrastructure related aspects of these practices is on making sure that existing hardware continues to work, rather than what the facilities might look like.

4.15 The need to make sure all relevant hardware is initially working and continues to work is very important. The Committee was informed of many instances where new houses, which had supposedly been completed by contractors, were found to be poorly finished, with substandard, or even missing fittings, unconnected plumbing, and gaps in walls.

4.16 Nevertheless it is not until recently that such a coordinated approach has been embraced by funding authorities and community organisations. For instance the ATSIC Health Infrastructure Priority Projects all now involve the independent inspection and monitoring of contractors by the program managers.

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

4.18 As Indigenous services are often located on Crown land, local building requirements are not always applicable or enforceable. There must 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.

> Because of the absence of the sort of coverage you are talking about, the absence of the standards and the inspection, in the

> design of our program we have the program manager performing that function.[4]

4.19 The nature of standards development and the range of organisations involved in the monitoring and provision of community services makes it difficult for communities to manage this process by themselves.

4.20 For instance in the Northern Territory, housing works constructed under community grant funds provided through the Indigenous Housing Authority are approved by self certification of a consultant appointed by the community. The regional Territory Health Services Environmental Health Officer is required to comment on plans for community food stores, public buildings, sanitary and ablution facilities, sewerage systems, rubbish collection and disposal sites and any plans to use scheduled poisons for pest and animal control. The regional Power and Water Authority is also required to comment on community food stores, sewerage systems and public buildings, as well as landscaping and environmental projects and any other proposals for connection to new, or upgraded, use of existing power or water connections.

4.21 A Commonwealth State Working Group on Indigenous Housing has developed a 'National Framework for the Design, Construction and Maintenance of Indigenous Housing' for endorsement by Commonwealth, State and Territory housing ministers. It is primarily concerned with Indigenous housing in rural and remote areas, where the housing need is greatest, but can also be applied to housing in other localities.

4.22 The framework will provide a structure to support a consistent approach to safe, healthy and sustainable housing. It also incorporates a guide, broadly based on the UPK principles mentioned earlier, to provide practical advice on the design, selection, construction, installation and maintenance of housing health hardware and other information on environmental health issues.

4.23 While the Committee fully supports the need for the development and implementation of such a guide, it is imperative that there are sufficient resources available to allow the monitoring of work undertaken under the guide. There also needs to be a clear understanding of which agency is responsible for such monitoring.

4.24 Implementation of an approach which focuses on effective maintenance, such as the UPK 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.

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4 Mr C McCarthy. Evidence. p1409.

4.25 To better identify the backlog, ATSIC is attempting to develop improved measures of need, taking into account the levels of overcrowding, homelessness, essential service provision, appropriateness, affordability and stock condition.

4.26 In late 1999 the ABS undertook a further Community Housing Infrastructure Needs survey on behalf of ATSIC, to collect data on dwelling condition, community infrastructure, health facilities and services and housing organisation details from all Indigenous communities and Indigenous housing organisations across Australia.

4.27 This survey found that, since the last survey in 1992, there has been some improvement in the overall state of existing housing stock, with the percentage of the stock of houses in need of major repair or replacement decreasing from 44 to 29 per cent.

4.28 In relation to the housing stock the survey found that:

- repairs and maintenance were undertaken on 69 per cent of dwellings during the financial year prior to the survey;
- the total reported maintenance expenditure for the financial year prior to the survey was $39 million; and
- the average maintenance expenditure per dwelling in the financial year prior to the survey was $1,942.

4.29 The survey also collected a range of community infrastructure information for those locations identified as discrete communities. In these communities 943 reported a usual population of less than 50, 348 of more than 50 and 149 of these had a usual population of 200 or more.

4.30 In these discrete communities 33 per cent of the housing was reported to be in need of major repair or replacement.

4.31 In relation to the 348 of these discrete communities with a population of 50 or more, however:

- no water quality testing was undertaken in 64 of the 233 communities not connected to town water, and the water supply failed testing in a further 58 communities in the 12 months prior to the survey;
- power interruptions occurred on at least twenty occasions during the 12 months prior to the survey in 57 communities with a total population of 18,490 people; and
- leakages in sewerage systems in the 12 months prior to the survey occurred in 204 communities affecting 2,428 dwellings.

4.32 The survey did not attempt to quantify the cost of meeting the backlog of identified need, but the Committee understands ATSIC has since commissioned consultants to estimate this cost. Their report is expected by the end of June.

4.33 These costs are likely to be significant, particularly in rural and remote communities.

4.34 Though governments may be reluctant to financially commit themselves to meeting this enormous unmet need, it should be considered that were this situation to have developed overnight, a state of national emergency would be declared.

4.35 The Committee commends a deficit reduction strategy on housing, sewerage, water and infrastructure programs. The nation's inability to address these needs is not something which we as Australians can be proud of.

Recommendation 14

4.36 **In the first annual report to Parliament the Minister for Aboriginal and Torres Strait Islander Affairs pay particular attention to the outcome of the recent Australian Bureau of Statistics' Community Housing and Infrastructure Needs Survey. It will report on a strategy to enable the Aboriginal and Torres Strait Islander Commission to address the backlog of need identified in the survey, in conjunction with the States and Territories within the next five years.**

4.37 The problems in this area are not only related to the lack of application of standards and inadequate construction, but to a lack of emphasis on maintenance services, as well as the failure to effectively involve the local community in such maintenance.

4.38 If health hardware is constructed then there must be ongoing funding to keep it in good working order. It is not simply a matter of building better facilities. Taps need to keep working, toilets keep flushing, roads remain sealed and houses in good order.

4.39 Effectively apportioning funds between providing new stock and maintaining existing stock, will ensure that new stock is simply not just replacing old non-viable stock.

4.40 If housing and infrastructure are not adequately maintained it deteriorates and must be replaced. This means that most of the available capital

funding is then used in replenishing existing stock instead of increasing the overall stock.

4.41 The Committee believes that although there needs to be a heavy focus on capital replacement for some time, if sufficient attention is given to maintenance issues then the focus on capital replacement will decrease significantly as the amount of viable stock increases.

4.42 The difficulty with this approach is that it actually means there are considerably higher costs in the early years. If the existing funds are simply split between maintenance and new stock, the increasing demand for housing engendered by the rising family numbers will mean increases in overcrowding and homelessness. This places even more pressure on the sustainability of current housing stock.

4.43 The Committee acknowledges this is a complex issue, with a need to balance progress across all areas, including infrastructure, health service delivery, education, training and employment. The Committee believes that efforts to improve planning and coordination, in conjunction with the communities themselves, will result in longer term improvements, rather than simply spending more money.

4.44 As with health services, this is not going to happen overnight. It will again require a long term and continued commitment to making some progress.

4.45 Mechanisms 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 results from funding arrangements which dictate unexpended funds must be returned, even though there may be legitimate reasons for the funds not being used in time.

Other housing matters

> Effectively, in public housing, for example, there is a subsidy of $1200 or $1300 per household. That subsidy is not there for indigenous community housing. So, particularly when you consider remote factors, you are looking at a client group which has even more need than public housing clients, and yet less capacity in the sector to be able to deliver effective services, maintain houses and so on.[5]

5 Mr C McCarthy. Evidence. p1405.

4.46 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 Northern Territory Government found that many organisations had never been resourced or trained for this purpose.

4.47 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.

4.48 In a number of the communities visited the Committee saw examples where people were paying a high proportion of their income for very poor accommodation, with no water or sewerage and only basic protection from the weather. The amount of rent payable must be linked not only to the capacity to pay, but to the quality of housing, based on national standards, not just local relativities.

4.49 There must be an acceptance the low socioeconomic status of Indigenous communities will prevent any effective rental contribution which adequately reflects the full costs of sustaining the current housing stock.

4.50 In some cases low literacy and educational standards within a community make it difficult for people to understand the reasons that rental charges are being levied. Often the linkages between rental payments and ongoing maintenance are poorly understood. Housing is generally provided through a community grant and there is sometimes a perception that the rent is paying for a house that the people already have.

4.51 As well as a recognition of the need to match rental income to a real capacity to pay, there should be considerably more effort invested in explaining how those funds are used to maintain the houses. This could be assisted by greater community involvement in the planning and delivery of maintenance programs.

4.52 The shortage of housing is a further complicating factor in maintaining the housing stock. 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.

4.53 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 must 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.

4.54 Some of the newer houses now being funded by ATSIC are addressing this problem. Extending the outside shelter areas and providing external access to ablution facilities, allows for accommodation of visitors. However, the Committee considers that there needs to be more innovation in developing housing which adequately reflects the family relationships of Indigenous Australians.

4.55 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.

4.56 Another factor which affects the usage of housing in Indigenous communities relates to cultural requirements to vacate a house for an extended period 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.

4.57 In some areas this period of enforced vacancy can be considerably reduced if the house is spiritually cleansed and then repainted, but often this is not possible because there are no funds available to allow for such changes. This should be incorporated as part of any rolling maintenance program.

4.58 Issues related to appropriate design and other cultural factors, such as this issue of a death in the house, require close consultation with the community as part of the development of greater community control and ownership.

Recommendation 15

4.59 **All future capital infrastructure programs identify an associated and ongoing allowance for the adequate and continued maintenance of the facilities concerned.**

Such maintenance programs are wherever possible undertaken by the community concerned and make appropriate provision for differing cultural requirements which might impact on the viability of community infrastructure.

Training issues

4.60 To support any ongoing maintenance program there must 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.

4.61 Development of effective infrastructure management is 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.

4.62 It has been suggested that to increase training opportunities approval of infrastructure projects, especially housing projects, should be based on incorporating some aspect of local training. This can present difficulties in implementation.

4.63 Many of these projects are undertaken by outside contractors and are often completed over a short period. Acquiring trade qualifications on the other hand, requires a number of years training which cannot be sustained by intermittent short term projects.

4.64 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.

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

4.66 A possible solution to this surely must be an innovative 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.

4.67 Focussing on ongoing maintenance and health hardware work in the communities on a long-term basis provides the potential for long-term meaningful employment which will also have considerable health benefits.

4.68 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.

4.69 The Army has provided upgraded facilities as well as some health assistance to clinics along with some degree of training in ongoing maintenance.

4.70 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.

4.71 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.

4.72 This must 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 community council. This would improve their career structure as well as creating a closer link in people's minds between their work and health outcomes.

Recommendation 16

4.73 **The Aboriginal and Torres Strait Islander Commission consult with the Department of Education, Training and Youth Affairs, the Australian National Training Authority, and with relevant State and Territory Authorities to develop, within two years:**

- **innovative approaches to support the training of community members in the basic and ongoing maintenance of community facilities; and**
- **mechanisms to upgrade that training over time to trade qualifications.**

Water

4.74 Whilst water services for Indigenous communities are generally funded by the Commonwealth (ATSIC), or State, Territory and Local government the above mentioned ABS survey found that there are major inadequacies with the quality and testing of water supplies for many communities.

4.75 The Committee 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 have detrimental effects on health, was irregular and inadequate.

4.76 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 results.

4.77 In another instance in New South Wales, the Committee was advised that water had not been connected to a small community outside of the town because of a dispute about access between the Land Council and the local municipal council. This matter was recently resolved, but not before the community went a number of years without adequate water. This may have been avoided if there was better planning and coordination of such services.

4.78 The lack of action in these areas contrasts sharply with the public attention given to the problems recently experienced with Sydney's water supply, even though the standard of water supplied to many Indigenous communities is regularly of worse quality.

4.79 Adequate supplies of water are 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.

Recommendation 17

4.80 **In view of the importance of potable water to the health and well-being of Indigenous communities:**

- **the Aboriginal and Torres Strait Islander Commission provide advice to the Minister for Aboriginal and Torres Strait Islander Affairs, within six months, of the costs of providing adequate water, within three years, to all those communities where water supplies do not meet national standards, including those for which no testing has been undertaken; and**
- **the Minister's annual report to Parliament provide advice about the Government's plans to address these outstanding needs.**

Roads and other access issues

4.81 Another critical health infrastructure issue for remote communities is the provision and maintenance of roads, both internal roads and access roads to other population centres.

4.82 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 diseases and skin disorders.

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

4.84 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 State and Territory governments.

4.85 In addition, the roads linking the communities to larger population centres were generally in poor condition and badly maintained, making it difficult to sustain a regular supply service or for medical evacuations, which then had to be undertaken by air at a much greater cost. Many of these roads are also affected by seasonal rains, which can leave communities isolated for extended periods, with access only by more expensive means such as air, or barge for some coastal communities.

4.86 Although the air strips had to assume more importance, because of the state of the roads, many of these were in poor condition and/or badly located.

4.87 In one remote community visited by the Committee the roads were appalling and the airstrip was unable to be used for night evacuations, because of its proximity to nearby hills. This meant there was no alternative to undertaking emergency night evacuations by road, with the possibility the eight hour trip, would in fact exacerbate the problems.

4.88 Responsibility for access roads generally rests with the State/Territory government, or in some instances, Local Government, while 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, as a key access point, is also a major area where funding responsibility is not clear.

Recommendation 18

4.89 **The Commonwealth Department of Transport review the current funding arrangements for roads and provide advise to the Minister for Aboriginal and Torres Strait Islander Affairs, within six months, about possible mechanisms to ensure that the responsible authorities are providing an adequate service to Indigenous communities.**

Some other barriers to access

4.90 As well as experiencing general problems in using the MBS and PBS schemes, the Committee was advised that many Indigenous Australians have difficulties accessing services because of transport problems.

4.91 In many communities, there are few people with access to private transport, resulting in considerable delays in getting to the health services, particularly hospital and specialist services.

4.92 Even in urban centres, the generally low socioeconomic circumstances of Indigenous Australians mean they are heavily reliant on public transport, which is not necessarily geared towards access to health facilities.

4.93 A survey by the ABS in 1994, found that for more than 23 per cent of Indigenous Australians 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 100km to get to a hospital.

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

4.95 In an emergency, the health service can often arrange an air or ambulance evacuation but the Federal nature of the health system can again complicate this issue. While the traditional lands of many Indigenous communities straddle State and Territory borders, the health system still operates inside those borders.

4.96 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, 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.

4.97 The decision to send patients to these areas is not the primary problem, but rather the fact that, when the patient is discharged, they are left to find their own way home without any resources. The Committee was informed of instances were the patient was just dumped at the airport or bus station, with a ticket but no other funds, no instructions and limited English skills.

4.98 The Committee was assured by representatives of State and Territory health services at the hearings that mechanisms were now in place to address these problems and that arrangements for cost sharing means that patients should be sent to the most convenient place, irrespective of where it was at. This conflicted with other advice from the services which were still having difficulties placing patients. It would appear that while at the State and Territory level agreements were in place, it was again dependent on the attitude of the local staff for these policies to be effective.

4.99 Even within some States or Territories, problems arise. For instance in the Kimberley region, the Committee was advised that Derby was considered to be the regional centre for health purposes, but unless it was an emergency patients had to travel through Broome from Kununurra, which was both difficult and more expensive. Even when medically evacuated directly to Derby patients then had to travel home via Broome.

4.100 The schemes operated by the States and Territories to assist with patient transport were 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.

4.101 A 1999 study of the Queensland Patient Transit Assistance Scheme found that:

> …clerks throughout the state are operating on a variety of interpretations of the criteria in the guidelines in their decision-making for approval of both patients and their escorts. Priority is given to purely physical or medical criteria rather than psychosocial considerations such as the patient's emotional state, financial situation and need for support.[6]

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

6 McGrath, P. *The Patient Transit Assistance Scheme: The Clerk's Perspective.* Australian Journal of Rural Health. 1999: 7, 140-147.

4.103 The need for health professionals to be made more aware of cultural issues, such as family relationships and responsibilities, is discussed in more detail in Chapter Seven.

4.104 The Committee was also advised 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 associated with an institutionalised bias that will require structural changes as well as cross-cultural training.

> …the majority of our people have within their vicinity hospitals or a medical service they can attend. It is making sure that they are more inclusive in responding to our needs.[7]

4.105 The Committee was advised of instances where:

- a patient had died despite repeated calls for an ambulance to attend. Then instead of eventually sending the ambulance to collect the body, a contractor was sent to remove the body in the back of his ute;
- a patient presented late on a Friday afternoon with an injured hand at a regional hospital, to be told he would need to travel to Sydney to have the matter attended to, despite being unable to use his hand and being in pain no effort was made to treat the hand at all;
- none of the doctors in one rural community would bulk bill an Indigenous patient, meaning there was no access to a doctor's service unless the full fee could be paid up front.

Infrastructure funding and service delivery issues

4.106 Funding provided by the States, Territories and Local Government for most Indigenous infrastructure services comes from either the general Financial Assistance Grants (FAGs) distributed by the Commonwealth, from Commonwealth Specific Purpose payments or from revenue raised directly by that State or Territory.

4.107 In determining the basis for horizontal equalisation of grants between States and Territories, 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 or Territory Indigenous population, but the process does not necessarily require the expenditure of any of the transferred funds for those purposes.

7 Mr P Buckskin. Evidence. p1427.

4.108 Under transitional arrangements for the new tax system, the Committee understands FAGs will be replaced with a Guaranteed Minimum Amount (GMA). This will ensure States are no worse off, but there will still be a similar process of fiscal equalisation involved.

