HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

CANBERRA

Friday, 6 February 1998

OFFICIAL HANSARD REPORT

CANBERRA

HOUSE OF REPRESENTATIVES
STANDING COMMITTEE AND FAMILY AND COMMUNITY AFFAIRS

Members

Mr Forrest (Chair)
Mr Quick (Deputy Chair)

Mr Cameron	Mrs De-Anne Kelly
Ms Ellis	Mr Lieberman
Mrs Elson	Ms Macklin
Mrs Elizabeth Grace	Mr Allan Morris
Mr Harry Jenkins	Dr Nelson
Mrs Johnston	Mrs West

Matters referred for inquiry into and 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.

WITNESSES

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Indigenous health

CANBERRA

Friday, 6 February 1998

Present

Mr Forrest (Chair)

Mr Jenkins

Mr Allan Morris

Mr Lieberman

The committee met at 9.13 a.m.

Mr Forrest took the chair.

CHAIR—Since this is the first hearing on the indigenous health inquiry, I want to put on the public record the determination of our committee to produce a report that produces some real progress towards meeting the needs of indigenous Australians. Late last year we punched out a number of reports in order to be free to focus on this inquiry for this year. The submissions we are considering summarise in a very sober way the nature of the problem. We are really determined as a committee to make some progress.

I am pleased to open this first day of public hearings. Although there are only four members of the committee here today, there are 14 members of the committee from all around Australia. Later on in the year we will be going out and conducting some grassroots type inspections. At this stage we are trying to come to grips with the nature and extent of the problem, and we are still assessing how the inquiry will be conducted further on.

For the record, the inquiry was referred to the committee by the Minister for Health and Family Services, Dr Michael Wooldridge, with the support of the Minister for Aboriginal and Torres Strait Islander Affairs, Senator Herron. And I should add here that Mr Lieberman chairs the House of Representatives standing committee with that jurisdiction.

The committee is looking at improved coordination, planning and delivery of indigenous health services against the background that past structures for the delivery of health services to indigenous populations have not resulted in significant improvement to the health status of those communities and that there still exists barriers to access to mainstream services for Aboriginal and Torres Strait Islander people.

The committee's investigations are aimed at shaping improved Commonwealth policy in the area of Aboriginal and Torres Strait Islander health, and aimed at contributing to improved health outcomes for Australia's indigenous populations. The inquiry will build on the experience of past attempts to assist in health care delivery to indigenous communities in urban, rural and in traditional and remote environments, and will examine factors which may have contributed to the poor health status currently being experienced in indigenous communities.

I want to stress that the committee is seeking to conduct this inquiry in a spirit of collaboration and cooperation with Aboriginal and Torres Strait Islander people. Obviously, it is important to consult communities directly and combine the collective experience of everyone who has worked in this area to arrive at the best possible practical strategies. It is important to build on individual successes. There are some good models out there and we are very keen to see those, as well as some that have not produced good outcomes.

As I have said, we have set aside several weeks to conduct inspections of remote and rural communities to experience at first-hand the living conditions of indigenous

people. Today's hearing in Canberra provides the first opportunity to engage in discussions on the public record with the major national organisations that have responsibilities in this area.

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O'DEA, Professor Kerin, Member, Aboriginal and Torres Strait Islander Health Research Agenda Working Group, National Health and Medical Research Council, GPO Box 9848, Canberra, Australian Capital Territory 2601

CHAIR—I welcome officers of the Department of Health and Family Services who are our first witnesses this morning. Before we proceed I wish to point out that while this committee does not swear witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the proceedings of the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of parliament. All of the submissions received have been incorporated in the published volumes already distributed as part of the inquiry. Ms Murnane, would you like to make an opening statement before we proceed to questions from the committee?

Ms Murnane—Mr Chairman, we have a summary of our submission and we can go through that if you wish, but I thought it might be useful at the start if Ms Evans outlines the role of the Department of Health and Family Services in relation to Aboriginal health. After that, Professor O'Dea, who as well as representing the NHMRC at this hearing is also the deputy chair of the research committee of the NHMRC and of the specific research agenda working group for Aboriginal health, could talk about the role of the NHMRC. Perhaps then we could go straight to questions.

CHAIR—That is good. I envisage that as the inquiry proceeds we will have you back, probably many times, as we get further down the track. We might regard this as a preliminary discussion, as the committee seeks your assistance in pointing us in the right direction.

Ms Murnane—Indeed.

CHAIR—I am happy with that procedure.

Ms Evans—Mr Chairman, most people are aware that responsibility at a Commonwealth level for Aboriginal health transferred to the Health and Family Services portfolio 2½ years ago. Since that time, we have been working to develop a comprehensive strategic approach on a number of fronts. No-one would dispute the fact that the underlying causes of poor health in indigenous people are very complex and multifactorial. The other lesson we have learnt from the past is that there is no easy, ad hoc or quick fix solution.

Indeed, reviewing the numerous reports that have been done on Aboriginal and Torres Strait Islander health over the years has highlighted that what is needed is a sustained and coordinated approach at the national, state and local level, one that commits all the major stakeholders to work together in partnership. It also highlights the need to ensure that Aboriginal and Torres Strait Islander people are key partners in that approach and that, no matter how good our strategic approach is, if that is not the case it is doomed to fail.

We have been working to put in place an overall strategic approach in the department. At the macro level, the Aboriginal health framework agreements are the mechanism we have developed for carrying that strategy forward and, at the local level, we have put a very strong emphasis on Aboriginal and Torres Strait Islander primary health care services as the key institutional structure.

As we say in our submission, under the broad framework there are three interrelated components to that strategy. The first component is strategies to develop the resource needs to achieve effective and sustained action in health. The second is strategies to address specific Aboriginal and Torres Strait Islander health issues, and the third is strategies to improve the evidence framework for Aboriginal and Torres Strait Islander health. Those are the components of our strategy.

I will briefly summarise for you—and this is contained in our submission on page 10—what we see as the five interrelated roles of the Office for Aboriginal and Torres Strait Islander Health. The first is supporting Aboriginal health services in a way that maximises their effectiveness, improves accountability and ensures that these services play a role which complements rather than duplicates mainstream services. The second is supporting other providers of primary, secondary and tertiary health services to Aboriginal

and Torres Strait Islander people, to maximise the effectiveness of that care. The third role is to work with other areas within our portfolio to promote policy and structural changes, including in particular the funding of mainstream health services, with the aim of removing barriers to access. That is a very key component and one of the major reasons why responsibility for Aboriginal health was transferred across to this portfolio.