4.109 The GMA will be paid in two parts:

- a State's Goods and Services Tax (GST) revenue grants, determined in accordance with horizontal fiscal equalisation principles; and,
- a transitional payment – the shortfall between its GMA and its GST revenue. This will take into account the impact of the reduction in States' own source revenues and equivalents. The transitional payment will continue until the State is no longer worse off under the new arrangements. Additionally, for the first two years, States which are better off, after receiving its base GST grant, will not be allowed to keep the excess, but, after the third year the better off States will be allowed to keep the excess.[8]

4.110 In a recent review of health services in the Northern Territory, an NT Legislative Assembly Committee considered that there were inequities in the disability factors for Aboriginal people, used by the CGC, including:

- The age factor does not adequately compensate the Northern Territory for providing services to Aboriginal people who have a life expectancy 18 years shorter than non-Aboriginal people and require access to health services (normally associated with old people) much earlier than non-Aboriginal people.
- The dispersion factor only takes into account straight line distances without consideration of road lengths and road quality.

4.111 The Commonwealth could provide funding for services on Indigenous lands, such as roads, directly, and did so to some extent until 1996-97, but the drawback to this approach is that it removes any incentive for the States or Territories to use other funding for this purpose.

4.112 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.

4.113 What the Committee believes is required is a more transparent process, which makes it explicit how much funding is being transferred to those

8 Commonwealth Grants Commission. *Discussion Paper CGC 99/2. Proposals for the treatment of new developments in State and Territory Finances, and data changes relevant to the 2000 update of relativities.* September 1999. p17.

States and Territories that benefit from the effects of disability factors associated with their Indigenous or remote populations.

4.114 In terms of transparency of funding, a recent amendment to the Commonwealth Grants Commission Act has required 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.

4.115 This will only generally apply to Commonwealth specific purpose payments at this stage, but it may be that the CGC could 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.

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

4.117 Funding provided by the Commonwealth for other infrastructure, like health and housing, is distributed through a range of Commonwealth, State, Territory and Local Government programs. Unlike health, where funding is generally provided through the health portfolios, there are numerous authorities and programs involved with other components of infrastructure services.

4.118 The way services are delivered through multiple agencies at the Commonwealth, State, Territory and local levels would appear to prevent an efficient and coordinated approach to the provision of infrastructure services.

4.119 There are two major Commonwealth funding channels for housing. Through ATSIC and through the Commonwealth State Housing Agreements (CSHA).

4.120 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.

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

4.122 Under these new arrangements, there is a pooling of the dedicated housing funds from ATSIC, the State and 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.

4.123 The housing Bilateral Agreements are a positive step to improving coordination 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[9]

4.124 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.

4.125 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.

Recommendation 19

4.126 **The Commonwealth Grants Commission report to the Minister for Aboriginal and Torres Strait Islander Affairs on**:

- **mechanisms to ensure there is a more transparent process for fiscal equalisation relative to the factors related to adjustments for Indigenous citizens as part of the allocation of Goods and Services Tax funding to the States and Territories; and**
- **ways to improve reporting by States and Territories on the use of those funds for Indigenous citizens.**

9 Mr S Houston. Evidence. p228.

5

Cultural, educational and employment issues as they relate to health

Health is not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community.[1]

5.1 Many of the submissions to the Inquiry, as well as many witnesses at the public hearings, have emphasised the need to consider Indigenous health within a framework encompassing all factors, not just the adequacy and availability of health services.

> It is very important that the final report looks holistically at cultural, social and economic issues (the underlying causes of good health). Dispossession, long standing discrimination and on-going poverty at a community not just an individual level are the major underlying factors in the poor health of Aboriginal people.[2]

5.2 As already discussed, environmental issues are a central component of improved health outcomes, but there are a number of other factors which can contribute to poor health, including lack of education, unemployment and the impact of social and cultural factors.

> There is no doubt that the dynamic of Aboriginal and Torres Strait Islander health is not just environmental health, it is not just

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

2 Doctors Reform Society (WA Branch). Response to Discussion Paper.

> housing infrastructure, it is not just education and it is not just health, and unless there is an umbrella that covers all these areas in an equal way, then there will be no improvement.[3]

5.3 A failure to achieve in either education and employment can not only create the sort of socioeconomic circumstances that contribute to poor health outcomes, but it is clear that health problems in turn create significant barriers to effective participation in learning and/or the workforce.

5.4 A significant, and some witnesses have said the central, but less tangible factor is the continuing legacy of colonisation, including dispossession, alienation and the loss of culture.

5.5 Dispossession has meant that many Indigenous Australians have been removed from their traditional lands and the importance of this linkage in promoting continued health and well-being is poorly understood by non-Indigenous Australians.

> The Aboriginals' bond with their land is unlike that which any people of agricultural or industrial societies experience. The whole of their lives, religious and cultural as well as physical is bound up in the love, conservation and celebration of the country. …In losing their land Aboriginals also lost their good health. The effects on their health were patent and gross. They make the World Health Organisation's definition of health – 'a state of complete physical, mental and social wellbeing, and not merely the absence of disease' – seem like a utopian dream.[4]

5.6 The present health problems of Indigenous Australians cannot be separated from past experience.

> The loss of a firm cultural grounding and loss of control over their own lives has led to a spiritual malaise and anomie which needs to be addressed if disparities in health status are to be overcome.[5]

> The other thing is that it is embedded in history. This has been said many times and perhaps repeated so much that it slipped past people, but it is embedded in history. It is embedded in dispossession of land, it is embedded in the destruction of

3 Mr N Jefford. Evidence. p1079.

4 McIlraith S, Reid J and Franklin M. *Aboriginal Health and Lifestyle. A health education and promotion monograph.* Australian Medical Association. 1982. p7.

5 Dr D Scrimgeour. *Community Control of Aboriginal Health Services in the Northern Territory*. Menzies School of Health Research. Occasional Papers. Issue No 2/97. p78.

> communities and cultures, particularly in the taking away of children and the breaking up of families.[6]

Cultural issues

> Lack of access to land can break down culture very effectively because a lot of the cultural activities are related to the land. As we break down culture we will get worse health not better. We will get worse mental health and we will get worse physical health. With poor mental health you get depression, you do not look after your diabetes, you eat the wrong foods, you have too much salt, you do not care about yourself, your blood pressure goes up and you have a stroke. We go into all these chronic diseases that are taking over from the infectious diseases in injuring and killing Aboriginal people.[7]

5.7 There is no universal definition, however, of culture and what it means to people.

> Aboriginal culture is the very antithesis of western ideology. The accent on individual commitment, the concept of linear time, the switch in focus from spiritual to worldly, the emphasis on possession and the pricing of goods and services, the rape of the environment and, above all, the devaluing of relationships between people, both within families and within the whole community, as the determinant of social behaviour are totally at variance with the fundamental belief system of Aboriginal people.[8]

5.8 Culture is an evolving matter which is shaped by experience and association:

> …tradition is not a static, bounded entity which can be easily translated in language and then translated into programmes. A truly 'culturally appropriate' service will be an outcome of a community-driven programme, in which the values and aspirations of that community have been successfully incorporated into the programme's design and implementation, often through a combination of dispute and collaboration.[9]

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6 Dr N Phillips. Evidence. p1335.

7 Ibid. p1336.

8 National Aboriginal Health Strategy Working Party. Op cit. pix.

9 Anderson I. 'Powers of Health.' *Arena Magazine.* June-July: 32-36 1994.

5.9 Despite this, it is very clear to the Committee that the issue of culture and its importance to Indigenous Australians is a key matter in the planning and delivery of services, if those services are going to be used by, and meet the needs of, Indigenous Australians.

5.10 One of the more enduring impressions gained by the Committee in talking to communities around the country was the feeling that, where those communities had been able to maintain their culture there was a greater sense of community well-being than in areas which had difficulties in establishing and maintaining those linkages.

5.11 However, many of the witnesses to the Inquiry found it difficult to articulate which were the most important aspects of culture and how they might then be encompassed by health and related services, particularly given the diversity of health beliefs between Indigenous groups and communities.

5.12 The Committee's view is that the idea of 'cultural security' or 'cultural safety' now being introduced by some Health providers, such as WA Health, is an effective way of addressing Indigenous concerns, while maintaining the cultural values of non-Indigenous staff.

> Cultural safety in health services happens when people feel able to use a service provided by people from another culture without risk to their culture[10]

> I think we need to recognise that there are two separate worlds, and the nation analogy endorses that, and that our objective should be to help people in each world understand the other world better. We are not necessarily going to move Aboriginal people into the medical world nor are we going to move medicos into the Aboriginal world, but if each side understands the other we are much better off.[11]

5.13 The Committee believes it is important to ensure that 'health' is the primary aim of any service. Health services need to be able to work with the community, to ensure that where there is conflict between traditional practice and good medicine, ways can be found that are both culturally and medically acceptable. For instance, the substitution of kangaroo blood for human blood in some initiation ceremonies to avoid infections.

> All of the components and elements that go to make up a culture are similar but it is the interpretations that we place on those through the environment we live in, the experiences we have, and the way we perceive things, that make the difference. When you

10 Irihapeti Ramsden. Remote Area Nurses Conference. 1999.

11 Dr P Carroll. Evidence. p1181.

> are talking about cross-cultural awareness you need to be aware of those sorts of factors and not get hooked on the idea that it is about traditional practices, although traditional practices are part of our culture.[12]

5.14 One significant barrier to establishing this working relationship is the differences between Indigenous and western health belief systems.

> The disparity between Aboriginal culture and mainstream Western culture appears to magnify the difficulties encountered in any cross-cultural health service delivery setting…The traditional health beliefs of Aboriginal people are interconnected with many aspects of Aboriginal life such as the land, kinship, obligations and religion. The sociomedical system of health beliefs held by Aboriginal people place emphasis on social and spiritual dysfunction causing illness…Sorcery and supernatural involvement are part of the perceived reality of Aboriginal life and in Aboriginal society explanations in terms of sorcery are often used.[13]

5.15 In Indigenous culture there are definite distinctions between the accepted roles of men and women in society and patients will often only be comfortable with treatment by health staff of the same sex.

5.16 Additionally there is a need to recognise the value to Indigenous patients of traditional medicine, including the role of traditional healers and bush medicines.

> Traditional healers are held in high regard. ….Traditional healers are trained to remove the influence of sorcery and evil spirits and to restore the wellbeing of the soul or spirit[14]

5.17 People tend to use a combination of western and traditional treatments, depending on the nature of their illness. The different world view of the underlying cause of a particular health problem can make a difference to the type of treatment used and the amount of compliance by the patient with the treatment.

> Difficulties arise in interactions between Aboriginal patients and health professionals when the health professional offers a version of reality that is different from the patients experience. It is

12 Mr L Collins. Evidence. p1281.

13 Maher, P. 'A Review of "Traditional" Aboriginal Health Beliefs'. *Aust J. Rural Health* (1999) 7, 229-236.

14 Ibid.

> important to explore the patients viewpoint to achieve congruency of meaning.[15]

Education

> The links between education and health outcomes cannot be overemphasised. International comparisons show that education, particularly female education, is an important determinant of health improvements in developing countries.[16]

5.18 While there is a clear rationale to improve education in order to improve health outcomes there is evidence to suggest that educational performance is significantly hindered by malnutrition, hearing loss and absenteeism.

5.19 A good education affects employment opportunities, which in turn impacts on income levels, access to good housing and health care. Poor health and poor quality housing, on the other hand affect school attendance, the ability to study and ultimately educational outcomes.

5.20 The low attendance and poor retention rates outlined in Appendix D may indicate the impact of such problems. Other relevant factors may be that many Aboriginal children perceive the education offered to have little relevance to their lives, or the failure to enforce compulsory education.

5.21 This latter point was emphasised in a recent review of Indigenous education in the Northern Territory, 'Learning Lessons' undertaken by The Hon Bob Collins. The review found that poor attendance is without doubt a significant cause of poor educational outcomes.

5.22 The isolation of many communities means that, even if they would like to, it is very difficult for children to proceed beyond primary education.

> …the lack of any decent educational facilities away from Alice Springs and the necessity for Aboriginal kids – who may have some kind of aptitude – generally speaking having to come in to Alice Springs to continue their high school creates enormous problems for them and their families, and it is actually very difficult for people to do.[17]

5.23 The Collins report also cited poor health as a significant barrier to learning outcomes, impeding attendance, participation and ability to learn.

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15 Ibid.

16 Menzies School of Health Research. Submission No 39. p1.

17 Mr E Tilton. Evidence. p1100.

> Several conditions are considered to be detrimental to educational outcomes, including nutritional deficits, hearing impairments, poor eyesight, anaemia and skin diseases.[18]

5.24 Hearing loss has a major effect on learning ability and there can be significant additional problems associated with trying to learn in a classroom where many of the students have a hearing difficulty and for most of whom English is, at best, a second language.

> We have nearly 100 per cent of our children suffering some form of hearing loss by the age of three months.[19]

5.25 The Collins report recommended further, that there should be a much closer link between the health and education providers, particularly at the local level and that health objectives should be incorporated into school action plans and the performance agreements of school principals. Community service agreements should be established between the school and the community health centre to effect these objectives.

> …one thing I do know is that the hearing of young Aboriginal kids at school is of critical importance not only to their educational attainment but also to their achievement in later life. A critical issue that the health department and the education department have to get their heads together on is hearing services for young kids.[20]

> For the last year, I suppose, in the Territory Health Services we have had a joint regional director of health and education in Alice Springs…There is a very successful interdepartmental task force that has been looking at environmental health… What we want to do is get an appropriate standard of service and standard of equipment and of building houses that is going to be accepted by the industry and then implemented at a government level.[21]

5.26 The Committee found that in many instances this was happening on an ad hoc basis, but on the other hand in many instances there was no communication whatsoever between the school and the clinic.

5.27 This is often related to workload and to the general turnover of staff in many communities, but the Committee believes there should be a more structured arrangement between the school and the health service.

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18 *Learning Lessons. An independent review of Indigenous education in the Northern Territory*. Northern Territory Department of Education. Darwin 1999. p149.

19 Mr B Barclay. Evidence. p1135.

20 Mr S Houston. Evidence. p1035.

21 Ms C Rae. Evidence. p1158.

5.28 The health service can assist with providing health education and support for hearing impaired students and the education sector can assist with opportunistic reinforcing of health messages.

5.29 The Collins report also recommended that all teachers should receive training and support in appropriate teaching practices for students with hearing impairments, as well as classroom improvements to minimise acoustic problems for these students.

5.30 There is an urgent need for an increased commitment to school education by parents and community leaders. This needs to be matched by an equal commitment from the education sector to accepting there are differences in cultural values and communications which need to be accommodated if this approach is to be acceptable to the Indigenous community.

> I think that what we have tended to do is to impose an education system on Aboriginal communities based on the way we think about it, which is primary schools, secondary schools, et cetera, and the adults are not brought into that. I think the strategy that can be pursued is to have an education strategy that includes adult education with children so that the adults start to get some commitment as well.[22]

5.31 The Committee believes that the education sector needs to raise the priority given to Indigenous education, encouraging teachers of greater ability to be involved and supporting them with training in dealing with children who are hearing impaired. The performance agreements for school principals should relate to Indigenous health and cooperation outside the school community, as well as attendance measures.

5.32 The performance measures for health service managers, both mainstream and community controlled should reflect the importance of cross sectoral involvement and include measures related to interaction with the school community.

5.33 The Committee believes that it is important for the local community and parents to recognise the value of education and to take positive steps to encourage children to attend school.

5.34 This should be coordinated with the health clinic who already have a degree of respect from the community. If the community see the different areas working together they are more likely to accept a commitment to education.

22 Dr B Bartlett. Evidence. p1114.

5.35 The Committee is encouraged to note that the Commonwealth recently introduced a new Education Strategy for Indigenous Students which takes many of these issues into account.

5.36 The Strategy focuses on the literacy and numeracy skills of Indigenous students, and other factors that influence levels of achievement, particularly school attendance. The six key elements of the Strategy are:

- lifting Indigenous school attendance rates to national levels;
- effectively addressing hearing and other health problems that undermine learning for many Indigenous students;
- enhancing pre-school opportunities;
- training sufficient teachers in skills and cultural awareness to operate effectively and stay for extended periods in Indigenous communities;
- ensuring that teaching methods used are the most effective; and
- having clear measures of success as the basis for accountability for schools and teachers.

5.37 In launching this new Strategy the Prime Minister commented that:

> Being able to read and write, add and subtract is fundamental to a good start in life. We are making progress, reflected in a fourfold increase since the 1970s in the proportion of indigenous children completing high school and a trebling of indigenous higher education enrolments. But more needs to be done and this landmark strategy contains practical measures to improve the situation.
>
> It includes action to lift school attendance rates, address hearing and health problems that affect educational performance, improve pre-school opportunities, train more teachers for indigenous communities and apply transparent measures of success to accurately gauge progress.

5.38 The Committee commends these initiatives but, as mentioned earlier, many of the hearing problems facing Indigenous children arise as a result of infections incurred from infancy.

5.39 It is therefore important there be initiatives that also focus on this early period of life. These initiatives need to include a balance of:

- monitoring for the presence and impact of ear disease, on a regular basis from birth, this could include opportunistic screening whenever the child presents to the clinic for other health needs; plus
- periodic testing, to detect any hearing loss as early as possible.

5.40 Screening for ear disease on a regular basis requires appropriate equipment and trained staff. The Commonwealth Department of Health and Aged Care is piloting initiatives in a number of communities to incorporate hearing screening and treatment into a comprehensive 0-5 year old child health program for Indigenous children.

5.41 The Committee believes there is sufficient evidence regarding the prevalence and impact of ear problems to warrant this program being introduced much more widely.

Recommendation 20

5.42 **The Commonwealth provide additional resources to ensure that within two years all Indigenous children are able to be monitored for ear disease on a regular basis from birth, and to allow the hearing ability of all Indigenous children to be tested by the age of three years.**

That the progress of all health services, including State and Territory health services, in this regard should be monitored and that the services' capacity to undertake these tasks should form part of the criteria for accreditation.

5.43 The Committee also notes, that many of the initiatives under the Government's new Strategy are to be introduced on a trial basis and the Committee would encourage the Government to move quickly to introduce these changes for all Indigenous students and schools as quickly as possible.

5.44 The Committee sees value as well in developing a role for environmental health workers to provide hygiene and other practical training about environmental health for children, as part of the children's broader health education.

Employment

5.45 There are few employment opportunities in rural and remote communities and those few that do exist tend to require a higher level of education than commonly obtained by Indigenous Australians.

5.46 Even in urban areas, where employment prospects are better, the low levels of educational attainment, and sometimes discrimination, mean that

the unemployment rates are significantly higher for the Indigenous populations of these areas.

5.47 The NT Government submission points out that:

> The situation is exacerbated by the need to achieve the maximum value in efficiently delivered services for the limited resources available. The capacity that existed in the past to subsidise the employment of Aboriginal people so that they could obtain work experience and so that people could act as role models for younger people has been removed by an increasing gap between resource availability and recognised need.[23]

5.48 In May 1999 the Government launched a new Indigenous employment policy, with the support of Aboriginal and Torres Strait Islander leaders and employer groups. However, the Minister, the Hon Peter Reith, MP cautioned that:

> This is a problem that requires long term planning and commitment by all parties, not just governments. No one should expect to see overnight solutions to this major social and economic issue.

5.49 In all there are seven elements of the new programme. They are:

- wage assistance for employers of disadvantaged Indigenous job seekers;
- a placement incentive for Community Development Employment Projects (CDEP);
- a package involving major private sector companies wishing to recruit Indigenous Australians;
- projects providing structured training and employment opportunities for Indigenous Australians in the private sector and with Indigenous community organisations;
- a Voluntary Service to Indigenous Communities Foundation which will aim to meet the needs of Indigenous communities for skilled business advice, mentoring and other specialist assistance;
- a National Indigenous Cadet programme will provide opportunities for Indigenous undergraduates with private and public sector employers; and

23 Northern Territory Government. Submission No 71. p19.

- a public awareness project aimed at Indigenous communities, employers and the broader Australian community to support the policy.

5.50 In supporting the policy the opposition spokesman, Mr Daryl Melham, MP, said:

> We welcome a return to a bipartisan approach to Aboriginal unemployment and a bipartisan approach to trying to obtain real full-time employment for indigenous Australians. The good thing about today, as well, is that Aboriginal people were at the table and they've been involved in this. It's a partnership.

5.51 The CDEP was introduced to assist in the development of communities through work programs so that they could have greater economic, social and cultural strength. The scheme involves individuals in the community pooling their social security benefits, with some additional funding from the Government, so that those resources could be directed to fund particular programs for the benefit of the whole community.

5.52 The scheme attempts to provide at least some form of employment and training in these communities, focussing on community development projects and giving the participants some form of workforce participation.

5.53 In recent years the CDEP has been responsible for some two-thirds of the jobs created for Indigenous Australians, but a recent review of the scheme noted that:

> Whilst it has been successful in improving employment, it has not been totally successful in raising income levels for Indigenous peoples.[24]

5.54 The CDEP has been successful in providing many participants with work preparation and other training. However, expectations of the scheme's ability to achieve any real increase in employment for many remote communities have to be tempered by the limited local labour market.

5.55 In many remote communities the prospect of other mainstream employment is limited, although the health services have played a key role in generating employment in these communities.

5.56 In the past the CDEP has often been used as a mechanism to supplement environmental health programs, such as garbage collection. While this is generally a result of community desires it often means that funding for such a program is not provided by the relevant authority. On the other

24 Spicer, I. *Independent Review of the Community Development Projects (CDEP) Scheme.* 1997. p2.

hand some communities have been able to turn such endeavours into a viable business by bidding for other services.

> …there is a lot of infrastructure and jobs that councils and communities are expected to do that are not necessarily funded. CDEP is good in some ways but it has got its downfalls because you are expecting people to do jobs that are jobs that are not necessarily funded through a council budget.[25]

5.57 The recent review of the CDEP program has resulted in greater emphasis on business development, accredited training and as a means of accessing jobs in the mainstream. The Committee fully supports this emphasis but considers that any changes should not be at the expense of flexibility, to ensure that allowances can be made for the diversity of needs and circumstances between communities.

> Instead of looking at what you can do in health, education and employment, we should have a look at the money that we all pour collectively into that and be more flexible about its use.[26]

A role for the health sector

5.58 It is clear there are a range of factors which can influence health outcomes, but which do not fall within what would normally be considered the health sector. The Indigenous view of health, which reflects their affinity with the land and an holistic approach, encompasses this multifactoral model but this is at odds with the way most government programs and services are delivered.

5.59 The Committee believes in the paramount importance of Indigenous cultural perspectives and considers that unless programs and services are developed which reflect these values, there will be little improvement in health outcomes.

5.60 This view of health can be accommodated by adopting a broad view that goes beyond the health sector, but the Commonwealth has to play a key role in promoting such a broad view. The health sector has to be prepared to take the lead in encouraging other sectors to understand the impact of their policies and activities on Indigenous health outcomes.

5.61 The ability of non-health areas to identify and tackle health issues cannot be assumed. Lack of action may be due to lack of awareness of the effect

25 Ms M Dowden. Evidence. p1173.

26 Mr P Buckskin. Evidence. p1414.

of certain actions on health, lack of motivation or unwillingness to become involved, or lack of an effective mechanism to initiate and encourage intersectoral cooperation.

Recommendation 21

5.62 **Within two years, the Minister for Health and Aged Care and the Minister for Aboriginal and Torres Strait Islander Affairs, in conjunction with other Ministers, develop performance measures for each Commonwealth Department that reflect Indigenous cultural perspectives and are able to highlight the impact on Indigenous health of specific policies and programs.**

The Australian Health Ministers Conference develop linkages with other relevant Ministerial Councils to ensure the States and Territories develop a similar approach to bringing the importance of cultural values and the impact on health and well-being of activities in those non-health areas to the attention of other sectors.

6

Other important health issues

6.1 The Committee agrees with NACCHO that health needs to be considered on an holistic basis, and not be broken down into body part type programs. Issues such as mental health and dental health have consequently not been dealt with on an individual basis by the Committee.

6.2 There are two issues, however, which the Committee believes need to be addressed separately and immediately if there is to be any progress in developing programs that are able to address the broader areas of Indigenous health. These issues are nutrition and substance abuse.

Nutrition

6.3 The loss of culture and traditional lifestyles discussed in the previous Chapter has also been accompanied by a move to fixed settlements and a more sedentary lifestyle, often coupled with poor diet. This change has contributed significantly to the poor health of the Indigenous population and is aggravated in many cases by the limited range of foods available at many of the community stores and takeaway food outlets in remote communities.

> Anaemia in children and malnutrition is probably up by around 80 per cent.[1]

6.4 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 Australians.

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

6.6 Accessing good healthy foods is not a straightforward issue. 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. A significant proportion of funds are also diverted for alcohol and other substances, gambling and cigarettes.

6.7 Consequently, Indigenous people tend to try and buy food which is cheap and filling, rather than healthy and nutritious.

6.8 While consumption of healthy foods is closely linked to availability and affordability, it is affected as well by other factors related to appropriate food storage and preparation, clean water, refrigeration and functional cooking appliances.

6.9 Many people 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 cost of food, even in urban areas in the Northern Territory, is higher than would be paid in urban areas elsewhere in Australia. A basket of goods bought in an urban Territory supermarket can be around 30% more expensive. These costs increase significantly in the more remote communities, where the price of food can be as much as 200% more than in urban areas.[2]

> The other point to make is that one of the things that keeps the prices down and keeps everybody reasonable, if not honest, is competition. They are monopolistic environments.[3]

6.10 A recent review of food prices in the Northern Territory, undertaken by the NT Legislative Assembly, found that:

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1 Ms M Dowden. Evidence. p1163.

2 Roy Morgan Research. *Report of Research into the cost, availability and preferences for fresh food compared with convenience food items in remote area Aboriginal communities.* 1997. p3.

3 Ms C Rae. Evidence. p1149.

> Food prices in the Northern Territory will only decrease without regulatory intervention to a comparable level to that of other capital cities and other locations elsewhere in Australia when the Territory's population reaches a level where substantial economies of scale and infrastructure would allow the market to become more conducive to a higher level of competition.[4]

6.11 The high costs of transport and the state of the roads 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.

6.12 As well as the high cost of freight, which can often exceed twenty per cent of the overall final cost, other significant components of the high cost of food in remote areas are the cost of electricity, because of the greater need for refrigeration, and a higher level of stock spoilage.

6.13 Many 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.

> In some remote Aboriginal communities the Community store may not be regarded as an economic enterprise, but rather a convenient source of funds for other community interests. This may have a detrimental effect in regard to providing reasonable food prices, namely that:
>
> - the store manager may refrain from making commercial decisions that would preserve the viability of the store;
> - the threat of insolvency may result in an even higher mark-up on food and other items; and
> - the wholesaler when dealing with a community store may see such a store as high risk and therefore charge accordingly.[5]

6.14 There is a real imperative to address this issue from both a demand and a supply side.

6.15 On the supply side there must be scope to apply some form of freight equalisation, similar to that applying in Tasmania, for remote Indigenous communities. It would also be beneficial to extend transport fuel credits for registered businesses to air transport businesses involved in transporting essential perishable food items to remote regions.

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4 Legislative Assembly of the Northern Territory, Select Committee on Territory Food Prices *Inquiry into Food Prices in the Northern Territory*. Darwin. 1999. p3.

5 Ibid. p7.

6.16 The challenge would be to ensure that any reduction in fuel or other input prices are passed on to the Indigenous community.

6.17 Monitoring prices on an ongoing basis to ensure that the benefit of such subsidy accrues to the consumer, rather than to the transport companies or store owners is vital if health status in Indigenous communities is to improve.

6.18 The Australian Competition and Consumer Commission (ACCC) should play an important part in ensuring that the prices paid in remote communities reflect the real costs of provision and do not include any element of profiteering.

6.19 The ACCC should also examine the costs incurred by store owners in providing a cheque cashing service to community members, where there are no banking facilities, and the validity of charges to community members for using those services.

Recommendation 21

6.20 **The Aboriginal and Torres Strait Islander Commission report to the Minister for Aboriginal and Torres Strait Islander Affairs, within the next six months, on**:

- **a series of pilot programs to trial alternative innovative strategies to encourage the supply and consumption of fresh fruit, vegetables and meat in remote communities; and**
- **mechanisms to monitor the new arrangements to ensure that any cost savings are passed on to consumers.**

6.21 On the supply side there may be benefit from organisations such as ATSIC, or land councils, establishing an association with one of the major food suppliers to supply community stores. If it was done through such bodies it would be done in such a way as to support the community development process.

6.22 The Committee visited communities where genuine interest was expressed in local food production. These communities were mindful of the importance of having supplies of fresh fruit and vegetables.

6.23 In many cases the condition of local infrastructure, in particular water reticulation, or soil quality would make such a process very difficult, but there are communities, particularly those in the rural areas, where the

development of local food enterprises and ventures should be encouraged and supported.

6.24 These initiatives could in practice be linked to CDEP projects or to other associated job programs.

Recommendation 22

6.25 **The Aboriginal and Torres Strait Islander Commission and other Commonwealth, State, Territory and local government funding bodies, actively support communities interested in the local production of food, by the flexible use of long term program funding, and the provision of appropriate training and support.**

6.26 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 communities visited by the Committee.

6.27 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 combined with local bush tucker. In another instance, the store had developed a colour coded system to indicate healthy food.

6.28 A number of stores were involved in providing some form of meal for school children. However, as this was out of store profits, in some cases it could mean that the overall costs of food remained high. It was suggested to the Committee that while such programs can show good results in the short term it would be of greater value if the parents were also involved in the program.

> We need to empower people to make the right sorts of decisions, responsible decisions for the care of their children.[6]

6.29 The Committee notes that the Commonwealth has provided funding to trial a number of nutrition programs, which will provide some meals to school children as part of the Government's new Education Strategy.

6.30 In a study of a nutritional program in a remote Northern Territory community the researchers noted that promoting nutritionally desirable foods as being most similar to traditional Indigenous foods was more

6 Mr S McMillan. Evidence. p1171.

effective than simply trying to convince people not to eat the undesirable foods, suggesting that:

> …reinforcement of traditional Aboriginal cultural concepts and food knowledge are more likely to succeed in the long term than a focus on the negative aspects of Western foods.[7]

6.31 A requirement for store managers to have formal qualifications and an understanding of health issues would greatly assists communities to balance store profitability with healthy shopping, particularly those communities which have had little experience in making such decisions and now rely heavily on non-Indigenous store managers. However, there is no requirement for such managers to have any such qualifications.

> The attitude of the store manager, and the interest they have in providing a range of good quality fresh food items on a regular basis and in the right quantities to meet the needs of the community, is critical and has a large influence on whether improved services are provided.[8]

> There are no standards for store managers or town clerks or community advisers or whatever you like to call them. There are no standards whatsoever.[9]

6.32 In the Northern Territory the Northern Land Council, the Central Land Council and Territory Health Services have been working to develop:

> Selection criteria and model contracts that individual communities can use to employ a store manager so that there is a requirement for them to have some basic skills, to participate in ongoing training and to perform against pre-set measures which include the quality of food.[10]

6.33 As well as addressing the costs and demand issues, a national process for registration and accreditation of remote store managers should be implemented.

6.34 Linked to this should be an ongoing, Commonwealth sponsored, training program for staff of remote community stores in all aspects of managing, handling and presenting food and produce. This should include development of community traineeships in stores management to try and

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7 Lee A J, Bonson APV, Yarmirr D, O'Dea K and Mathews J. *Sustainability of a successful health and nutrition program in a remote Aboriginal community*. The Medical Journal of Australia. 1995; 162: 632-635.

8 Roy Morgan Research. Op cit. pii.

9 Dr B Bartlett. Evidence. p1089.

10 Territory Health Services. Evidence. p1148.

move away from the continued reliance on non-Indigenous stores managers.

Recommendation 23

6.35 **The Aboriginal and Torres Strait Islander Commission and the Commonwealth Department of Education, Training and Youth Affairs work with the States and Territories to develop within twelve months a national mechanism for training and accreditation of store managers, within twelve months, particularly ensuring that this process encompasses:**

- **an understanding of health and nutrition;**
- **an acceptance that the store manager has a key role in educating the community about appropriate food choices and in presenting food in ways to encourage such choices; and**
- **establishment of community traineeships in store management.**

6.36 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.

> In Aboriginal communities, nutrition problems are very complex and are not due solely to lack of knowledge about contemporary foods. They will not be alleviated by nutrition education alone, but require social and political action within the framework of community development programs.[11]

6.37 The Committee understands that the Commonwealth is currently developing a national nutrition policy, which will also address Indigenous nutrition issues.

6.38 The Committee believes that the issues related to Indigenous nutrition are so important, and so different from the issues which are relevant to non-Indigenous Australians, that the matter needs to be addressed both separately and immediately.

11 Lee A J, Bonson APV, Yarmirr D, O'Dea K and Mathews J. Op cit.

6.39 It is very difficult to consider the nutritional issues raised above in isolation from the impact of education, employment and poverty that are relevant to Indigenous communities.

Substance misuse

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

6.41 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.[12]

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

6.43 Alcohol consumption has been linked to many health conditions, such as cirrhosis of the liver, stroke and suicide. Alcohol has also played a significant role in the high rates of injury amongst the Indigenous community, particularly in relation to road accidents and intentional injury, including domestic violence.

6.44 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

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

> than $10,000 per annum and to come from a household where English was not usually spoken at home.[13]

6.45 The Royal Australian and New Zealand College of Psychiatrists have also indicated that the misuse 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.[14]

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

6.47 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.

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

6.49 There are some State and Territory mainstream treatment services, but generally Indigenous Australians are reluctant to use these services, which they see as culturally inappropriate and primarily for non-Indigenous Australians. Even where these services might be acceptable to Indigenous Australians there are often insufficient places available.

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

> Substance abuse is enacted and maintained in people's daily lives through their locally-based interactions with others. It is only when some sort of grassroots movement arises from concerned

13 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.

14 Submission No 88. p1038.

> local people that action will follow. This has been happening with increasing intensity among Aboriginal people in different areas.[15]

6.51 On the supply side these initiatives 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
- in relation to sniffing, replacing petrol with Avgas.

6.52 In many communities visited by the Committee the operation of the canteen was a major concern to sections of the community, particularly the elder women, because it contributed to domestic violence and neglect of children by parents.

6.53 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.

6.54 In many instances, the canteen is 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.

6.55 The nexus between the canteen and the need to provide community services – including services to address the problems of alcohol abuse needs to be broken, and the incentives should be limited.