The fourth role is working with organisations outside the health sector, through a process of intersectorial collaboration to bring about improvements in such areas as environmental infrastructure, and that is a particular issue in remote areas. The fifth one is working with health information and data systems in order to improve the quality and appropriateness of individual health data, to give us a solid base for planning and being able to assess what is working and not working. Those are the five roles that we see the office as playing.

CHAIR—I imagine that those kinds of broad strategies have been in place for quite a long time, and yet we have not seen dramatic improvement.

Ms Evans—What has not been the case is a coordinated and integrated approach, one that locks all the partners in. Certainly there has been effort across all the sectors over a long time, but what has been missing is the coordination and the commitment to work together and on a long-term basis to achieve these changes.

Ms Murnane—In structural terms, the framework agreements with most of the states are definitely a new feature of the agenda and a feature that can help us work in cooperation with the states to achieve the aims that Ms Evans has outlined.

CHAIR—I have to say that reading through the submissions we are considering today provides very little encouragement when you can see massive changes in some other countries, particularly Canada. I know the reason in New Zealand with New Zealand Maoris is that they do not have states, so they have one government driving things. But Canada is a federation of states. Why can they report much more dramatic progress on this issue with their indigenous peoples than we can? What are the ingredients that make it harder here in Australia?

Ms Murnane—I do not think there is any one answer to that question. I suggest that at this stage Professor O'Dea outlines the research agenda and also some of the research findings and then we may explore that. But I must put on the record now that we do not have a single explanation for the differences that you just alluded to between Australia and the North American continent. We are quite happy to assist you to try to reach some conclusions here, but it might be as well to put on the record what we have got in train and what has been achieved and, from a research perspective, Professor O'Dea can do that.

Prof. O'Dea—I would like to focus on the work of the committee called RAWG,

the Research Agenda Working Group, which has a strategic coordination role. It is a committee that is chaired by Dr Jack Best, chairman of one of the major committees of NHMRC, the Strategic Research and Development Committee. I am its deputy chair, representing the research committee. It has representation from Barbara Flick from the National Health Advisory Committee, NHAC. It has also got representation from OATSIHS and NACCHO. So we have got a strong indigenous representation, and we think we have got the major key players. This is the first time that this has happened in a systematic way like this. We are determined and, I have to say, probably for the first time, too, we are very committed—and it would not be the first time we have been committed to this, but we are trying to get a pathway to it at NHMRC—to linking research much more closely to health service practice and to population health research and, in fact, population health outcomes.

Our focus is to look very clearly at, and we are currently having a systematic review of, what we have funded in the past within NHMRC. We are having a systematic review with OATSIHS of what they have funded. We want to be much more systematic about the whole thing. In the past we have, I guess, let the researchers direct the agenda, rather than the organisation having a role in that. While we are still very much committed at NHMRC to the type of research that researchers think is important, we are recognising that we need to have a strategic role.

One of the greatest challenges is how to get the results of research into practice. One area where we are actively working on this now, and it was alluded to in our brief submission to you, is in the area of otitis media, ear infection—a common cause of deafness and a very serious health problem, particularly when it affects young children's learning ability and their whole educational achievement. What we are doing there is having a research agenda workshop, chaired by Dr Aileen Plant, to bring together the key people in the area and to work out what is the real research agenda—not just what this or that person thinks ought to be done, but really getting a consensus—and we will put some funds towards it through the Research Strategy Development Committee. That is the type of approach that we want to take with the major health problems.

We want to bring the best minds in the country to bear on Aboriginal and Torres Strait Islander health. This probably has not been the case in the past. This is a role that NHMRC can play. People give an enormous amount of free time to the NHMRC, and we want to bring this focus to these important health problems. We certainly are working in partnership with the Office of Aboriginal and Torres Strait Islander Health and other key stakeholders.

We see our role, too, in this committee as a coordination and brokerage role. We cannot fund everything, so we are looking to where we can get partnerships for joint funding of projects. We are talking to the National Heart Foundation, for example, in the area of cardiovascular disease; we are talking to Diabetes Australia in the area of diabetes; and these are two of the very serious chronic disease problems. This is the basic approach

that we are taking now, and we think it is really probably the first time it is has been systematised like this.

CHAIR—Are the approaches adopted from the bottom up, or are they top down? It seems to me that sometimes when you say it is a complex problem it could very well have a simple solution, but we have made it complicated because we are trying to drive it from the wrong position.

Prof. O'Dea—With otitis media, we are bringing together community people, biomedical researchers, population health researchers and Aboriginal health organisation representatives precisely for that reason. I think you are absolutely right. We have often had very much a magic bullet approach or we have tried to have a very purist, biomedical approach to some of these problems, whereas in fact there are often much simpler social problems that are driving them and, if we deal with those at the grassroots level, we are much more likely to have prevention of the conditions. We really have to move much more upstream, if you like, in terms of intervening. Our focus has in the past been really much more downstream focused, once the condition is embedded and serious.

We want to take that new approach in relation to a number of problems. It is not an easy approach. It means, if we are looking at diabetes, cardiovascular disease and renal disease—three very serious and interconnected problems—there is evidence now developing that the genesis of these conditions is even in utero, and so we really have to go back to very early steps. That is looking at primary prevention in its most extreme form. It is very long-term. We have to have a very long-term commitment to this. It is certainly not going to be fixed in a few years. We hope we can have markers, and some of the markers for that type of problem would be the reduction in low birth weight in Aboriginal communities.

There are a number of exciting projects—two that I can think of—that are really addressing this in a systematic way. There is the Strong Women, Strong Babies, Strong Culture program in the Northern Territory and there is a program that Sandra Eades and Fiona Stanley are involved with in the south-west of Western Australia, where they have achieved significant improvements in birth weight. We do not know but we suspect from other populations around the world that that will have positive outcomes down the track. We have to look at these problems in a very integrated way, and that is what we have not done in the past. We have thought of diabetes in Aboriginal communities as being an adult problem but we actually have to go right back and recognise that it is a problem linked with maternal and child health.