6.56 A range of initiatives are currently seeking to address these problems:

- 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.

6.57 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.

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15 Brady, M. *Drug and Alcohol Issues for Aboriginal Communities.* In Drug and Alcohol Services in Rural and Remote Australia. Australian Rural Health Research Institute Issues Paper. p34.

6.58 There 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.

6.59 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.

6.60 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.

6.61 The aim of this framework 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 be supported in developing appropriate service standards to ensure ongoing quality improvement.

6.62 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.[16]

6.63 The social and cultural influences on the misuse of substances are complex and it is unlikely that any one activity will resolve the problems.

6.64 Substance misuse 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.

6.65 Alcohol abuse needs to be seen as both part of broader health concerns, but also as a chronic and immediate problem which will require additional and focussed effort:

16 Submission No 27. p610.

> Adherence to a single abstinence-based approach is simply not sufficient to deal with the range of drinking problems.[17]

Recommendation 24

6.66 **The Commonwealth Department of Health and Aged Care ensure that Commonwealth, State and Territory substance misuse programs incorporate:**

- **early and opportunistic intervention programs by health professionals;**
- **diversionary and sobering-up shelters, including night patrols;**
- **detoxification programs; and**
- **rehabilitation programs, including residential and family rehabilitation, and follow up after care programs.**

6.67 The program should be coordinated at the national level and funded separately. It must form part of the overall Commonwealth State agreements on health with appropriate mechanisms for quality control, monitoring, developing of national standards and reporting arrangements.

Impact of the welfare system

6.68 In many Indigenous communities, particularly those in remote areas where there is little opportunity for employment or enterprise, the majority of the adult population is in receipt of some form of welfare payment.

6.69 It has been said that this reliance on welfare has been the basis for much of the social dysfunction evident in many Indigenous communities, and that many of the problems associated with substance misuse and violence are compounded by the way that welfare payments are provided.

> It has become patently obvious that the passivity and disempowerment of our welfare condition are, together with

17 Brady, M. Op cit. p36.

> racism and the legacy of our colonial dispossession, the fundamental causes of dysfunction in our society.[18]

6.70 Such payments generally arrive on the one pension day for the whole community, resulting in a massive influx of funds into the community and considerable social pressure on the community members.

6.71 Alcohol abuse and violence are common around this time.

6.72 In a study of Indigenous communities in Cape York in 1997 it was found that:

- assaults, including domestic violence were identified as the most common cause of injury;
- the biggest single injury was head injury; and
- alcohol appeared to play a major role in the high rates of injury.[19]

6.73 Recent government initiatives to allow people to elect on which day their pensions will be paid provide an opportunity for communities to spread welfare payments evenly over the fortnight. This would minimise the impact of payments all arriving on the same day, and consequently relieve the pressures referred to above.

6.74 On the other hand, for some communities like Tennant Creek, which has been able to limit the problems associated with alcohol abuse by restricting alcohol sales on the pension payday, changing the date may seriously limit the impact of their efforts.

6.75 Since all communities are different the impact of changing welfare payments, or alternative arrangements for alcohol sales, will vary considerably between communities, and there is a need to ensure maximum flexibility in considering ways to address this matter.

6.76 It has been suggested that communities could accept responsibility for the communities' own well-being in return for receiving welfare payments and that this would require the community to play a greater role in the management of its own well-being.

6.77 It has also been proposed that the community may be in a better position to manage the impact of welfare payments if they were allowed to control all payments at the community level, on behalf of all residents.

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18 Pearson, N. *Aboriginal Australia at a Crossroads (2) Reciprocity, Initiative and Community*. Address to the Brisbane Institute. 26 July 1999. p8.

19 Gladman DJ, Hunter EM, McDermott RA, Merrit TD and Tulip FJ. *Study of Injury in Five Cape York Communities.* AIHW Injury Surveillance Unit and Queensland Health. April 1997. p8.

> It is the Community and its leaders who need to develop strategies for the development of their community. It is the community that needs to develop ideas that address the educational, health and recreational needs of their people so that individuals are empowered and engaged in the solution of their own problems and that of their families and communities.[20]

6.78 Under such an approach the community would receive the bulk of welfare payments on behalf of their citizens and would then manage those funds in terms of their contribution to community maintenance, particularly housing and infrastructure maintenance, as well as the provision of food etc.

6.79 The Commonwealth would supplement these payments to provide the community with the additional resources necessary to manage all the payments as well as to introduce a long term community development plan.

6.80 The voluntary cooperation of all the members of the community would be essential for such an approach to be effective, and would most likely only be manageable for remote and geographically isolated communities.

6.81 As well as individual welfare payments impacting on the community there are also a range of Commonwealth, State and local government programs which provide funding to those communities.

6.82 There consequently also needs to be a simpler mechanism to allow the community to play a greater role in the application of these programs as well, to maximise their impact and to minimise any duplication.

> The joining together of the resources of the various government silos can only happen at an appropriate locational management level. It can only happen through a partnership with the community, through its agencies and its representatives.[21]

6.83 The Committee understands that the Commonwealth and Queensland Governments are currently examining the feasibility of piloting a number of approaches, including community management of welfare payments, to determine the benefits of a more flexible approach to the management and delivery of government programs to Indigenous communities.

6.84 While the opinions of Committee Members varied on this issue the Committee understands there may be some communities that might wish to participate in such programs.

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20 Pearson, N. Op Cit. pp10-11.

21 Pearson, N. Op Cit. p10.

Recommendation 25

6.85 **The Commonwealth facilitate innovative models of income support and funding to Indigenous communities which volunteer to participate in such programs. The Commonwealth must increase resources and practical assistance to participating Indigenous communities in consultation and cooperation with the Aboriginal and Torres Strait Islander Commission.**

7

Health professional issues

> In some respects the Western model of Health service delivery has been a reactive health model. So if I am a GP or a nurse in some type of health delivery setting , I wait for a person to come see me before I do anything. It does not work in Aboriginal health. We need a more proactive and community development approach where you establish relationships with the community, where you have presence with the community.[1]

7.1 One of the keys to achieving any effective improvement in primary and secondary health care for Indigenous Australians is adequate staffing, both in terms of numbers of staff and skill levels.

7.2 The range of professions associated with the delivery of existing Indigenous health programs includes Aboriginal Health Workers, nurses, general practitioners, specialists, dentists, other allied health professionals and administrators.

Aboriginal Health Workers

7.3 Aboriginal Health Workers (AHW) are the key to delivering an effective service for Indigenous Australians. They play a crucial role in the delivery of programs across a broad range of services and locations, but their real value is ensuring the acceptability of the service to Indigenous Australians

1 Ms C Croumbie-Brown. Evidence. p1347.

and in providing a linkage between the Indigenous patients and the non-Indigenous health professionals.

7.4 The major issue relating to AHW 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.

7.5 Under the current arrangements there is no consensus on the role of AHW, 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.[2]

7.6 The Menzies School of Health Research submission pointed out that AHW 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 have serious long-term implications for health, nor to implement preventative programs.[3]

7.7 At a National Aboriginal and Torres Strait Islander Health Workers' Conference in 1997 AHW 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 AHW; and
- the tension between community expectations of what services AHW should be providing and the limitations imposed on them by their employers, their colleagues and a general lack of resources.

7.8 Strategies to develop a common approach to the role and treatment of AHW need to be developed, including the development of a national

2 Ibid. p550.

3 Submission No 39. p651.

framework for the training and registration of health workers, linked to appropriate accreditation that will be recognisable and portable.

> The other thing I do not think has been resolved adequately is the actual role of Aboriginal health workers. It is stated that it is a primary health-care role, but more often than not it is a clinical role in treating what fronts at the clinic rather than looking at prevention and education within the communities.[4]

> If we are going to make Indigenous health a real priority we need to look at it on a national scale. We need to start recognising health workers as a profession and start pushing for this registration.[5]

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

7.10 Some efforts have already been made in this regard, with the development of national competencies for AHW training. There was some difficulty in reaching agreement on these competencies, which were seen by some jurisdictions as being set too much at the lowest common denominator.

7.11 The Commonwealth has also initiated a national review of Aboriginal and Torres Strait Islander Health Worker training as a basis for the development of a strategic approach to Health Worker Training at both the National and State and Territory levels.

7.12 In developing a national approach, the Committee supports the need to ensure that an appropriate role is included for the many health workers who may not be able to satisfy a more academic or clinically oriented model.

> There are health workers in communities in Central Australia and in the Northern Territory who have limited English literacy and numeracy who may never reach registration in the Northern Territory. There is a registration Board that looks at Health Worker Practice and these health workers are not likely to reach registration for safe practice. But they play a vital role. There does not seem to be any way for those health workers to be recognised in their role.[6]

> I think there are a lot of very competent people out there who will not meet the registration requirements but we have to find a role for them as health workers. We have to respect their ability, their

4 Mrs J Tye. Evidence. p1076.

5 Ms W Sexton. Evidence. p1247.

6 Mrs J Tye. Evidence. p1076.

> training and the things they have done, and find a new role for them…it might not be as a registered health worker that does the clinical work, but we can look at the community education role.[7]

7.13 The Committee rejects the suggestion that including such workers as part of the health team may lead to a lowering of standards.

> But I do not think standards should be lowered. If you are going to provide quality of care and you are actually going to make any dent in this huge burden of disease that Aboriginal people live with day after day, then we have to have good quality people who make good observations, are able to refer on, able to make an assessment and treat, and it is really very important to maintain standards.[8]

7.14 The Committee agrees, however, with the need to maintain standards. This can be achieved through accreditation and agreement on the appropriate roles for the differing levels of health workers. These needs are not currently being adequately met in the areas of health education and environmental health.

7.15 The Committee received criticisms that the move toward institutional based training does not recognise some of the cultural and educational limitations associated with recruiting and training AHW for community acceptance.

7.16 Institution based training takes 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.

7.17 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.

7.18 There is limited support at the moment for on the job training of AHW. 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 AHW but have struggled to gain support from the education sector, which has primary responsibility for training.

7.19 Recent changes to educational funding arrangements have meant that there is more scope for such alternative training arrangements. The organisations have advised that this has been offset to some extent by a

7 Ms C Rae. Evidence. p1177.

8 Ibid. p1165.

reduction in the additional support that was previously available to Indigenous students under Abstudy.

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

7.21 The other major issue for AHW is the lack of recognition of their value to the service, particularly from other health professionals as well as other members of the community. Their qualifications are not universally recognised nor is there any sort of career structure to allow them a relative position within the staffing structure of the health service.

7.22 From the community perspective the AHW bears a heavy load in terms of cultural expectations and can often be blamed for the death or illness of their patients. Since they live within the community and are members of that community, they are on call twenty four hours a day.

7.23 Whilst non-Indigenous staff are provided with housing AHW are not. This is done on the basis that they live within the community and are eligible for community housing. This is despite the demonstrated lack of housing and overcrowding that exists in most communities.

Recommendation 26

7.24 **The Commonwealth, in conjunction with States, Territories and the community controlled sector, develop within the next two years a national system of training for Aboriginal Health Workers (AHW), which is based on agreed national standards and competencies, and takes into account the varied nature of the roles of AHW. The national system must incorporate a combination of:**

- **basic local training, based in community controlled organisations and involving practical work within the community;**
- **block release type training, leading to more advanced qualifications, through accredited training organisations, including the AMS; and**
- **more formal undergraduate and post-graduate training through TAFE and University.**

That the development of a national training system also be supported by the introduction of common classifications for AHW, and an agreed career structure.

Other health professionals

7.25 The majority of evidence to the Committee has supported the need for both improved training of the non-Indigenous health workforce in cultural matters, to ensure mainstream services are more responsive to Indigenous health needs, as well as more efforts to increase the numbers of Indigenous health professionals.

7.26 As well as improving the effectiveness of clinical services it is considered that cultural training of health staff in mainstream services will make those staff more responsive and understanding in working with the Indigenous community, to develop new programs and improve services.

7.27 There was considerable evidence about the difficulties associated with the recruitment, training and ongoing support of all these staff, particularly in rural and remote areas.

7.28 Factors raised regarding the difficulties in recruiting and retaining staff included inadequate staff numbers, 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.

> One of the biggest things you battle against as a health professional working in remote areas, is that turnover of staff. It is extraordinarily expensive to be always recruiting and trying to bring people up to speed so that there is safety for them and safety for the people they are looking after.[9]

7.29 The issues of remuneration cannot be considered in isolation from other funding matters. It needs to be addressed as part of the overall determination of funding levels required for the delivery of adequate health services to the Indigenous population. The determination of any allocations of funding for the delivery of adequate health services should include realistic allowances for an appropriate staffing structure.

7.30 The Committee believes that this funding must allow for a certain minimum level of staffing, no matter what size the service, to ensure that appropriate professional and other support is available.

9 Ms P Field. Evidence. p1379.

7.31 There was only one nurse assigned to some clinics the Committee visited. This nurse was then expected to be on call twenty four hours a day as well as deal with a range of problems that would not be seen by many urban general practitioners. This is obviously unsustainable in the long run, leading to significant stress and subsequent staff turnover. This should be alleviated by providing sufficient funding for at least two nurses, as well as for adequate relief arrangements.

7.32 A key factor observed by the Committee when visiting the more successful clinics was the stability of staffing in those clinics. In 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, or even every year.

> Basically it all comes down to professional people feeling secure in an organisation.[10]

7.33 Many of these clinics were community controlled services, which had been able to develop a stable management structure, but not all were community controlled. Not all the community controlled services visited were successful in retaining staff.

7.34 The Committee recognises that the appropriate level of staff cannot be arbitrarily determined across the board for all organisations, as it will depend on the nature of the services to be provided. 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.

7.35 The Royal Flying Doctor Service has had considerably more success in recruiting and retaining doctors to work in remote areas, because they are able to provide a stable professional environment which offers a variety of work, established relief arrangements and peer support.

7.36 Allowances need to be built into funding arrangements which take into account a viable staffing structure irrespective of the nature of the service delivery arrangements.

10 Mr S Blunden. Evidence. p1385.

Recommendation 27

7.37 **The Commonwealth in conjunction with the States and Territories ensure funding for health services includes appropriate allowances for the recruitment, ongoing training and retention of all staff, taking into account the nature of the services provided, the location of the service, the needs of the local communities and the need for basic minimum numbers of staff.**

The Minister for Aboriginal and Torres Strait Islander Affairs report to the Parliament within two years on the adequate level of staff determined as required to maintain viable health services, given the needs of the Indigenous community.

7.38 A major concern expressed to the Committee, in terms of recruiting and retaining good staff, was inappropriate staff housing, particularly in remote communities. In many communities staff are expected to live in small, makeshift and often sub-standard accommodation. Limited funding available to the health system is focussed on service delivery rather than appropriate housing. This is despite the provision of good staff housing in the same communities by other government agencies, such as the State and Territory education departments.

7.39 The Commonwealth Department of Health and Aged Care 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 appears to be no systematic program directed at providing housing for all health staff. The Committee considers that staff housing must be a primary component of any health service funding arrangements.

Recommendation 28

7.40 **Over the next five years, the Commonwealth, in conjunction with the States and Territories, develop a program for provision of adequate housing for health service staff, including AHW, in remote areas. This program should be linked to the revised regional funding arrangements recommended by the Committee.**

7.41 Health service staff have advised there is a lack of understanding about what is required when working in Indigenous health services. What might be expected in terms of working and living conditions often makes people reluctant to apply for such positions.

7.42 The gap between expectations and reality often means that there is a constant staff turnover in many communities.

7.43 From the Committee's perspective the important factors in recruiting and retaining staff would appear to be:

- proper preparation, both in terms of professional training and cultural awareness of the local area;
- adequate staffing numbers to ensure that the workload is not unduly harsh;
- professional support to ensure standards are maintained;
- staff housing;
- organisational stability;
- varied and challenging work; and
- appropriate bonus's where necessary to allow staff to re-enter mainstream services with no penalty, professional or financial.

7.44 To support this framework the Committee believes that the regional approach to funding service delivery, proposed in Chapter Two, needs to encompass comprehensive workforce planning, based on a realistic assessment of staffing needs.

7.45 If not enough particular professionals, such as doctors, are available, local relations with training organisations can then be developed to meet identified needs. Alternatively a more flexible allocation of other health professionals can be considered. This should also assist in developing cooperative arrangements between mainstream and community controlled services.

7.46 The Commonwealth has commissioned a National Workforce Modelling Project, to assess the current and future health workforce requirements of Indigenous Australians across the National, State, Territory and community sectors.

7.47 The Committee supports the need for such an audit. However, the Committee believes that, unless accurate service requirements are determined through the regional and national planning processes, the project will not be able to accurately estimate workforce needs.

General training issues

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

> It becomes a major problem when Aboriginal people sit at home and wait until they are very ill before they will go to the hospital. The hospital is seen as a government department and Aboriginal people usually only go to hospital to either die or have their children taken from them.[11]

7.49 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.

7.50 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.

7.51 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.

7.52 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.

7.53 The Committee recognises that despite this many of the health and medical schools have already identified the need for exposure to Indigenous health matters, and are making efforts to address the issue.

7.54 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.

7.55 This could include the placement of trainees within community controlled medical services, for first hand exposure to cross-cultural service delivery. It would be necessary to ensure that the services have adequate resources to support such training placements, both in terms of infrastructure and

11 Mr C Scott. Evidence. p1350.

supervisory / training staff. The process should not become a burden or adversely impact on the delivery of services.