They are very complicated problems and they do need long-term approaches. I guess that the challenge for a committee like yours—and I am not speaking as a NHMRC person but as an individual—is to make this truly bipartisan and take it out of the political arena and have a commitment for long-term investment in what is going to be a very long-term solution.

CHAIR—You have got my personal commitment on that, but politics wastes too much energy. I said from the outset that we have a very strong bipartisan resolve in the committee.

Prof. O'Dea—Good.

CHAIR—And we are determined not to go back and look for scapegoats because it has not worked, but to try firstly with the parliament to get some consensus and drive it with that. But is there anyone else from the department, Ms Murnane, who could comment on my bottom up, tops down concept? I feel that, if the ownership is at the grass roots, at the coalface, and there is a drive for preventive participation, that must be the key.

Ms Murnane—In our submission we point out the importance of Aboriginal and Torres Strait Islander involvement in defining and solving their own health problems. In a formal way this is represented through community controlled health organisations. Helen Evans and Ian Anderson can talk now in more detail about how this operates and how we try to link what happens on the ground with the findings of the research that Professor O'Dea outlined.

Ms Evans—To answer your question, Mr Chairman, it is both. It is a top down and a bottom up process. It is probably true to say that in the past we have tried top down, and top down does not work. But without an overall approach, a coordination of resources and a combined effort—and that requires a top approach—we are not going to achieve it.

Similarly, unless we have grassroots and on the ground involvement and participation, it is not going to change either, so it is a combination of the two. I might get Dr Anderson, who has a lot of experience in the provision of primary health care services on the ground, to comment further on that aspect of it.

Dr Anderson—In terms of how a lot of Aboriginal communities in Aboriginal community organisations talk about this, it is really talking about the centrality of self-determination in terms of health care and delivery. It is based on a fairly simple observation that health care is something which people participate in; you do not do health care to people. That is a really central feature of the way in which Aboriginal community controlled health services are set up, and we see them as being really fundamental in ensuring that there is a link between communities, health care providers and the organisations that provide services to communities. That link is then built into strong regional structures that feed in through the framework agreements processes and the National Aboriginal Health Council into a policy process.

If you are going to make sound and effective policy in Aboriginal and Torres Strait Islander health, it is absolutely fundamental that at a Commonwealth level you have a very strong link between Aboriginal community controlled primary health care services

which provide advice about the realities in communities, their needs and the priorities, what is doable and what is feasible, and that a very strong and clear pathway for that sort of advice is built into the health policy process.

CHAIR—Can you give examples where that approach has produced a really good outcome?

Dr Anderson—In some of the groundbreaking work that has been done in some Aboriginal community health services around issues related to sexual health, there are very clear examples of communities taking on very culturally sensitive issues that often deal with some very personal and intimate aspects of people's private and social lives. They have been able to develop an effective approach to prevention and promotion based on comprehensive primary clinical care service. In regions where historically there have been very poor primary care delivery and hyperendemic rates of STDs, they have actually started to produce a demonstrable decline in the rates of sexually transmitted diseases.

In that case, that model that was developed is actually now providing a national model for how we approach issues in sexual health. Work done by organisations such as the community Aboriginal medical services, a number of Aboriginal health services, and many other such organisations, has been really fundamental in shaping that policy process.

CHAIR—I know that on other committees I work on I get really frustrated when the chairman hogs all the questions, so I am happy to allow colleagues at any time—

Mr ALLAN MORRIS—Can I just start with perception. One of the problems we have is that we are dealing with perceptions and some variety of realities. I just want to point to another submission which says that the Aboriginal health strategy in a 1989 survey of medical undergraduates of the University of Queensland pointed out that 90 per cent of Aboriginals were to blame for their own health problems. If 90 per cent of medical students think that the Aboriginals are to blame for their own problems, then it seems to me that we have a fairly major problem in dealing with that perception. So that question of perceptions and reality is very disturbing. That is the first point.

Secondly, with things such as trachoma, otitis media and a range of other conditions—which you and others have said manifest themselves much later in life—we are still learning about those ourselves. Yet we somehow expect to explain those to people who, in many cases, are undereducated, or ill themselves. So that perception that treatment is the answer I see as part of the problem.

Thirdly, in your submission, you make it very clear that there have been substantial improvements in a number of areas. Yet the perception out in the community is that things have actually got much worse. So we have got about three different things running at the same time. Firstly, there are perceptions in the profession that it is the fault of Aborigines. Secondly, there is a failure to reconcile primary causes early in life with issues, such as

diabetes and other conditions, later in life. Thirdly, there have been major improvements which we have all discounted—when I say 'we' I mean that the community at large says that it has got worse, that it is disastrous and we have not made any improvements.

All of those point to a fairly major failure on the part of your department, or those departments that have been involved because they are all to do with perceptions, information and communication. That is an observation, not a criticism. It is obvious from your submission that you are coming to terms with that, but I do not see a clarity about that. I see that what you are doing is still sort of medico community jargon rather than an actual explanation to people like ourselves and the community at large. Even when we look at your own submission about the improvements, it is couched in such vague and indeterminate language as to be discounted.

The point I am making is that this is very bureaucratic and full of medico jargon and we are talking about our own community where comprehension is going to be a problem in the first place. If medical students think that it is all the Aborigines' own fault, what in the hell hope have the rest of us got in thinking otherwise?

Prof. O'Dea—Let me just address that first point and Ian will probably want to add to this. It has certainly been recognised that to get good health professionals—and they are not just medical people—out into rural and remote areas, the best way to do it is for them to have been there some time in their training. There have been a number of schemes at universities, through many medical schools, to get people out on a voluntary basis. To really address this issue much more about the quality of the work force in rural and remote Australia, there have been a number of university departments of rural health set up to really create a career path for people, to make it attractive for them to go out and train there, to have students go through as a routine from city medical schools and have that experience. There is nothing like first-hand experience to dispel some of these myths. I think that all through our society we face these misconceptions about Aborigines and Aboriginal health, and this is an example. So in terms of the work force, I hope that the university departments of rural health will help turn this perception around and help galvanise and develop a much stronger health work force in rural and remote Australia. That is one of the goals. As you say, it is a real problem, but I really think that there are attempts to try and reverse it.