7.56 There is 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.

7.57 It has 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.

7.58 The Committee supports this approach and believes that inclusion of workforce planning within the regional planning framework will facilitate the development of such linkages between the training institutions, funds providers and services.

7.59 The Commonwealth is developing some initiatives to address the cultural needs of the health workforce, including:

- developing a pilot cultural awareness program for medical education, that could be used by all health science faculties; and
- developing Indigenous health as a core subject in undergraduate health and medical sciences courses. Discussions are being held with the Deans of Medical Schools and the Schools of Nursing.

7.60 The Committee supports these initiatives but considers that progress needs to be made in instituting such programs across the board.

Recommendation 29

7.61 **Within two years, all undergraduate and post-graduate health science courses should include an effective cross cultural awareness component, as well as dealing in detail with the current health status of Indigenous Australians and the factors which have contributed to their ongoing social and cultural disadvantage.**

All continuing medical education courses should also expand on these matters and continue to expose health professionals to cross-cultural learning.

Doctors

7.62 Although the AHW is clearly a crucial part of any successful Indigenous Health Service it is the doctor that is often seen as the centre of the team.

7.63 Difficulties identified during the Inquiry relating specifically to the role of doctors in Indigenous health have focussed on the capacity of doctors to provide culturally sensitive services and on the problems in recruiting and retaining doctors in remote and rural areas.

7.64 As indicated above, the difficulties associated with providing culturally sensitive services are reasonably common to all the health professions.

7.65 Problems with recruiting and retaining doctors are also not significantly different to those outlined above for professionals generally. These include the relevance of training, the level of remuneration and the availability of professional support.

7.66 The focus in the past on selecting medical students solely on the basis of academic performance has made it difficult for people who may be committed to Indigenous health to gain access to the medical profession.

7.67 Medical schools, such as that at Newcastle University, have recognised this and are now selecting students on the basis of much broader criteria, which is having some impact on providing graduates who are prepared to practice in other than urban areas.

7.68 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 Indigenous health in rural, remote or urban areas.

7.69 The Committee believes a framework for general practitioner (GP) training and support is needed which provides for:

- cross cultural awareness training and raising awareness of Indigenous health issues for all GPs. This is currently being addressed in the GP training of Registrars plus the increased incorporation of Indigenous population health into GP training but also needs to be addressed at undergraduate level and in the continuing medical education for GPs already in practice, possibly through the Divisions of General Practice;
- opportunities to work in AMS or private practice with a high Indigenous patient profile. This would allow GPs to try whether Indigenous health is for them. This is also happening to a small degree through the Royal Australian College of General Practitioners (RACGP) training programs, but not yet constantly and

comprehensively. It is limited at present by the availability of funds to support the trainees and by the lack of staff with the time and qualifications to supervise more trainees; and

- development of a specific Indigenous health training stream that could provide training on site over a period of years, using distance education as necessary and tailored to the needs of each individual Registrar. Under this approach, learning is facilitated through providing a service to the community. It allows for those people who are unable to complete the current training requirements because it involves moving around to undertake different streams. These people are disadvantaged at present because they are committed to staying and supporting the community where they work. Currently there is no program of this nature.

7.70 The Committee has also 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 prospects. On the other hand the Committee was informed that the breadth of experience gained by doctors working in Indigenous health was considered valuable, no matter where the doctor might want to practice in the future.

7.71 There is no doubt that even if there are professional barriers, and this is not clear, there are other financial barriers to doctors returning to a city practice from remote or rural communities.

> The issues are things like buying into another practice. The goodwill that has to be paid when you go back into a city practice are huge, whereas there is virtually no goodwill in rural practice now. You do not get anything for the practice that you were in in the rural community, yet you have to pay out a huge amount to get into the city. The house you may have bought in the country will not have increased in price in the time that you are there – if it has not actually fallen – to enable you to buy a house in the city.[12]

7.72 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.

7.73 In the 2000-2001 Budget the Government has introduced a further range of measures to attract doctors to rural and remote areas, many of which should be applicable to doctors who wish to practice in Indigenous health.

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12 Dr S Strasser. Evidence. p1386.

7.74 The number of places for vocational training for general practice will increase by 50 places, taking the total number of places to 450 per year and the distribution of these training places will also be changed to favour rural general practice. The rural emphasis in the allocation of places will also be complemented by financial incentives to encourage medical practitioners to undertake their vocational training in rural and regional locations.

7.75 There will be a new outreach program for specialist services. This includes incentives and / or travel costs for specialists to conduct outreach speciality work and to act as mentors for local health professionals to help them increase their skills. This will ensure that when specialist services are not directly available, rural and regional communities will have access to the skills and services required to meet their health needs.

7.76 The rural Divisions of General Practice will be resourced to expand their role to attract and keep doctors in areas of need. The types of support on offer for doctors will include professional and family support, links with other health professionals, mentoring of medical students and continuing medical education.

7.77 In order to strengthen the rural focus in medical training and increase opportunities for medical students to complete training in rural and regional service nine new clinical schools in rural and regional areas and three new University Departments of Rural Health will be established. This will also increase the number of health professionals in rural and regional areas where clinical schools and University Departments of Rural Health are located, providing support and continuing education opportunities for existing health professionals in those areas.

7.78 Graduating medical students who are willing to commit to regional practice will be allowed to work off their Higher Education Contribution Scheme (HECS) debt in a designated regional area. One fifth of the HECS debt will be foregone for each year worked in a designated regional area and the interest on the HECS debt will be foregone after five years work.

7.79 Additional scholarships will be offered to new medical students each year in return for a commitment to practice in rural and regional areas for at least six years after completing post graduate training. The number of medical school places will be increased cumulatively by 100. Students who accept the scholarships will be issued with a restricted Medicare provider number for the six-year period. They will only be eligible to charge for and receive a rebate for medical services in urban areas after they have met their obligations.

7.80 The Rural Australian Medical Undergraduate Scholarships (RAMUS) Scheme will be expanded. The scholarships provide financial assistance towards the cost of accommodation, living and travel expenses.

7.81 The Committee commends the Government for recognising the difficulties associated with attracting and retaining doctors in rural and remote areas, but considers that there also needs to be a specific effort to ensure that Indigenous communities are able to benefit from these new arrangements.

7.82 There are problems in attracting all health professionals to rural and remote areas, not just doctors. 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 left isolated in just one area.

7.83 It must be recognised though, that with the increasing Indigenous population, there may never be enough trained doctors to meet the needs of all Indigenous communities.

7.84 Consideration consequently needs to be given to how best to provide a doctor's service to all communities. The Commonwealth is currently developing a program for the provision of female doctors for some remote communities on a fly in fly out basis.

7.85 While this is not ideal it may be acceptable if the doctors are adequately supported by sufficient numbers of other staff on the ground.

7.86 It is also possible to use telemedicine for specialist consultations or more general consultations, as long as the community is comfortable in using those services.

> There is something that is important about telemedicine, that the talking head on the box – the psychiatrist's head or the specialist's head – really needs to belong to someone who also goes to the area. You do not have much credibility in country areas if you never turn up and do not understand who you are dealing with in the environment if you do not go.[13]

7.87 It has been suggested that the development of a career structure for doctors working in Indigenous health may be beneficial in retaining doctors and in using their expertise to train other doctors.

> We also find that people who work in an AMS in a rural area will probably move into an AMS in an urban area…The issue of having a career structure is important.[14]

13 Dr N Phillips. Evidence. p1367.

14 Dr S Strasser. Evidence. p1387.

> There are models around at the moment that are using that sort of concept and the career services they are using tend to be either state government services or the Royal Flying Doctor Service.[15]

7.88 The Committee does not believe such an approach is impossible and that it should be explored by the community controlled services and the other employers.

Recommendation 30

7.89 **The Commonwealth explore further ways to encourage doctors to practice in Indigenous communities, including:**

- **additional assistance to return to mainstream practice after the completion of a specified period;**
- **more professional support, in terms of initial training and local orientation before commencing work as well as continuing medical education;**
- **a greater focus on the use of doctors as a part of a regional team; and**
- **increased professional recognition for service in Indigenous health.**

Nurses

7.90 Mechanisms to support a broader role for doctors, could include a concomitant increase in nurses and AHW in the area, to provide more day to day support for the local communities. The doctor, or preferably doctors, could live in a more central location and provide support through telemedicine, as well as regular scheduled and emergency visits.

7.91 The Committee notes that the Government's recent initiatives were aimed primarily at getting more doctors into rural areas.

7.92 The Committee considers there is an equal need for more nurses in Indigenous communities and believes there may be a need to re-examine the role of the nurses in health and to recognise that it could take some time, if ever, to encourage doctors to work in all remote areas.

15 Ms M McDonald. Evidence. p1391.

7.93 Nurses already play a vital part in the delivery of services for Indigenous communities, particularly in rural and remote areas where there is a shortage of medical staff.

7.94 Nurses are often responsible for managing clinics and providing ongoing medical support for a range of conditions which may not be seen in any other area of the country.

7.95 At the same time they are often working in isolated circumstances with only limited professional support and minimal equipment.

7.96 This leads to the absurd situation where they are on call 24 hours a day, contributing significantly to stress and the high turnover of staff common in remote communities. In one community visited by the Committee the only nurse had been working on this basis for more than two years and was ready to leave because of the burden.

7.97 It needs to be recognised that unless there is some added benefit to nurses for working in these areas then it will only be the few truly dedicated and committed nurses who are prepared to be involved.

> First and foremost, on a national perspective, there is a nursing shortage worldwide…Secondly, for them to go to rural or remote is way down the patch. Evidence that we collated in the early part of this year from every tertiary institution shows that not one of those tertiary institutions in their 1997-98 curriculum had anything to do with rural or remote health as part of core curriculum.[16]

7.98 The Committee agrees that:

> …the role of nurse practitioner must be seriously considered and traditional doctor/nurse demarcation re-examined.[17]

7.99 It has 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.

7.100 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.

> Nurse practitioners in New South Wales now have an approved category of work. In the far west of the state they will be important in assisting doctors and I suggest we could have that through.[18]

16 Mr N Jefford. Evidence. p1102.

17 WA Branch. Australian Nursing Federation. Submission No 19. p551.

7.101 At the same time it is important to ensure that any expanded role for nurses is not just an increased clinical responsibility, but that it encompasses broader responsibility across health education and prevention, as well as environmental health matters and community development.

> It is difficult for nurses and health workers to pull themselves away from clinical work. There is a need, I think for all communities to have specific positions which are just community health education. Everyone talks about prevention, everyone talks about education, but there is no action.[19]

7.102 Again this gets down to adequate resources and staffing numbers, simply upgrading the skills of existing nurses will not resolve the problems, nurse practitioners need to be seen as an additional member of the health team, not just the same person with a new title.

Recommendation 31

7.103 **The Commonwealth work with the States and Territories, and nursing professional bodies, to develop within two years an expanded role for nurse practitioners in rural and remote Indigenous communities that will provide both increased career potential for nurses and better meet the health needs of the community.**

Indigenous health professionals

7.104 It has been proposed 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.

7.105 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.

7.106 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.

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18 Mr K Yeoward. Evidence. p1365.

19 Ms M Dowdan. Evidence. p1128.

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

7.108 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.

7.109 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.

7.110 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.

7.111 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.

> What remains as a challenge is to help Aboriginal people to broaden their roles into the assessment of public health priorities; the management of health services, and health education.[20]

Support for Indigenous students

7.112 A recent review of proposed changes to the Abstudy arrangements for Indigenous students, commissioned by ATSIC, found that:

> The pattern of post school study in the Indigenous communities of Australia shows clearly that the participation in further study has been markedly different to that in the mainstream community. The transition from school to further study for many Indigenous Australians is not generally a continuous formal education process with entry into TAFE or university courses immediately after completion of secondary school education.[21]

7.113 What the study found was that Indigenous students return to study later in life after developing a base of community and family support. The

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20 McLaren B, *Refelctions on 18 Months in a remote Aboriginal Practice.* Australian Family Physician. Vol 24 No 8. August 1995. 1479-1488.

21 Institute of Koori Education, Deakin University. *An analysis of the Proposed Changes to Abstudy for the Year 2000 on Indigenous Students.* 1999. p3.

Committee was advised by other witnesses that Indigenous students often come to study medicine or other health studies after first entering university at a basic level and then using that to gain the necessary educational standards to advance to more demanding degrees.

> The point I would like to raise is that for a lot of us older Aboriginal students, the only way for us to get into tertiary study is to start at the most basic levels. It is a big vertical jump to get in there and go from nothing to medicine, but once you are in there and study a bit, it becomes lateral and you can move sideways. [22]

7.114 The result is that not only are these students disadvantaged in terms of the level of financial support they receive, they are often unable to complete their studies within the time limits allowed, ending up with no financial support at all.

> Students have a limited time to complete a course before their Abstudy support is cut. It is not only that; if it takes a health worker three years to do what is normally a one-year full-time training course, by the time they are onto the second half of that training the units they enrol in to study determine that they are a part-time student, so they do not qualify for full time Abstudy support.[23]

7.115 The review of the impact of the Abstudy changes mentioned above also considered that the proposed changes would damage the opportunity for life-long learning for Indigenous Australians, as the changes will significantly disadvantage Indigenous TAFE and University students who are 21 years and older and independent.

7.116 The changes support a pattern of study which is more suited to non-Indigenous middle class Australians than Indigenous students.

7.117 During the course of the Inquiry the Committee was also advised of an instance in which an Indigenous medical student was offered a scholarship from the Queensland Government, in return for agreeing to work for Queensland Health for a specified period after qualifying. The amount of the scholarship was helpful but not exorbitant and before accepting the student checked to ensure that such a decision would not affect his eligibility for Abstudy.

7.118 After assurances that it would not affect his eligibility, he accepted the scholarship only to be told sometime later that he was no longer eligible for Abstudy. He would have to repay the funds he had already received, all of which he had spent.

22 Mr Christopher Whitney. Evidence. p665.

23 Mrs J Tye. Evidence. p1106

7.119 This created considerable financial and emotional stress for this student and he eventually had to relinquish the Queensland scholarship.

7.120 It means that access to a medical graduate for certain rural and remote areas had been lost because of the inflexibility of financial supporting arrangements.

7.121 The Committee believes that the offer of conditional scholarships is a valid means to get students to agree to work in rural and remote areas and that the effectiveness of such proposals should not be limited by other arrangements.

7.122 It is unlikely that the sponsoring organisations would be in a position to offer any further amounts without support from the Commonwealth. The Committee considers that the best way for the Commonwealth to provide this support is by ensuring that Abstudy / Austudy continues to apply in those instances where additional income is related to a conditional scholarship. This should also apply for those additional scholarships recently announced by the Commonwealth.

Recommendation 32

7.123 **The Commonwealth ensures that:**

- **Abstudy/Austudy arrangements are flexible enough to take into account students differing educational experiences and that Indigenous students are not disadvantaged, either in terms of the level of financial support or time required for completion of degrees, because they have taken a different path to learning; and**
- **the eligibility criteria is amended to ensure that medical students who agree to scholarships from the Commonwealth or State and Territory Health Authorities, in return for an agreed period of work in remote or rural communities, continue to be eligible for the full Abstudy/Austudy allowances.**

8

Research and data collection

> There is a danger in evidence based (research) because if we are always looking for improvements in morbidity statistics, the intersectoral, the broader social determinants stuff, is a long time away from sometimes showing improvement in morbidity. So if we get too stuck on evidence based, we can lose a lot in there.[1]

8.1 A key to making any progress, and to supporting any efforts to report on that progress, in improving the health and well-being of Indigenous Australians will depend on the development of effective measures of change.

8.2 While the data presented at Appendix A regarding the health and well-being of the Indigenous population is important in highlighting the relative levels of disadvantage facing Indigenous Australians there are a number of deficiencies in its availability and completeness:

- Many jurisdictions do not have adequate mechanisms for identifying Indigenous Australians in administrative data sets – for instance the ABS publish data on indigenous deaths only for Western Australia, South Australia and the Northern Territory;
- There are real difficulties in estimating the size of the Indigenous population based on census data; and
- There are real problems related to the regular collection of information about Indigenous Australians.

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1 Ms P Field. Evidence. p1403.

8.3 It may seem paradoxical to first use the data, as we have, to highlight the significant problems of the Indigenous community, and then point out the inadequacies of that data.

8.4 There is sufficient consistency in the health problems highlighted by the data presently collected between jurisdictions to allow inferences about the national level of disadvantage to be made with reasonable confidence.

8.5 The Committee is satisfied that the information presented in Appendix D is a very good picture of the current overall level of disadvantaged faced by the Indigenous population. The Committee considers the limitations in the data collected mean that it is very difficult to identify regional or local variations in the pattern of ill-health and disadvantage.

8.6 It is reasonable to use the existing data to make statements and draw inferences about the Indigenous population at specific points in time and to make comparisons with other populations for similar periods. However, it is very difficult to monitor changes in Indigenous health over any period of time, or to use the data as a basis for the development of new policy and programs.

8.7 The main source of information about the Indigenous population is the National Census. Despite the same question about Indigenous status being asked in the last four censuses, it is apparent that not all people have answered the question consistently over time.