Dr Anderson—It would have to be acknowledged that there are a range of different elements that need to be taken into account in dealing strategically with Aboriginal health over a long period of time. We need to make sure that people have better access to education, for example, and to housing, environmental infrastructure, employment, et cetera.

We do know, though, that improved quality of health care provision is important in improving a number of health conditions and is also important in providing a vehicle through which communities can organise action in other areas that impact on health, such

as housing and education.

The vehicle through which those health promotion, prevention and early intervention strategies and some of the clinical or treatment type services are actually brought together is the primary health care service. The example of sexual health shows there is a good reason for that.

Work that was done in the Northern Territory towards the end of last year demonstrated that one of the key factors in producing the high rates of STDs in Aboriginal communities was not people's personal behaviour but access to health care, specifically primary health care treatment services. That is because, essentially, people had infections which are asymptomatic, and they had them for long periods of time so they did not know about it and they never got treated. Over a period of time—a number of years—a particular pattern of illness builds up in the community. A clinical solution to that problem is not adequate. It is not adequate to go up there and simply treat people. You need to actually promote access to care. You need to talk it through in a culturally appropriate way, in a way which people can understand, and you also need to promote a broader, healthier self-esteem and respect that goes along with good protective behaviours. I think you are quite right in pointing to the importance of the primary prevention and early intervention type of work. I think it is through actively supported primary health care services that that is possible.

The importance of acknowledging that there have been changes in Aboriginal and Torres Strait Islander health over the last 20 years cannot be underestimated. One of the reasons why the submission actually documents what is reported in other reports is to draw attention to the fact that although the picture is still extremely inadequate, the national picture is a disgrace et cetera, nevertheless there have been some improvements in health status. We need to know why because we need to build on those good experiences; we need to build on those positive examples. The positive impact of creating and supporting primary health care services is one of the examples of why we need to know that.

The other example is to note that health change sometimes carries a cost. We know that improved infant mortality rates in the early 1970s probably reflected better public infrastructure such as sewerage and housing and probably also better access to maternal and child health services. One of the consequences of that decline was that whilst babies lived longer they were not necessarily any less sick. Essentially, we had a larger group of what you would call low birth weight, unwell babies living who then got into adult life and were at greater risk of getting diseases such as diabetes and heart disease.

The third reason for pointing out the nature of those changes is that it does require a long-term investment. This is where the substantial difference is between Australia and other nations. It is not in the elements of the package that we have described because people in broad terms agree that we need to support health care, better housing, better

education and so on; it is in the length of the investment.

The United States were making significant investments in Indian health in the late 1940s. New Zealand had made a significant investment in Maori health in the early 1900s. That investment in Australia really did not start to occur until the end of the 1970s. In a lot of ways, one of the things we need to look at is the length of time people gave attention to the problem and put resources into providing solutions. I think that is a really important factor to take into account when you are looking at international comparisons.

Ms Evans—Could I just make a comment about your third point and the general comment on perceptions in the community and the need to change that. I think we would certainly agree absolutely with that as an issue and a concern—and it is an issue we have been discussing with NACCHO and with the states—that in a sense we may be victims of our own publicity. It has been extremely important to put Aboriginal health on the agenda but in fact now we have to look at a very strong perception in the community that it is all hopeless and there is nothing that can be done. I think I would agree that is a very real problem. It is certainly something that we are talking about in terms of communication strategy and, as you say, moving outside technical, medical, bureaucratic jargon and trying to get some information out into the general media, general publicity that things are happening, that things are improving. That is not to say it is not a huge problem but things are improving and improvements can take place. I think that is a very important message.

To follow up on Dr Anderson's point, we have talked about an evidence based approach and getting more information. That is also extremely important. There is a lot of rhetoric around that is based on anecdote and assumptions and it is therefore very important to get the facts and figures to find out what is working, what is not working, how many dollars are going in et cetera so we can have a stronger base for putting forward a picture of what is actually happening. But I would agree there is a need for a big effort for a much more positive picture to be put forward. There is a flow-on effect in terms of attracting people to work in the area. A lot of people feel that it is a terrible problem but, really, if there is nothing to be done is it worth the effort? I think that is a barrier we have to overcome.

Mr LIEBERMAN—Would it be possible for the department, and how long would it take, to produce a summary of the illnesses and diseases known to be predominant and a problem in indigenous communities across Australia; the areas identified for each of those; the numbers of people estimated to be involved and affected by those problems; the programs, initiatives and services now on the ground or in the regions available to address those, even though not adequate and even though needing some review; the research data available so far, even though perhaps not complete or contemporary, relating to each of those problems; a set of recommendations as to what further specific research is needed; and a program that is immediate, medium and long term with respect to those? I know I have covered a lot of areas but I think you have already gathered the direction I am travelling in. Would someone like to comment on those questions?

Ms Evans—As you say it is a pretty broad—

Mr LIEBERMAN—I do not mind, if the chairman is agreeable, for you to come back on that in writing as quickly as possible and, if the chairman is agreeable, in further discussions as quickly as possible. But could you just touch base in a preliminary way?

Ms Evans—I think we would like to take it on notice in terms of the specifics. In relation to the first request relating to the specific identification of issues, you may or may not be aware of a publication that came out last year produced by the ABS which essentially pulled together all the information we had to date on medical conditions and population—I do not know whether Dr Anderson who is much more familiar with the ins and outs would like to comment on that in particular—documenting what is currently available and on the ground. That essentially is the process we are undertaking under the framework agreements in regional planning on a state by state basis. It is a very big exercise but it is an exercise that is under way. It is at various stages in various states so I do not think I would be in a position to undertake to give you a report by the middle of the year, but that is under way.

Mr LIEBERMAN—Perhaps I could just insert another subparagraph to my question. In the cases where you still do not know yet the nature and extent of services on the ground or in the region with respect to those matters, can you identify those and tell us what you do know about them and tell us what you are doing to find out about them and how long it will take to get the answers on that?

Ms Evans—Right, I will take that one on notice. In terms of the research strategy, I do not know whether Professor O'Dea wants to talk about it.

Prof. O'Dea—The Research Agenda Working Group is trying to take precisely that approach. It is a very big job, and with the resources that we have we are not moving all that fast, but we are moving area by area.

Mr LIEBERMAN—I would like to add another supplementary question. Could we have a statement from the department of the resources that you have now to respond to those issues, and the department's view as to what extra resources you need to provide, within a reasonable time, the responses to those issues?

Prof. O'Dea—What is a reasonable time?

Mr LIEBERMAN—I would invite the department to offer us advice in respect to those matters. I would like it yesterday, but I realise that is not possible. I have a sense of urgency about this, and I know you would share it. I think someone said that it is only since the 1970s that we have really had a program, if you like. If you take that 30-year period alone, the sense of urgency that I have today is based on my inadequate knowledge but disappointment and perception that something gravely wrong has been in the model.

Ms Murnane—We can certainly provide some of the information that you have asked for very quickly. The information on what services are on the ground, provided by different levels of government, is incredibly important to future planning. One of the contributing causes to the current situation in Australia has been that coordination between the Commonwealth and the states has not been at optimum levels. That is something that we are striving towards. We regard that as critical in the success that we are trying to achieve. We are doing that through these framework agreements and forums at the state level.

I can sympathise with and understand your frustration, that surely it seems pretty simple: you get a group of people around a table; the states know what their regions are and what services are in them; the Commonwealth knows theirs; we put those together and we might not have everything, but we have a pretty good idea of what is there and then we can work from the basis of what the needs are to what there should be. That is precisely what we are trying to do.

I will have to talk to Ms Evans, Dr Anderson and people in the Office of Aboriginal and Torres Strait Islander Health and we will look at what is feasible and what we can get to you. I can understand, too, that what you would like is to have some sort of matrix, as you described, that you could then use as a way in which you made sense of what you saw when you embarked on the fieldwork of this committee. We will do our best. We will get you what we can. If we can get back to the chair and the secretary early next week, Ms Evans and I will get in touch and say what we can do.

CHAIR—I am happy for all that to be taken on notice. That is the kind of thing that I envisage will occur with the regular interchange between you and us. Perhaps it is a bit unfair to pin you down to a timetable right here, but if we could have some idea of that in the early stages of this inquiry, it would be very useful.

Ms Murnane—We will let you know what we are going to be able to provide and in what time line by Tuesday next week.

Mr LIEBERMAN—That is great. I noted and appreciated in your submission—and at the same time was very worried to note—that some of the states have not yet signed on with respect to the agreements and also that, with some of those who have signed on, the performance to deliver what was signed up to do and to happen is lacking. I think that is, in essence, what you said. Could you elaborate on that, please, because I am terribly disappointed about that. I think the committee would appreciate a bit of a briefing from you now as to what the position is there.

CHAIR—Disappointed, but not surprised.

Ms Murnane—There is a positive in this too—and Ms Evans will outline what we have yet to do—about what has been achieved through those framework agreements,

including the signing of them by the states.

Ms Evans—In relation to the Northern Territory and Tasmania, which have not yet signed, as we document in our submission, I am very pleased to be able to say that the Tasmanian one is well on the way. Two of the four signatories have signed and it is now a matter of the other two, who have agreed to sign. We anticipate that will be completed by the end of next week, so Tasmania is essentially there.

In the Northern Territory, negotiations are still continuing, although we are advised that there has been quite a lot of progress on that. I would be hopeful that we will get an agreement signed there in the very near future and I shall advise you when that happens. That is certainly our hope.

It is quite correct to say that progress in the states that have signed has varied; in some states there has been very positive progress and in other states the progress has been more disappointing. I can give you a state-by-state run-down, or would you like me to provide that to you in writing?

Mr LIEBERMAN—Yes, in due course, but as quickly as possible please.

Ms Evans—Yes, certainly.

Mr LIEBERMAN—And can you give any advice in your written response as to action that might be appropriate to try and address the reasons for the delay and eliminate them?

Ms Evans—Yes.

CHAIR—I am pleased to hear the response about Tasmania, because we will be there on Monday.

Mr ALLAN MORRIS—I am not sure if the department is aware of this, but we are talking to state governments and it would probably be handy for us to know that in advance of those hearings. Perhaps you could liaise with the secretary—

Ms Evans—We will certainly do that.

Mr ALLAN MORRIS—so that when we are talking to state government officials we are aware of where they are up to and we can perhaps better understand their problems.

Ms Evans—Yes. In terms of the actual signing of the agreement, Dr Wooldridge has signed and the Tasmanian NACCHO affiliate have signed. It is with State Health to sign and ATSIC are signing soon, so it is on the way.

On a positive note, South Australia has met regularly and, indeed, have finished their regional planning process and have comprehensive regional reports. That is probably the state where it is most progressed. But I will give you a detailed report on it, state by state.

Mr LIEBERMAN—Pardon my ignorance—I should know this but I do not: in regard to the current negotiations between the states and the Commonwealth on the next Medicare agreement, which apparently are deadlocked at the moment—we will not go into that—are there provisions in the Medicare agreement, hopefully to be signed soon by everyone, dealing with performance on indigenous health issues and accountability measures? Can you brief us on that and also on time scales? In other words, in any action plan under the Medicare funding arrangement, is there a time scale for performance?

Ms Murnane—Dr Loy will talk on that.

Dr Loy—The existing Medicare agreements are for the funding of public hospitals and essentially are a deal between the Commonwealth and the states that for a Commonwealth contribution to the funding of public hospitals the states undertake to treat all public patients for free. That is the fundamental nature of the deal. The existing Medicare agreements simply describe that compact for the entire population and have no particular drawing out of services for Aboriginal and Torres Strait Islander people.

In what we are discussing with the states in the current negotiations, obviously the big ticket item is the quantum of money at the end of the day that the Commonwealth will contribute. Naturally, since that is a very large item in any state government's budget, we can expect quite a lot of angst and storms and so on between now and when those agreements are signed.

In discussing the structure of the agreements to take effect from 30 June this year with the states, we have foreshadowed that the Commonwealth would like to see included in the agreements some indicators to measure state performance in terms of access by Aboriginal and Torres Strait Islander people to the health services described in the agreements—largely hospital services but also public hospital and related services.

The states have accepted in the discussions to date that those kinds of indicators should be part of the agreements. So what we will expect to happen as a result of that is that the agreements will commit the states to report against a number of indicators that will measure the access that Aboriginal people have to services in the states.