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

> As a result, there are large differences in some areas (especially in the south-eastern States) between what had previously been projected for 1996 (based on the 1991 census figures) and what was actually observed.[2]

8.9 The Committee was consistently advised during community consultations that ABS estimates of the local population understate the numbers of Indigenous Australians in the area. The volatility in the numbers of people who are prepared to identify themselves as Indigenous on census forms 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.

8.10 Additionally, most other survey-based information has only been collected once:

2 Australian Bureau of Statistics and Australian Institute of Health and Welfare. Op cit. p9.

- the 1995 National Health Survey was the first to include a sufficient sample of Indigenous Australians from non-remote areas which would allow publishable estimates for those areas; and
- the 1994 National Aboriginal and Torres Strait Islander Survey, which collected information across a wide range of areas from all around the country, has not been repeated.

Link between data and funding

8.11 Any change to service funding and delivery must focus on outcomes, rather than the amounts being spent, or where these are spent. There needs to be a balanced approach which covers all services for Indigenous Australians, not just those provided by the community controlled sector.

> I think we are actually quite unfair when we impose on the Aboriginal sector the need to be giving outcomes when in fact we do not demand the same outcomes of any health system in the country.[3]

8.12 Satisfactory improvements in many of the mortality and morbidity statistics currently used to measure health status may take ten to twenty years. This should not deter efforts in this area. To focus solely on these measures could induce a sense of overwhelming difficulty which can swamp workers and lead to a sense of futility.

8.13 The Committee believes there should be a more concentrated focus on coordinating reports across all portfolios. This would identify a more realistic range of short, medium and long term goals.

> One thing I would suggest you add to what you are looking at is the need for a broader range of information rather than that just described by the basic collections – important though that is in its own right. [4]

8.14 In the short term the issues would be structural and financial, reporting on changes in the level of funding, planning outcomes, resource allocation, service delivery arrangements, staffing levels (particularly Indigenous staffing). In the medium term this could be expanded to include some health measures, particularly for children, as well as environmental health services, new health services, educational outcomes, and so on.

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3 Prof N Thomson. Evidence. p1062.

4 Prof N Thomson. Evidence. p1051.

8.15 It would only be in the long term that major changes in mortality and morbidity would be significant, although it may be appropriate to review some of these measures on an earlier basis through research in discrete communities. This would ensure efforts are not being diluted.

8.16 A set of about 60 national performance indicators has been developed by Australian Health Ministers, but many of these 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 targeted outcomes against which all jurisdictions must report.

8.17 Reporting should be on the same basis as regional planning and aggregated across all sectors.

8.18 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.

8.19 Given the general lack of information about Indigenous health mentioned earlier, the Committee was 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.

8.20 The Committee noted that the usefulness of this information would generally be limited to the particular service and community because of issues related to its comparability with other services, especially mainstream services.

8.21 As discussed earlier, there is a very poor amount of data available about Indigenous health matters generally. The Committee is proposing new measures be developed which will require reporting about activities but not necessarily at the individual level, at least initially, which should allow time to better develop the current sources of data.

8.22 The Committee understands that there are a number of initiatives underway 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 Australians in administrative data sets.

Recommendation 33

8.23 **The Commonwealth pursue initiatives to improve the collection of data on Indigenous health as a matter of urgency. Additional resources should be allocated if necessary to support the process, recognising that in many instances it is a State matter, but that additional support from the Commonwealth must be sufficient to encourage the States and Territories to resolve the issue.**

8.24 The better identification of Indigenous Australians was also recommended by the NAHS working party, which proposed an education campaign for community members to explain the importance of identification. The Committee would support this approach but would suggest that it needs to encompass staff of the mainstream services to ensure they understand the need for sensitivity in this area.

8.25 In a recent study of the costs of providing hospital services to Indigenous patients the researchers arranged for the ward staff to recheck the data collected from reception to ensure that there was a better identification of Indigenous patients. This proved to be much more effective and acceptable to those patients and demonstrates that it is possible to develop mechanisms to address this issue if the matter is given priority.

8.26 It is also important to develop mechanisms to measure progress over time. As discussed earlier this is not possible at the moment but should be one of the aims and form part of the progress measures. As a first step the Committee believes that the Commonwealth should provide additional resources to the ABS to enable the National Aboriginal and Torres Strait Islander Survey to be undertaken again, and on a regular basis.

Recommendation 34

8.27 **The ABS be funded to repeat the 1994 National Aboriginal and Torres Strait Islander Survey on a regular basis, to provide an adequate measure of the change in the levels of Indigenous disadvantage over time.**

The ABS also develop new mechanisms to record the Indigenous population, which take into account the mobility of community members and which do not rely on single point in time recordings.

8.28 As well as the collection of additional and more accurate information there is a need to ensure that relevant people, particularly members of the Indigenous community and AMS, have ready access to that data.

8.29 While the Committee appreciates the need for the ABS to charge for the provision of certain information, it does not believe that information about the health and welfare of Indigenous people should fall into this category. Any funding provided for additional Indigenous data collection should allow for the dissemination of that information.

8.30 The Committee was also impressed by the National Aboriginal and Torres Strait Islander Health Clearinghouse, which is an internet site sponsored by the Commonwealth Department of Health and Aged Care and Edith Cowan University.

8.31 This service provides a range of data about Indigenous health statistics, government policy and programs, academic research and activities, as well as other useful information and links to related sites.

8.32 The site could provide a valuable mechanism for the dissemination of any additional information collected by the ABS, as well as be a useful tool for the proposed Council on Indigenous Health Affairs to spread and collect information.

8.33 The Committee believes that the Clearinghouse could play a greater role with additional financial and technical support from the Commonwealth, States and Territories. The Committee would encourage all of those jurisdictions to work with the Clearinghouse to develop a long term program for improved dissemination of information about all aspects of Indigenous health.

Research

> …what we are trying to do, what I am trying to do, is to get health research focused and make it useful research, which are the words that I usually use. I consider that a lot of research has been airy-

> fairy type research and it is basically for the individual researcher and sometimes it is of little or no use to communities.[5]

8.34 Appropriate research is an important tool in developing and enhancing measures to assess the effectiveness of programs and services, as well as for developing new and improved interventions for existing problems.

8.35 The Committee was left in no doubt about the lack of confidence and mistrust that many communities have of research and researchers. They have been involved on too many occasions when the research was of academic interest to the scientific community, but not necessarily of any immediate practical assistance to the community.

8.36 While the committee appreciates the need for pure research it believes that the current state of Indigenous health does not allow for any luxury in this regard.

8.37 The Committee believes that research in the Indigenous health area should:

- be developed in conjunction with the Indigenous community, to reflect community priorities, and involve the community at all stages of the process, particularly the dissemination of research findings;
- be focussed on achieving a benefit to the community and on improving health outcomes;
- provide mechanisms for the involvement of Indigenous people in the conduct of the research and facilitate the transfer of knowledge to the community;
- provide information which is useful for health and other authorities in developing policies and programs which will be effective in meeting the health needs of the Indigenous community.

8.38 The Committee was impressed by the approach to working with communities in the Northern Territory taken by the Menzies School of Health Research, and by the recently established Cooperative Research Centre for Aboriginal and Tropical Health. This Centre, which has brought together a number of research institutions and community controlled health services to provide a cross-cultural framework for strategic research, is a very positive step in the Indigenous health research area.

8.39 Both these organisations should receive greater support in the allocation of research funds, but the Committee considers that, given the current

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5 Mr J Liddle. Evidence. p1195.

health needs of the Indigenous community, mainstream research should play a greater role in this area.

8.40 The Committee considers that the National Health and Medical Research Council (NHMRC) should review its priorities and ensure that Indigenous health is given a much greater focus, including a significantly increased share of available funding. There should be revised guidelines which differentiate research in this area from normal scientific research, and which take into account the need for community involvement, as well as the need to involve researchers best suited to the task.

8.41 The best researchers in this area may not be the academic based professionals, but a local team of doctors, nurses or AHWs who have the confidence of the community and a very clear idea of what improvements are required to achieve the proposed outcomes.

8.42 The Committee notes that the NHMRC has been trying to improve its efforts in this regard over a number of years, but given the enormity of the problem does not believe that anything less than a radical restructuring of the way Indigenous health research is managed will achieve what is needed.

Recommendation 35

8.43 **For the next five years, the Commonwealth ensure the National Health and Medical Research Council allocate at least five per cent of total annual research funding for Indigenous health research. This research should be directly related to the health problems experienced by the Indigenous community and be aimed at either developing strategies to address those problems directly, or to provide evidence which will support government programs and policies to address the problems. Such research must also be developed and conducted in conjunction with the Indigenous community.**

Barry Wakelin MP

Chairman. 29 May 2000.

Appendix A

List of Submissions

1	Ms Judith Costin
2	The S.E.P Consultancy
3	Age Concern Pty Ltd
4	Dr Chris Harrison
5	Professor Kevin Forsyth, Flinders University of South Australia
6	Australian Dental Association Inc
7	Mr Alan Mitchell
8	Mr Doug Gladman
9	Associate Professor Peter Jull, University of Queensland
10	Royal Flying Doctor Service, Western Operations
11	A/Professor A-K Eckermann, University of New England
12	Mr Greg Seiffert
13	Torres Strait Regional Authority
14	Fitzroy Valley Cultural Health Services

15 Professor Richard Heller, University of Newcastle

16 Mr Chris Jones

17 Mr Robert Milliken

18 Mr Ian Stokes

19 Australian Nursing Federation (WA Branch)

20 Mr W.T Wilson

21 Dr Brian Hillcoat

22 Board for Social Responsibility, The Uniting Church in Australia

23 Royal Australian College of Obstetricians and Gynaecologists

24 Walgett Aboriginal Medical Service Cooperative Ltd

25 Professor Peter Mudge, University of Queensland

26 Plan Health Pty Ltd

27 Central Australian Aboriginal Congress Inc.

28 Queensland Regional Committee, Australasian Faculty of Public Health Medicine

29 Top End Primary Health Care Network

30 Frontier Services, The Uniting Church in Australia

31 Confidential Submission

32 Australian Medical Association and the Public Health Association of Australia Inc

33 Mr Douglas McIver

34 Townsville District Health Service

35 Dr Margaret Niemann and Dr Michael Dawkins

36 Mr Yarran Cavalier

37 Roma Aboriginal Corporation

38 Dr A.C Walker

39 Menzies School of Health Research

40 Australian Kidney Foundation

41 Aboriginal and Torres Strait Islander Commission

42 Mr Neil Willmett

43	Wellington Aboriginal Corporation Health Service
44	Doctors Reform Society, WA Branch
45	The Australian Medical Students' Association Ltd
46	Australian Healthcare Association
47	Department of Human Services, Victoria
48	Pintubi Homelands Health Service
49	Apunipima Cape York Health Council
50	Dr Beverley Sibthorpe, National Centre for Epidemiology and Population Health
51	Public Health Association of Australia Inc.
52	Ms Roslyn Blackwood
53	National Health and Medical Research Council
54	Aboriginal Community Support Service
55	World Vision Australia
56	Diabetes Australia
57	Aboriginal Affairs Department, Western Australia
58	Women's Hospitals Australia and the Australian Association of Paediatric Teaching Centres
59	Central Australian and Barkly Aboriginal Health Workers Association
60	Dental Health Services Victoria
61	Minister for Health, Queensland
62	Minister for Aboriginal and Torres Strait Islander Affairs
63	Aboriginal Medical Services Alliance of the Northern Territory
64	National Aboriginal Community Controlled Health Organisation
65	Royal College of Nursing Australia
66	Minister for Aboriginal Affairs, Tasmania
67	Australian Centre for International and Tropical Health and Nutrition
68	Commonwealth Department of Health and Family Services
69	Commonwealth Department of Social Security
71	Minister for Health, Family and Children's Services, Northern Territory

72	Awabakal Aboriginal Cooperative Ltd
73	Government of South Australia
74	Aboriginal, Torres Strait and South Sea Islander Health Unit, Mackay
75	Aboriginal and Torres Strait Islander Student Liaison Office, University of Newcastle
76	Professor Max Kamien AM
77	Dr Graham Brown
78	NSW Aboriginal Health Resource Cooperaitve Ltd
80	Mr Neville Whiffen
81	Congress of Aboriginal and Torres Strait Islander Nurses
82	Mr Luke Morcom
83	Dr Dan Naidoo
84	Mr Albert Lamb
85	Australian Physiotherapy Association
86	Mr Robert Peckham and Dr Neil Phillips
87	Deafness Forum of Australia
88	The Royal Australian and New Zealand College of Psychiatrists
89	City of Salisbury
90	Deafness Association of the NT Inc.
91	Human Rights International
92	Department of Public Health and Community Medicine, University of Sydney
93	The Heart Foundation
94	Dr Robert Cooter
95	Mr David Lindner
96	Professor Ian Ring, James Cook University
97	Commonwealth Department of Education,Training and Youth Affairs
98	Ms Rosemary O'Grady

B

Appendix B

List of Public Hearings and Witnesses

6 February 1998 - Canberra

Public Health Association of Australia

Professor Stephen Leeder – National President

Ms Lynne Flemming – Executive Director

Professor Tony Adams – Life Member

Ms Marjorie Baldwin-Jones - Member

Australian Medical Association

Dr Keith Woollard – Federal President

Dr Ngaire Brown – Indigenous Health Adviser

Dr Basil Hetzel – Member, AMA Expert Panel on Indigenous Health

Professor Sir Gustav Nossal – Member, AMA Expert Panel on Indigenous Health

Professor Ian Ring – Member, AMA Expert Panel on Indigenous Health

Department of Health and Family Services

Ms Mary Murnane – Deputy Secretary

Ms Helen Evans – First Assistant Secretary, Office for Aboriginal and Torres Strait Island Health Services

Dr Ian Anderson – Medical Adviser, Office for Aboriginal and Torres Strait Island Health Services

Ms Marion Dunlop – Assistant Secretary, Health Strategies and Research Branch

Dr John Loy – First Assistant Secretary, Health Services Development Division

Dr Louise Morauta – First Assistant Secretary, Health Benefits Division

Professor Kerin O'Dea – National Health and Medical Research Council

Aboriginal and Torres Strait Island Commission

Mr John Delaney – Health Portfolio Commissioner

Mr John Eldridge – General Manager, Social and Cultural Division

Mr Colin Plowman – Assistant General Manager, Housing, Infrastructure, Health and Heritage Branch

Mr Noel Baxendell – Housing, Infrastructure and Health Policy Section

Australian Healthcare Association

Professor Don Hindle – National Director

National Aboriginal Community Controlled Health Organisation

Ms Naomi Mayers – Deputy Chairperson

Mr Steven Larkin – Chief Executive Officer

Australian National University

Dr Beverley Sibthorpe – Fellow, National Centre for Epidemiology and Population Health

9 February 1998 – Hobart

Department of Community and Health Services

Ms Barbara Lypka – Acting Director, Corporate Strategy Division

Ms Debra Reid – Policy Officer, Aboriginal Health

17 February 1998 – Adelaide

Division of State Aboriginal Affairs

Ms Ceilia Divakaran-Brown – Team Leader, Heritage and Strategic Development

South Australian Health Commission

Mr Brian Dixon – Executive Director, Aboriginal Health Division

Ms Leanne Goodes – State Coordinator, South Australian Aboriginal Health Partnership

Ms Vicki-Lee Knowles – Senior Policy and Planning Officer, Aboriginal Health Division

Flinders University of South Australia

Professor Kevin Forsyth – Head of Paediatrics and Chair, Information Technology Developers Group

Individual

Mr Ian Stokes

19 February 1998 - Perth

Doctors Reform Society of Western Australia

Dr David Atkinson – President

Dr Alison Creagh – Secretary

Dr David Paul - Treasurer

Aboriginal Community Support Service

Mr Michael Wright – Manager

Ms Sheryl Carmody – Member, Management Group and Executive Manager, Daughters of Charity Services

Royal Flying Doctor Service (Western Operations)

Ms Kath Craft – Consultant, Health Services Outcomes Project

Ms Barb Stott – Project Manager

Health Department of Western Australia

Mr Edward Shane Houston – General Manager, Office of Aboriginal Health

Professor Michael Gracey – Principal Medical Adviser, Office of Aboriginal Health

Mr Ian Leslie – Acting Manager, Policy Development Section, Office of Aboriginal Health

Perth Aboriginal Medical Service

Mr Edward Wilkes – Director

Ms Heather D'Antoine – Deputy Director

Australian Nursing Federation (Western Australian Branch)

Ms Marea Vidovich – Nursing research and Development Officer

Ms Gail Williams – Member

17 March 1998 - Brisbane

Centre for Research in Aboriginal and Multicultural Studies, University of New England

Professor Anne-Katrin Eckermann - Director

Dr Lynette Dowd – Consultant Researcher

Queensland Health

Ms Geri Taylor – Director, Health System Strategy Branch

Ms Debra Blumel – Manager, Public Health Planning and Research Unit

Dr Noel Hayman – General Practitioner

Dr Ian Ring – Principal Epidemiologist, Manager, Health Information Centre

Ms Laurel McCarthy – Coordinator for Implementation of the Aboriginal and Torres Strait Islander Health Policy, Cairns and Surrounding District Health Service

Dr Claire Runciman – Acting Director, Aboriginal and Torres Strait Islander Health Unit

Australian Faculty of Public Health Medicine, Queensland Regional Committee

Professor Ian Riley - Chair

Dr Rod Davison – Secretary

18 March 1998 Townsville

Townsville District Health Service

Dr Christopher Kennedy – Manager

Mackay District Health Service

Mr Andrew Ramsamy – Manager, Aboriginal, Torres Strait and South Sea Islander Health Unit

University of Queensland

Professor Peter Mudge – Clinical Dean, North Queensland Clinical School

20 April 1998 - Alice Springs

Central Australian and Barkley Aboriginal Health Workers Association

Mrs Kathy Abbott – President

Mr Tony McMasters – Acting President

Ms Rosemary Elliot – Project Officer

Ms Debra Fry – Project Officer

Central Australian Aboriginal Congress

Mr John Liddle - Director

Dr John Boffa – Senior Medical Officer

Papunya Regional Council

Ms Alison Anderson – Deputy Chairperson

Commonwealth Department of Health and Family Services

Mr Graham Castine – Regional Manager

Alice Springs ATSIC Regional Council

Mr William Tilmouth – Chairman

8 May 1998 - Cairns

Apunipima Cape York Health Council

Ms Barbara Flick – Administrator

Ms Joan Staples – Project Officer

National Aboriginal Community Controlled Health Organisation

Mr Puggy Hunter – Chairperson

Individuals

Ms Ann Kreger

Mr Douglas Gladman

11 June 1998 - Sydney

Uniting Church in Australia

Reverend Harry Herbert – Executive Director, Uniting Church Board for Social Responsibility

Reverend Brian Smith – National Secretary, Uniting Church in Australia Frontier Services

NSW Department of Health

Mr Timothy Agius – Director, Aboriginal Health

NSW Aboriginal Health Resource Cooperative Ltd

Ms Sandra Bailey – Chief Executive Officer

Mr Frank Vincent

Plan Health Pty Ltd

Dr William Bartlett – Public Health Consultant

Australian Dental Association Inc.