The Commonwealth has not proposed to tie particular amounts of funding to those measures. Rather, we have taken the approach that the better way is to make it a part of the total package that there be the reporting of these indicators. We could use the public publication and reporting of the indicators to compare the performance of states as the mechanism to try to improve the outcomes rather than simply get into a wrangle of saying

X dollars is tied to performance Y in that indicator. But certainly the states are accepting that there should be those indicators in the new agreements.

Mr LIEBERMAN—One of our terms of reference is quite interesting. Paragraph F requires that the committee in its inquiry examine and report on '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.' Obviously we have to keep an open mind but it is no secret that some of us, me included, think that one of the reasons for the disappointing performance in indigenous health in the last 30 years in this nation has been due to the cumbersome nature of the deliverers of health, the lack of coordination—which you people are working hard on—the lack of accountability and reporting, and the lack of action plans and strategies—all of those things.

It just seems fundamental to me that in 1998—I think we are about to go into another formal five-year Medicare agreement—the opportunity is presenting itself for some more stringent performance measures and clauses in those agreements to bring about more action, accountability and perhaps sanction. I am not recommending it but it seems to me that the nub of our problem has been that the parties have not worked at the partnership properly. They have dragged their feet. There has been a transferring of obligations, cost shiftings and all of those sorts of things. Is this not the opportunity to up the ante?

Ms Murnane—I understand what you are saying but, as Dr Loy said, the health care agreements are about hospitals, acute care, tertiary care.

Mr LIEBERMAN—I know.

Ms Murnane—That is important and, undoubtedly, the access of Aboriginal and Torres Strait Islanders to appropriate acute care is tremendously important. As Dr Loy has said, he and Dr Wooldridge are now in the midst of negotiations with the states. We will take into the account the point you have made now. Dr Anderson can talk in more detail about an accountability framework that has been agreed by Commonwealth and state ministers. In fact, it is an epoch making agreement because Commonwealth and state ministers have committed themselves to performance indicators and to some targets in the field of Aboriginal health.

I think it is very important to get that on the record. That agreement actually provides a comprehensive list of the markers through which we can track our progress in the future. And perhaps Dr Anderson might like to talk in more detail about those. It will give you some feeling for what they are actually measuring and what role they will play in our future work.

Dr Anderson—I will talk about the scope of the indicators. Historically, one of the quite legitimate criticisms from Aboriginal primary health care services made of

government in the area of Aboriginal health was that people were being asked to account for their performance in services that they delivered to their communities through the provision of performance related information. But the governments were never being asked to account for their performance in Aboriginal and Torres Strait Islander health.

I will just go back to the earlier point raised about the international comparison and say that the other key difference, apart from the time and effort made in, say, North America, in native American health particularly, has been the key leadership role played at a national level in ceding action and having a high level of political commitment to delivering resources in an accountable way. That has not been a feature of the Australian approach.

Framework agreements make provision for the development of agreed performance indicators that each jurisdiction will report against. A draft set of indicators was agreed to at the end of last year by Australian health ministers and these are in the process of being refined prior to the next AHMAC meeting. The indicators cover a number of areas and I will just briefly run through them. They are also detailed on page 74 of our submission.

The indicators include reporting on infant mortality rates, which is a very sensitive indicator of health status of populations, and on key illnesses, including the main causes of death such as heart disease, injury, respiratory disease, diabetes et cetera. The indicators of access to health services cover the availability of comprehensive health services and also the development of community control, health services capacity, and access for small communities and outstations. Indicators of health service impacts include population health measures such as child immunisation and screening rates for cervical cancer. Indicators of work force development include the extent of Aboriginal and Torres Strait Islander participation in the health work force.

There are indicators relating to specific risk factors such as smoking, obesity, et cetera. Indicators of the degree to which jurisdictions are able to work collaboratively with other sectors, for example, the housing sector, are indicators of commitment to a community development process covering the degree of involvement of the Aboriginal and Torres Strait Islander Commission, and the Aboriginal community health sector in regional planning strategies. There are also indicators of the quality of service provision covering issues such as service deficiencies and strategies to deal with racism.

That is a fairly comprehensive accountability framework. At this stage, all parties are highly committed to the implementation of this accountability framework. There is no doubt that it will take significant ongoing work to ensure that the systems are developed that provide that information. We need to ensure that it is collated and analysed in an effective way and disseminated appropriately so that the broader public can have a view of government performance in this area. It is certainly quite a significant milestone.

CHAIR—The committee has run into this problem in virtually every inquiry it has

had so far: the issue of diversity amongst the states. The frustrations that Mr Lieberman has expressed drive some people to suggest that the Commonwealth should have its own service for Aboriginal health delivery. In fact, there is a submission before us in today's evidence about that. Is that a realistic option?

Dr Loy—I would like to make an observation that the health services cover the gamut and I cannot see in my lifetime that we are going to have a situation in which the Commonwealth runs the Alice Springs Hospital or the Katherine Hospital or any number of services in Western Australia and Queensland. Yes, the Commonwealth can participate in the way that we are doing in the support of the community controlled medical services and build on that, but I do not think it is realistic to suggest that the beginning, middle and end of health services can be taken over by the Commonwealth without a sort of revolution in Commonwealth-state relationships that I do not foresee happening.

Mr ALLAN MORRIS—Dr Loy, the contraction of state health services from country areas has been going on now for quite a long while. Because a third of Aboriginal people live in remote and outlying areas and another third live in rural areas, they will be affected much more disproportionately than others. So the Commonwealth has sat back and watched the states contract those health services from country towns and smaller areas, particularly in the level of expertise in outreach services. That is really a significant shift in the last 15 to 20 years.

Dr Loy—I accept that the states face the same problem as everybody in trying to provide services in remote and rural areas. It is difficult. The Commonwealth has tried a number of ways of assisting that, and Professor O'Dea mentioned a most recent one—the establishment of the university departments of rural health. That is an initiative which builds on other initiatives in the past: the rural health support, education and training program. That is trying to improve the infrastructure in rural and remote areas to support there being a more sophisticated and professional health work force in those areas. It is not an easy thing to do, but we do take initiatives of that kind and that is the most recent one.

Ms Murnane—To sum up, our answer to that line of questioning is no, we do not think it is realistic for the Commonwealth to be the sole provider. We have talked a lot in our submission and a lot this morning about the need to form collaborative relationships with the states. That we regard as the realistic part and that is what we are putting a lot of effort into. That does not mean that the Commonwealth will not continue, and it is planning to continue, to have a direct role in the funding of Aboriginal medical services. But we are also conscious that the state is involved in a multitude of ways in the health of the population generally and that includes the health of Aboriginal and Torres Strait Islanders.

Mr JENKINS—From the outset, I say that, post the republic, hopefully there is a constitutional convention that will address these matters of federation. One of the parts of

your submissions that I thought was interesting, because it goes to the points of perception that Mr Morris raised, was that there is a perception abroad—and it has been underscored regrettably by one of our parliamentary colleagues—that bucketloads of money have been thrown at Aboriginal problems. Amongst those problems have been health concerns and your submission, drawing from other work, puts that into better perspective. There is a statistic there that shows that on a per capita basis the share of health care funding that goes to indigenous people is only 10 per cent over and above the rest of the population. Given the type of indicators of the state of health that we have of indigenous people, I do not think that is a very great amount. But I do not want to fall into the trap of emphasising the share of health care funding because I understand that there are other factors. There are environmental factors. There are things about the social make-up of indigenous communities and their reaction with non-indigenous communities that this inquiry, I am sure, will have to address.

I would like some comment about the fact that indigenous Australians do not access mainstream health things like Medicare and the PBS as much. Is that really a problem? Is it just an observation? Should we find other paths to give them access to things provided under Medicare and PBS? Or is it something that we need to understand? Besides the economic problems that are suggested by the studies and other factors, are there cultural factors about the way in which services are provided under those programs that we should address? I regret that is a broad question.

Dr Morauta—On MBS and PBS, it is a problem that the access is lower because the two programs are designed for all Australians. They are not designed simply for those people who are able to access them easily or who have in the past accessed them.

The present government and the previous government have looked at a number of areas for addressing these problems. They really fall into two categories: where you have got an MBS provider—a doctor—who is in private practice, there are problems sometimes about people accessing those services. They include access to Medicare cards themselves, the way the process works and a whole lot of other issues. Where there are not MBS providers in the normal way, this government has made a number of steps forward allowing bulk-billing by salaried doctors in AMSs and other services, so that the MBS benefits flow into those communities that way.

There has also been another initiative, which I think is actually quite radical, in the coordinated care trials. The government has cashed out MBS and PBS. It has just handed it over as a lump of dollars to a community controlled management process to enable the MBS benefits to flow into the community without there being the doctors or the particular health providers that we normally have to help people access MBS.

I have to say that, in the coordinated care trials, we also address the question about Commonwealth-state that you have been talking about. It is not that the MBS and PBS were cashed out whatever. They were cashed out on the condition that the state also

cashed out its hospital funding for the same population. In the MBS and PBS cash out, we cashed out above what the population was using because it was recognised that there was a gap between what they were using and what they ought to have. The states, at the same time, and as a condition of the arrangement, brought their hospital money into the pool. We tried to address the two sides of the problem at the same time. There is no doubt that is an area where a lot more work has to be done.

Mr JENKINS—How many of those coordinated care trials were in indigenous communities?

Ms Evans—There are two coordinated care trials that are signed off and operating: one on Tiwi and one in Wilcannia. There are two that we are negotiating at the moment: one at west Katherine, which is undoubtedly on hold at the moment, and another in Western Australia involving multiple sites. There are nine mainstream ones and, we hope, four Aboriginal ones.

To add to what Dr Morauta said, I think there are problems over and above accessing MBS and PBS in terms of mainstream health services meeting the needs of Aboriginal people. There is the fact that private GPs working in private practice are not often well-equipped to meet the needs of Aboriginal people because of cultural differences, because of the multiple medical conditions they have, and because of the need for a population approach to health. So I think there are broader problems and I think that is what you are alluding to. I do not know whether Dr Anderson wants to add to that.

Mr JENKINS—Can I just ask a simple question that I need to ask right from the outset of the inquiry or I will get off on the wrong step. When we talk about cultural differences, we are talking about multicultural differences. How transferable would the efforts of one community be to another community?

Dr Anderson—I was formerly administrator of the Aboriginal health service in Victoria, and also worked for a number of years as a clinician in that organisation. There are two key elements to actually understanding how you work through cultural factors. One is to understand that oftentimes it is hard to articulate what cultural difference actually means. It is about values; it is about mores; it is about beliefs; it is about a lot of indefinable things. So when it comes to saying, 'What is a culturally appropriate diabetes program?' it is actually hard to say. Is it just posters? Is it just the people who deliver it?

In my experience, a culturally appropriate program emerges if you actually involve the people who are going to be the recipients of that program in its development, because those values actually start to become embedded, without people knowing it, in the nature of the program.

The second thing is that in terms of non-Aboriginal professional relationships with Aboriginal and Torres Strait Islander people, the most significant thing you can do in

terms of cross-cultural teaching practice is to teach them what they actually do not know. They actually have a knowledge and understanding of Aboriginal and Torres Strait Islander people which is derived from a lack of actual real relationship with people. Therefore, what you do is teach clinicians how to learn from their patients, from their patients' families, and from Aboriginal health workers and other people who have worked with those patients all their lives and know their ins and outs. That prevents the problem of teaching people to be cross-culturally aware in a stereotypical way. They then have skills that can be transferred from Melbourne to Hobart, to the Northern Territory, or to Western Australia.

That approach is built into the model of Aboriginal community primary health care services. It is a model whereby you build in a strong working relationship between usually a non-Aboriginal professional—although there is a growing but small number of Aboriginal doctors and nurses—and an Aboriginal health worker. It is the nature of that relationship which is really fundamental to the quality of an effective, culturally appropriate program.

CHAIR—This will be the last question and we will then have a brief break. There are a lot of people that we wish to talk to today. We will be having the department back on a regular basis, I imagine.

Mr ALLAN MORRIS—I have two questions and perhaps you can treat them as being on notice. Firstly, on that figure, the one to one, I doubt if they have been statistically massaged to take into account the fact that one-third of the recipients are actually in remote areas as opposed to only three per cent of the normal population. I would be grateful if you could give us the actual sums. The sums do not show the breakdown as to how they are derived and it may well be that the figure is actually less than one to one, given that ratio of locational costs. What is the cost of servicing somebody else? Given that three per cent of non-indigenous Australians live in remote Australia, what is the cost per head to them, and has that been apportioned statistically?