Dr Herbert Hammer – President.

Australian Kideny Foundation

Dr John Knight – Medical Director

12 June 1998 - Newcastle

Centre for Clinical Epidemiology and Biostatistics, Royal Newcastle Hospital

Professor Richard Heller – Director

Dr Catherine D'Este – Lecturer in Biostatistics

Ms Leisa Clague – Student

Mr Peter Waples – Student

University of Newcastle

Professor Rob Sanson-Fisher – Dean, Faculty of Medicine and Health Sciences

Ms Gail Garvey – Director, Aboriginal Student Liaison Office, Faculty of Medicine and Health Sciences

Mr Christopher Whitney – Medical Student

Ms Patricia Neal – Aboriginal Liaison Officer, Faculty of Nursing

Awabakal Aboriginal Co-operative

Mr Raymond Kelly – Chief Executive Officer

Mr Craig Ritchie – Medical Program Coordinator

Individual

Mr Neil Willmett

19 June 1998 - Melbourne

Dental Health Services Victoria

Dr Martin Dooland – Chief Executive

World Vision Australia

Dr Sekai Shand – Program Officer, Health and Development

Dr Mark Wenitong – Medical Coordinator, Indigenous Programs

Department of Human Services

Mr Ian Hamm – Acting Manager, Koori Health Unit

Mr Ray Judd – Manager, Health Development

Mr David Murray-Smith – Special Projects Officer

Age Concern Pty Ltd

Ms Prudence Mellor – Managing Director

Pintubi Homelands Health Service

Dr William Williams – Medical Director

17 August 1998 - Darwin

Danila Dilba Medical Service

Mr Lindsay Ah Mat – Chairperson

Mr John Robinson - Administrator

Territory Health Services

Ms Patricia Angus – Assistant Secretary, Aboriginal and Community Health Policy

Mr Kevin Williams – Assistant Secretary, Health Planning and Systems Support

Julanimawu Health Centre

Dr Christopher Harrison

Top End Primary Health Care Network

Dr Michael Glasby

Office of Aboriginal Development

Mr Raymond Hempel – Assistant Director

Northern Territory Treasury

Mrs Jennifer Prince – Deputy Under Treasurer

Menzies School of Health Research

Professor John Mathews – Director

Royal Darwin Hospital

Professor Alan Walker - Department of Paediatrics

22 February 1999 - Canberra

Department of Health and Family Services

Ms Helen Evans – First Assistant Secretary, Office for Aboriginal and Torres Strait Island Health Services

Ms Marion Dunlop – Assistant Secretary, Health Strategies and Research Branch

Ms Mary McDonald – Assistant Secretary, Program, Planning and Development Branch

Aboriginal and Torres Strait Islander Commission

Mr Peter Taylor – Acting Assistant General Manager, Housing, Infrastructure, Health and Heritage Branch

Mr Noel Baxendell – Housing, Infrastructure, Health and Heritage Branch

Department of Family and Community Services

Ms Tricia Rushton – Assistant Secretary, Community Branch

Mr Barry Smith – Director, Indigenous Policy Unit

National Aboriginal Community Controlled Health Organisation

Ms Naomi Mayers – Deputy Chairperson

Mr Steven Larkin – Chief Executive Officer

Department of Education, Training and Youth Affairs

Mr Tony Greer – First Assistant Secretary, Schools Division

Mr Peter Buckskin – Assistant Secretary, Indigenous Education Branch

Ms Lois Sparkes – Acting Assistant Secretary, Quality Schooling Branch

Dr Tom Karmel – Assistant Secretary, Operations Branch

9 November 1999 Alice Springs

Central Australian Aboriginal Congress

Dr William Bartlett – Public Health Medical Officer

Council of Remote Area Nurses of Australia Inc.

Mr Nigel Jefford – Director

Central Australian Regional Indigenous Health Planning Committee

Ms Helena Maher – Project Officer

Aboriginal Medical Services Alliance

Mr Edward Tilton – Research Officer

Batchelor Institute of Indigenous Tertiary Education

Mrs Julie Tye – Acting Senior Lecturer, School of Health Studies

Nganampa Health Council

Dr John Wilson – Health Services Manager

Individual

Mr Albert Lamb

10 November 1999 Darwin

Tiwi Health Board

Mr William Barclay – Chief Executive

Ms Louise Brown – Education Coordinator

Mr Marius Puruntatameri – Member

Australian Physiotherapy Association, Northern Territory Branch

Mr Robert Curry – Member, Aboriginal Health Subcommittee

Mr Patrick Maher – Government Liaison

Ngalkunbuy Health Centre, Galiwinku

Ms Michelle Dowden – Community Health Educator

Aboriginal Medical Services Alliance Northern Territory

Mr James Gallacher – Policy / Research Officer

Territory Health Services

Ms Trish Jones – Senior Policy Officer

Mrs Cheryl Rae – Regional Director Operations North

Aboriginal Resource and Development Services Inc.

Mr Stuart McMillan – Educator

Deafness Association Northern Territory Inc.

Mrs Mary Salter AM – President

Individuals

Ms Maisie Austin

Dr Peter Carroll

Mr David Lindner

Dr Alan Walker

Cooperative Research Centre for Aboriginal and Tropical Health

Dr Lowitja O'Donoghue - Chairperson

Ms Donna Ah Chee

Ms Pat Anderson

Professor Ian Anderson

Dr David Ashbridge

Professor Michael Good

Professor Gregroy Hill

Mr Paul Hughes

Mr Dave Kemp

Mr John Liddle

Ms Sally Mathews

Mr Charles Tipungwuti

29 November 1999 Cairns

Community Health

Ms Cathie Archer - Child and Family Health Nurse

Australian Medical Association

Dr Ngaire Brown - Indigenous Health Adviser

Queensland University of Technology

Ms Yvonne Cadet-James - Lecturer, Indigenous Health, Centre for Indigenous Health Education and Research

Douglas Shire Multipurpose Health Service

Mr Graeme Channells - Secretary, Indigenous Health Sub-Committee

James Cook University

Professor Richard Hays - Foundation Dean, School of Medicine

Professor Ian Ring – Head, School of Public Health and Tropical Medicine

Tablelands Alcohol and Drugs Service

Mrs Rose Isherwood - Project Officer

House of Representatives Standing Committee on Family and Community Affairs

Mr Bjarne Nordin – Committee Secretary

Mr Jim Kennedy - Inquiry Secretary

Queensland Police Service

Constable Jennifer Land – Far North Region Cross Cultural Unit, Office of the Assistant Commissioner

Mookai Rosie Bi-Bayan

Ms Lillian Levers - Manager

Mrs Sandra Tanna - Chairperson

Wangetti Education Centre

Mrs Diane Nona - Female Counsellor

Townsville District Health Service

Mr Phillip Peachy - Coordinator, Aboriginal and Islander Health Program

Aboriginal and Islander Alcohol Relief Services

Mr Arthur Poa - Drug and Alcohol Counsellor

Cairns District Health Service

Ms Wendy Sexton - Acting Aboriginal and Torres Strait Islander Coordinator Health Policy

Indigenous Injury Prevention Project

Ms Veronica Williams - Health Promotion Officer

Individuals

Mr John Meany

Mr Barclay Miller

Mrs Lorraine Peeters

Ms Mary Mitrovic-Calvert – Community Worker, Home and Community Care

Mrs Valda Miller - Senior Health Worker, Yarrabah

30 November 1999 Brisbane

North Coast Aboriginal Corporation for Community Health

Mrs Margaret McMahon – Chairperson

Mrs Sharon Barry - Member

Mr John Spink – Chief Executive Officer

Queensland University of Technology

Professor Leo Carney – Head of School, School of Optometry

Ms Julia Mainstone – Research Optometrist, School of Optometry

Cherbourg Community Health Service

Mr Harold Fatnowna – Health Promotion Officer

Mr Edward Watson – Mental Health Worker

Kambu Medical Aboriginal and Torres Strait Health Service

Mr Robert Holt – Chairperson

Mr Rudy Sandy - Director

Queensland Health

Mrs Maureen Kirk – Indigenous Project Officer, Women's Cancer Screening Services

Department of Health and Aged Care

Ms Toni Malamoo – Director, Health Branch

Mr Lance Parsons – Assistant Director, Health Branch

Wide Bay Aboriginal and Torres Strait Islander Community Health Service

Mrs Lori Salam – Member

Individuals

Mr Les Collins

Miss Hayley Madge

Ms Karla Mulherin

Ms Rosemary O'Grady

Ms Elizabeth Shield

1 December 1999 Sydney

Proprietary Medicines Association of Australia

Mrs Judith Brimer - Public Relations Officer

AIDS Council of New South Wales

Ms Kooncha Brown

Mr Chris Lawrence - Aboriginal Men's Project Officer

New South Wales Department of Health

Ms Claire Croumbie-Brown - Manager, Policy Unit, Aboriginal Health Branch

Ms Geraldine Wilson - Senior Project Officer, Aboriginal Health Branch

International Centre for Eyecare Education

Ms Fiona Dimond - Executive Coordinator

Brothers of St John of God

Brother Michael Gravener

Australian Health and Development Group

Dr John Hirshman – President

Aboriginal Health and Medical Research Council of New South Wales

Ms Lola McNaughton - Policy Officer

Mr John Williams - Policy Officer

Paul Consulting Services Pty Ltd

Mr Kenneth Paul – Director

Royal Australian and New Zealand College of Psychiatrists

Dr Neil Phillips - Chair, Aboriginal and Torres Strait Islander Mental Health Committee

Centre for Mental Health Studies, University of Newcastle

Professor Wayne Reid - Director of Clinical Psychology, Department of Psychology

Wentworth Area Health Service

Mr Clarke Scott - Aboriginal Community Health Liaison Officer

Armidale and District Services Inc. (Aboriginal Medical Services)

Mr Kym Yeoward - Accountant

10 December 1999 Canberra

Aboriginal and Torres Strait Islander Commission

Mr Noel Baxendell - Health Policy Officer, Housing, Infrastructure, Health and Heritage Branch

Mr Chris McCarthy - Acting Assistant General Manager, Housing, Infrastructure, Health and Heritage

Durri Aboriginal Corporation Medical Service

Mr Stephen Blunden – Chief Executive Officer / Public Officer

Winnunga Nimmityjah Aboriginal Health Service

Ms Julie Tongs - Chief Executive Officer

Ms Mary Buckskin - Board Member

Department of Education, Training and Youth Affairs

Mr Peter Buckskin - Assistant Secretary

Royal Australian College of General Practitioners

Dr Sarah Strasser - Director of Rural Training

Canberra Journey of Healing Network

Ms Ricki Dargavel - Convenor, Implementation Task Force

National Heart Foundation

Ms Patricia Field - National Program Manager, Rural, Remote Aboriginal and Torres Strait Islander Programs

Department of Health and Aged Care

Ms Mary McDonald - Acting First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health

Mr Andrew Price - Assistant Director, Executive Policy Unit, Office for Aboriginal and Torres Strait Islander Health

Australian National University

Dr Beverly Sibthorpe – Fellow, National Centre for Epidemiology and Population Health

Individuals

Professor John Deeble

Mr William Wilson

Dr Robert Cooter

C

Appendix C

Communities and Organisations consulted by the Committee

Tasmanian Aboriginal Centre, Hobart, TAS	Monday, 9 February 1998
Nunkawarrin Yunti Medical Service, Adelaide, SA	Tuesday, 17 February 1998
Perth Aboriginal Medical Service, WA	Wednesday, 18 February
National Aboriginal and Torres Strait Islander Health Clearing House, Curtin University, Perth, WA	Thursday,19 February 1998
NPY Women's Council, Alice Springs, NT	Monday, 20 April 1998
Central Australian Aboriginal Congress, Alice Springs, NT	Monday, 20 April 1998
Yuendumu, NT	Tuesday 21 April 1998
Alice Springs District Health Service, NT	Tuesday, 21 April 1998
Ngnampa Health Council, Alice Springs, NT	Wednesday, 22 April 1998
Torres Strait Regional Authority, Thursday Island, Torres Strait	Tuesday 5 May 1998
Badu Island, Torres Strait	Tuesday, 5 May 1998

Kuban (Moa Island), Torres Strait	Tuesday, 5 May 1998
Bamaga, QLD	Wednesday, 6 May 1998
Napranum, QLD	Wednesday, 6 May 1998
Pormpuraaw, QLD	Thursday, 7 May 1998
Kowanyama, QLD	Thursday, 7 May 1998
Wu Chopperin Aboriginal Medical Service, Cairns, QLD	Friday, 8 May 1998
Redfern Aboriginal Medical Service, NSW	Thursday, 11 June 1998
Aboriginal Health Unit, Faculty of Medicine and Health Sciences, University of Newcastle, NSW	Friday, 12 June, 1998
Awabakal Aboriginal Medical Service, Newcastle, NSW	Friday, 12 June 1998
Bathurst Island, NT	Tuesday, 18 August 1998
Katherine West Health Board, NT	Wednesday, 19 August 1998
Danila Dilba Aboriginal Medical Service, Darwin, NT	Wednesday, 19 August 1998
Batchelor College, Batchelor, NT	Thursday, 20 August 1998
Mildura Aboriginal Health Service, VIC	Monday, 1 March 1999
Coomealla Aboriginal Health Service, Dareton, NSW	Monday, 1 March 1999
Far West Ward Aboriginal Health Service, Broken Hill, NSW	Tuesday, 2 March 1999
Far West Area Health Service, Broken Hill, NSW	Tuesday, 2 March 1999
Royal Flying Doctor Service, Broken Hill, NSW	Tuesday, 2 March 1999
University of Sydney, Department of Rural Health, Broken Hill, NSW	Tuesday, 2 March 1999
Wellington Aboriginal Health Service, NSW	Wednesday, 3 March 1999
Walgett Aboriginal Medical Service, NSW	Wednesday, 3 March 1999
Booroongen Djugen, Kempsey, NSW	Thursday 4 March 1999
Durri Aboriginal Health Service, Kempsey, NSW	Thursday 4 March 1999
Benelong's Haven, Kempsey, NSW	Thursday 4 March 1999
Mutijulu, NT	Tuesday, 16 March 1999
Umoona Tsutagku Health Service, Coober Pedy, SA	Wednesday, 17 March 1999

Oak Valley, SA	Wednesday, 17 March 1999
Docker River, NT	Thursday, 18 March 1999
Ngunytju Tjitju Purni, Kalgoorlie, WA	Tuesday, 27 April 1999
Bega Garnbirringu Aboriginal Medical Service, Kalgoorlie, WA	Tuesday, 27 April 1999
Ninga Mia Village, WA	Tuesday, 27 April 1999
Wirraka Maya Health Service, Port Hedland, WA	Wednesday, 28 April 1999
Kimberley Aboriginal Medical Services Council, WA	Wednesday, 28 April 1999
Broome Regional Aboriginal Medical Service, WA	Wednesday, 28 April 1999
Nindilingarri Cultural Health Service, Fitzroy Crossing, WA	Thursday, 29 April 1999
Yura Yungi Aboriginal Medical Service, Halls Creek, WA	Thursday, 29 April 1999
East Kimberley Aboriginal Medical Service, Kununurra, WA	Friday, 30 April 1999
Waringarri Substance Abuse Service, Kununurra, WA	Friday, 30 April 1999
Miwatj Aboriginal Health Service, Nhulunbuy, NT	Monday 24 May 1999
East Arnhem District Health Service, Nhulunbuy, NT	Monday 24 May 1999
Maningrida, NT	Tuesday, 25 May 1999
Yirrkala, NT	Tuesday, 25 May 1999
Anyingini Congress Aboriginal Health Service, Tennant Creek, NT	Wednesday, 26 May 1999
Barkly District Health Service, Tennant Creek, NT	Wednesday, 26 May 1999
Nganampa Health Council, Umuwa SA	Monday, 26 July 1999
Nganampa Health Clinic, Fregon, SA	Monday, 26 July 1999
Nganampa Health Clinic, Ernabella, SA	Monday, 26 July 1999
Pipalyatjara, SA	Monday, 26 July 1999
Kintore, NT	Tuesday, 27 July 1999

D

Appendix D

The Indigenous population

1.1 At the 1996 Census, it was estimated that there were 386,000 Indigenous people resident in Australia, representing 2.1 per cent of the total Australian population.

1.2 At that time the average annual growth rate for the Indigenous population was 2.3 per cent, which was significantly higher than the 1.4 per cent average growth rate of the non-Indigenous population.

1.3 The Indigenous population was also much younger than the non-Indigenous population, with 40 per cent, or around 155,000 people, under 15 years compared to 21 per cent of the non-Indigenous population. The median age of 20 years was some 14 years younger than for the non-Indigenous population.

> In the context of significant population growth, this youthful demographic profile means the number of Indigenous people moving into the ages in which families are being formed is increasing rapidly. At the household level, the important demographic trend between 1991 and 1996 was the substantial relative increase in total number of Indigenous households, which increased by 25 per cent compared to 9 per cent amongst non-Indigenous households[1]

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1 Daley, A.E. and Smith, D.E. *Indigenous household demography and socioeconomic status: the policy implications of 1996 Census data.* Centre for Aboriginal Economic Policy Research. Discussion Paper No. 181. The Australian National University. Canberra. 1999. p 4.

1.4 Only 2.6 per cent of the Indigenous population, around 10,000 people, were older than 65 years.

1.5 More than half of the Indigenous population live in New South Wales (28.5 per cent) and Queensland (27.2 per cent). Another quarter live in Western Australia (14.4 per cent) and the Northern Territory (13.1 per cent).

Estimated resident Indigenous population, 30 June 1996

	Indigenous population	*Proportion of Indigenous population*	*Proportion of total State population*
	'000	*%*	*%*
New South Wales	109.9	28.5	1.8
Victoria	22.6	5.9	0.5
Queensland	104.8	27.2	3.1
South Australia	22.1	5.7	1.5
Western Australia	56.2	14.6	3.2
Tasmania	15.3	4.0	3.2
Northern Territory	51.9	13.4	28.5
Australian Capital Territory	3.1	0.8	1.0
Australia	386.0	100.0	2.1

Source: ABS Experimental Estimates of the Indigenous Population

1.6 Since 1991, the overall percentage of the Indigenous population living in urban areas (defined by the ABS as a population centre of more than 1000 people) has increased as well, from 67.6 per cent to 72.6 per cent. This compares to 85.9 per cent for the non-Indigenous population

1.7 Unlike the non-Indigenous population, however, a higher proportion of Indigenous people, 42.3 per cent compared to 23 per cent of the non-Indigenous population, are living in the smaller urban centres (those with populations between 1000 and 99,999 people) rather than the major cities.

1.8 This increase does not necessarily represent more Indigenous people moving to the cities. Instead the increases come both from changes in classification of some smaller urban centres, as well as a greater willingness of Indigenous people in urban areas to identify as such on the census forms.

1.9 There are also considerable regional differences in this distribution pattern.

> In New South Wales there are about 8% of the New South Wales Aboriginal population living in remote communities…In Western Australia 50 per cent of Aboriginal people, or close to 29,000, live in rural or remote communities.[2]

1.10 What this means though is that, despite popular misconceptions, Indigenous people do not all live in remote areas. The population is evenly distributed through urban, rural and remote areas, but, environmental problems, and many other health problems, are often more visible in remote communities, and so tend to be the focus of media images.

> I get quite tired of seeing file tapes of the health of Aboriginals on the media, on TV, that show the deplorable health of Aboriginal people in the Northern Territory and Western Australia, when I know from personal experience that our people in New South Wales are just as vulnerable to being ill.[3]

1.11 The Committee has itself used many examples from remote areas in this report, to illustrate particular issues. This is not to say that the Committee is not well aware of the differences between communities, and the need for programs to apply across all areas, not just the remote regions.

Levels of disadvantage

1.12 As well as a population which is younger, and growing at a much faster rate than the general population, the data also shows that Indigenous people are the most disadvantaged in the country no matter where they live, particularly with regard to health and well-being.

> As a group, Indigenous people are disadvantaged relative to other Australians with respect to a number of socioeconomic factors, and these disadvantages place them at greater risk of ill health and reduced well-being.[4]

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2 Mr Shane Houston. Evidence. p1018.

3 Ms L McNaughton. Evidence. p1327.

4 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. p2.

1.13 Indigenous people are more likely to be:

Unemployed or receiving lower incomes:

- At the time of the 1996 census the unemployment rate for Indigenous Australians was 23 per cent, compared to 9 per cent for the non Indigenous population. This would be closer to 34 per cent if all people participating in the Community Development Employment Projects (CDEP) Scheme, which is a work for the dole type program, were counted as unemployed.
- More than half of those aged 20-24 are unemployed.
- Sixty percent of Indigenous Australians earned less than $12,000 a year and their median personal income was $190 per week, which is 65.1 per cent of the median personal income for all Australians.

Less educated:

- In 1996, some 60 per cent of Indigenous people nationally said they had left school before 17 years. Only 2 per cent of Indigenous adults in 1996 had completed a Bachelor degree or higher, compared to 11 per cent of the non-Indigenous population.
- Across the Northern Territory in 1998, 14 per cent of Indigenous students progressed from year 8 to year 12, compared to 80 per cent of non-Indigenous students. Nationally only 30.9 per cent completed year 12 compared to 72.8 per cent of Non-Indigenous students.
- Impaired hearing impacts on educational performance , with up to 70 per cent of children in some communities having hearing difficulties, resulting in learning problems.

Imprisoned or in care:

- In 1994, some 25 per cent of Indigenous people between 18 and 44 had been arrested at least once in the past five years, and in 1997 the imprisonment rate for Indigenous adults was over 14 times that for other adult Australians.
- Indigenous children are also dramatically over represented in the juvenile justice system, with about 41 per cent of the children in corrective institutions in 1996 being Indigenous.

Homeless or living in overcrowded conditions:

- In 1996-97 it was estimated there were about 12,000 homeless Indigenous Australians. For those who did have a place to live in 1996, 7 per cent lived in a dwelling with 10 or more people. This was more

than 50 times greater than the proportion of non-Indigenous people living in such conditions.

Unwell or dying early:

The health disadvantage of Indigenous Australians begins early in life and continues through the life-cycle.[5]

- On average, Indigenous mothers are younger and their babies are twice as likely to be of low birth weight and more than twice as likely than other babies to die around the time of birth.
- Indigenous people die almost 20 years younger than other Australians and are more likely to be hospitalised, to smoke and to suffer from obesity or chronic illness.
- In the period 1991-96, life expectancy at birth for Indigenous Australians was 56.9 years for males and 61.7 years for females, compared to 75.2 years and 81.1 years respectively for all Australians.
- More than half the deaths among Indigenous males in the 1995-1997 period occurred among people who had not yet reached 50 years of age and three out of four Indigenous males who died had not reached 65 years. In comparison, more than 73 per cent of male deaths in the general population occurred in people older than 65 years.

1.14 While it seems reasonable, in terms of equity, to suggest that government support should be available at the same level for all Australians this is a difficult position to maintain in the face of this level of disadvantage compared to non-Indigenous Australians.

Changing patterns of ill-health

1.15 The gap in health status between Indigenous and non-Indigenous Australians is considerable, but, over the last twenty years the causes of excess mortality in the Indigenous population have progressed from acute infections to chronic non-communicable diseases and deaths resulting from accident and injury.

1.16 Between 1985 and 1994, there was very little improvement in the mortality experiences of Indigenous Australians, and about three out of every four deaths among Indigenous people now result from one of the following:

5 Australian Bureau of Statistics and Australian Institute of Health and Welfare. Op cit. p5.

- 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).

1.17 Adult morbidity patterns have similarly changed, with a reduction in communicable diseases being counterbalanced by an increase in non-communicable diseases, particularly hypertension, ischaemic heart disease and diabetes.

1.18 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 incidence and prevalence of childhood infections in the Indigenous community should be no greater.

1.19 Infant mortality rates have been decreasing since the 1970s and birth weights have been increasing, but there are still many infants born underweight, especially in remote areas.

1.20 Infant and childhood malnutrition continue to contribute to growth retardation and predispose children to infectious disease. This is particularly relevant in considering present mortality patterns as there is evidence to suggest that low birth weight and growth retardation before birth can contribute to diabetes mellitus, hypertension and heart disease in later life.

1.21 There have been rapid increases, over the past ten years, in the incidence of kidney disease and renal failure within the Indigenous population. Although the reasons for this rapid increase are complex, and not completely understood, there is also some evidence linking past infections to increased susceptibility to kidney failure. The incidence of renal failure in the Top End is estimated as being some 15 times higher than the Australian aggregate rate.

1.22 Mental health, particularly mental and emotional well-being, is also seen as a major problem within the Indigenous community.

1.23 The impact of these changes has also been fairly general, in that they are not limited to any specific geographic or socioeconomic area. While there are some regional differences for specific conditions the overall health outcomes for Indigenous Australians in urban areas is as poor as that for Indigenous people in rural or remote areas.

1.24 To address this continuing gap will require the development of more programs which recognise the underlying levels of disadvantage and are built on an understanding of the impact of the past on Indigenous people and culture. It also means that programs for Indigenous people cannot be the same as other Australians until such time as their health status is also equal.

E

Appendix E

Overseas experiences

1.1 As mentioned above Indigenous infant mortality rates in Australia have been declining, but life expectancy has not greatly improved owing to continued high mortality rates.

1.2 This is in contrast with the experience of the Indigenous populations of Canada, the United States and New Zealand.

1.3 Between 1985 and 1996, the mortality rates for Indigenous Australians only fell by about 9 per cent. This was insufficient to close the gap between non-Indigenous mortality rates, which also fell over the same period.

1.4 Death rates for NZ and US Indigenous people, however, decreased more significantly, falling relatively rapidly in the 1970's and then more slowly.

> The all causes mortality for the Aboriginal and Torres Strait Islander population is twice as high as the Maori rate, 2.3 times the United States Indigenous rate and 3.1 times the total Australian rate. The Maori death rate declined by 44% in the period between 1974 and 1994 and the United States Indigenous rate by 30% in the same period.[1]

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1 Australian Medical Association and Public Health Association of Australia. Submission No 32. p50.

United States

1.5 In 1972-74, life expectancy at birth for American Indians and Alaska Natives was 63.5 years (higher than the current life expectancy of Indigenous Australians). By 1992-94 this had increased to 71.1 years, only 4.4 years less than that for US All Races and 5.2 years less than that for US Whites.

1.6 Over this same period maternal and infant mortality rates had also declined by 86 per cent and 68 per cent respectively.

1.7 The leading causes of death were diseases of the heart and cancer (the same as for the total population). However, the second leading cause of death for Indian males was accidents. The age adjusted death rates for American Indians and Alaska Natives is 35 per cent higher than for US All Races and were considerably higher for the following causes:

- Alcoholism - 579 per cent, tuberculosis - 475 per cent, diabetes mellitus - 231 per cent, accidents – 212 per cent and suicide 70 per cent.

1.8 The population structure is similar to Australia's Indigenous population, although slightly older reflecting their improved mortality, with 33 per cent under 15 years and 6 per cent older than 64 years. This compares to 22 per cent and 13 per cent respectively for the US All Races population. The median age was 24.2 years compared to 32.9 years.

1.9 In 1989, median household income for Indians in reservation States was $19,897, 66 per cent of the $30,056 for the US All Races population. 31.6 per cent of Indians lived below the poverty level compared to 13.1 per cent of the total population

Canada

1.10 Life expectancy for Registered Indians in Canada continues to approach parity with the general population. In 1995, the life expectancy for Indian males and females was 69.1 years and 76.2 years respectively and the difference between the general population is expected to be less than six years when 1996 data is released.

1.11 Between 1985 and 1994, injury and poisoning were the leading causes of death among registered Indians, but the rates had declined by almost half over that period. The next leading causes of death in 1994 were diseases of the circulatory system and neoplasms.

1.12 In 1990, average income among Aboriginal persons was $14,198, 70.1 per cent of the $20,264 for the non-Aboriginal population, increasing from 57 per cent in 1985.

1.13 General educational attainment, despite significant improvements between 1986 to 1991, remains lower than for the non-Aboriginal population. The unemployment rate for Aboriginal persons in 1991 was roughly double the non-Aboriginal rates.

New Zealand

1.14 Over the past 40 years, life expectancy for Maori females increased by 17 years and for Maori males by 14 years.

1.15 At the same time, the disparity between Maori and non-Maori life expectancy also narrowed, decreasing from 14.2 years to 5.4 years for Maori males and from 16.5 years to 6.2 years for Maori females.

1.16 From 1987 to 1996, mortality rates have decreased by 18 per cent for males and 16 per cent for females, but they are still higher than the non-Maori rates in all age groups except 5-9 years. Maoris had a total age-standardised death rate in 1996 which was almost twice the non-Maori death rate.

1.17 The leading causes of death in 1996 were neoplasms and ischaemic heart diseases.

1.18 Maori males also had more than twice the Maori female mortality rate for motor vehicle accidents and approximately three times the suicide rate.

1.19 Since the mid-1980s, Maori participation in all sectors of education has increased. Between 1984 and 1994, the proportion of Maoris over 16 years still in secondary school increased from 48.8 per cent to 72.4 per cent. Nevertheless disparities persist with non-Maoris. Maoris are less likely to attend early childhood education, remain to senior levels of secondary school or obtain a formal qualification on leaving school.

1.20 Over the 1987-1997 decade, the average income of Maori households rose from $26,000 to $37,000, but as the rate of non-Maori income increased at a greater rate the disparity had increased and the average household income is some 78.7 per cent of the non-Maori average.

F

Appendix F

Some previous reports on Indigenous health matters

YEAR	MAJOR REPORTS OR DECISIONS	KEY RECOMMENDATIONS OR ACTIONS
1979	*"Aboriginal Health"*	Report of the House of Representatives Standing Committee on Aboriginal Affairs.
	Recommendations included:	The need for the highest priority to be given to providing clean and adequate water supplies, improved sewerage systems and adequate housing for all Aboriginal communities;
		Designing health programs which encompass Aboriginal cultural beliefs and practices;
		Allowing Aboriginal communities to determine the types of health care that would best suit their needs, as well as providing appropriate support for the community to make an informed choice;
		Involving Aboriginal people to the fullest possible extent in all stages of the provision of health care services and developing programs to train sufficient Aboriginal people to assume responsibility for the health of their own people;

		The introduction of a component dealing with Aboriginal health by all training institutions for health professionals, at both undergraduate and graduate levels; and
		Special allowances and entitlements to encourage people to work in remote Aboriginal communities.
1987 (Dec)	Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health recognised there had been limited progress in the implementation of recommendations from earlier reports, and noted that there was no agreed National Aboriginal Health Strategy.	Ministers agreed at that time to the establishment of the National Aboriginal Health Strategy Working Party, with representatives from the Commonwealth, States and communities, to develop such a National Strategy.
1988	*Report of the National Aboriginal Health Strategy (NAHS) Working Party*.	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. The key concept underlying the report was Aboriginal people's holistic view of health involving not just individual physical well-being but the social, emotional and cultural well-being of the whole community.
	Recommendations included:	Increased community involvement, through; • establishment of a national Council for Aboriginal Health, to report to Ministers for Health and Aboriginal Affairs; • recognition of the National Aboriginal Community Controlled Health Organisation; and • a significant increase in the numbers of community controlled Aboriginal Health Services, which should also take over the existing primary health services being provided by the States and Territories;

		Improved service quality through development of minimum standards, particularly for Aboriginal Health Services, improved funding arrangements and increased specialist services ;
		Improved environmental health conditions, with adequate funding to bring all communities to an acceptable standard. Accompanied by appropriate training in hygiene and the use of facilities, as well as to carry out ongoing maintenance and repair work;
		Improved educational and working arrangements, particularly for Aboriginal Health Workers, such as; • development of a national training and accreditation system and career structure for Aboriginal Health Workers; • support for more Aboriginals to undertake training as a health professional; and • appropriate training for all health professionals, including cultural, social and professional orientation and preparation to work in the field of Aboriginal health.
1989 (Dec)	Report of the Health Development Group	Further working group established by Health and Aboriginal Affairs Ministers to assess the NAHS Report.
		The Health Development Group generally endorsed the NAHS Working Party's recommendations, but made only 21 recommendations for action. These were much broader and substantially less in number and scope than the NAHS report.
1990 (June)	Recommendations of the Health Development Group endorsed by Health and Aboriginal Affairs Ministers.	

1991	Report of the Royal Commission into Aboriginal Deaths in Custody.	The Commission's Report expressed concern at the lack of progress in improving Indigenous health. The Report 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.
1994	Report on the Evaluation of the National Aboriginal Health Strategy.	This Report found there had been minimal gains in Aboriginal health and that the National Aboriginal Health Strategy had never been effectively implemented.