Dr Anderson—In terms of that analysis, it has not been weighted in terms of location. That is just the crude dollars.

Mr ALLAN MORRIS—I thought so. Could I ask if someone could do that? I suspect when it is done you would find the figure was less than one to one, it may well be 0.95 to one. In other words, we may be spending less per person on Aboriginal communities than we do on the non-Aboriginal community.

Secondly, I have some concerns about the possible reductions in funding by your department and DEET for the training of Aboriginal education workers. I recall that we were funding medical students at Newcastle—and I am very proud of that program. I am concerned that the department has cut funding in that area and in the public health area. Do not answer now, but I would be grateful to look at the dollar spending by the

department on the training of health professionals who are from indigenous backgrounds. You mentioned it in general terms but I would be interested to see the quantification of that over time. Perhaps those two questions could be considered as questions on notice because it is a bit unfair to expect answers to those now.

CHAIR—Could you take those questions on notice and give some consideration to providing the committee with some good working examples—models that you have made reference to that work and that you are pleased have had a good result. They are the kinds of concrete examples we will be looking for when next we meet. I think there was reference to a model in respect of—

Mr ALLAN MORRIS—Mr Chairman, I think the submission is a very worthwhile contribution to the public debate. I want to express my appreciation of the quality of the submission.

CHAIR—Thank you very much for attending. I think we are off to a good start. This is a preliminary discussion.

Proceedings suspended from 10.30 a.m. to 10.40 a.m.

[10.40 a.m.]

BAXENDELL, Mr Noel, Housing Infrastructure and Health Policy Section, Aboriginal and Torres Strait Islander Commission, PO Box 17, Woden, Australian Capital Territory 2606

DELANEY, Mr John, Health Portfolio Commissioner, Aboriginal and Torres Strait Islander Commission, PO Box 17, Woden, Australian Capital Territory 2606

ELDRIDGE, Mr John, General Manager, Social and Cultural Division, Aboriginal and Torres Strait Islander Commission, PO Box 17, Woden, Australian Capital Territory 2606

PLOWMAN, Mr Colin, Assistant General Manager, Housing Infrastructure, Health and Heritage Branch, Aboriginal and Torres Strait Islander Commission, PO Box 17, Woden, Australian Capital Territory 2606

CHAIR—Welcome, gentlemen. Before we proceed, I need to point out that, whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of parliament and warrant the same respect as that attributed to the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament. Your submission has been incorporated in the published volumes and already distributed as part of the inquiry. Commissioner, you may wish to make an opening statement and any other members of your group may contribute before we proceed to questions.

Mr Delaney—Thank you, Chair. My name is Anselm John Delaney—I use John because outside the immediate family people find it difficult to pronounce the name. First of all, I am the ATSIC commissioner with the responsibility for health and substance misuse. I have an extensive background in community controlled organisations, particularly in health. I am a member of three Aboriginal medical services within the New South Wales metropolitan region and I have also been involved in employment and enterprise development in community organisations. I represent ATSIC on a number of consultative bodies, which include the Aboriginal and Torres Strait Islander Health Council and various other subcommittees in substance misuse, mental health and sexual health. I also represent the board on the National Health and Medical Research Council and the National Health Alliance.

I would like to open by making a few observations. First of all, I believe that the final answer to Aboriginal and Torres Strait Islander access to equity in this country requires a consolidation of service provision by community controlled entities. By that, I think we should all come under one entity. ATSIC is the constituted Commonwealth body to appropriate that consolidation.

We speak a lot about resources. I find that the allocation to Aboriginal medical services in the community controlled sector might be considered as adequate, but only on the proviso about all the other preludes to health and wellbeing of our people. We are so far behind the eight ball to start with that there is no way the allocations to health services can enhance and bring us up to a standard that is our right.

As I said in the pre-preliminary hearing, there needs to be an initial infusion of funds and resources to get up to a level standing right across the Aboriginal and Torres Strait Islander communities. We spoke about inclusion that might bring us up to this standard. You mentioned the reduction in funds to all other departments. You mentioned DEETYA. I can mention Health, ATSIC, DSS and Housing. Also a great impact on the services that were being provided was the reduction of the ATSIC budget, which took away our community support organisations that supplemented the current Aboriginal medical services. We had drug and alcohol counsellors with organisations. We had sex education processes. In medical services, for instance, we had prenatal and postnatal courses in Sydney that had been most successful taken away because of the cuts.

The medical services have utilised the other mainstream activities, such as the breast screening proposal. The first time it came to the inner city there were not too many Aboriginal and Islander respondents. But the next time they came, they did it through the Aboriginal medical service in Redfern and the numbers to undertake the screening expanded to about 10 times to what they were in the first instance with the mainstream thing. This again alludes to the fact that Aboriginal community controlled services—in this instance, health services—can best provide and promote the access to general health and wellbeing. If we look at the forced closure of the community youth support programs within ATSIC as a result of the government's cuts right across the board, this has impacted more on the community controlled health services than it has on the mandatory standard departments such as Health and Family Services, DSS and the like.

I would like to comment on a question you raised, Chair, about the Canadian and New Zealand experiences. I have had some very good advisers on these matters. You are alluding to a bottom-up or a top-down approach, which we certainly have in Australia in all service provision to Aboriginal and Torres Strait Islander people. My confidante from Canada was a gentleman by the name of Alan Benson, who is a traditional member of the Ma-te tribe or nation. My expert on the New Zealand experiences is a son-in-law in my extended family who is Aboriginal Kamilaroi—the same as me—and Napui nation in New Zealand. So I get a fairly good cross-section of understanding of the Maoris in New Zealand. Their plight is certainly not as bad as ours because they do have fairly good consolidated access to the departments there. I have some very good advisers. I can tell you that your allusion to the top-down approach is exactly what happens. What I am on about, and what I think most Aboriginal people in the communities are on about, is consolidation of the community controlled sector to do all the other things.

I will talk about the bilateral agreements. I would be interested in the submission

of the Department of Health and Family Services on this. Let me say, from my observations and understanding and connections across Australia, that South Australia is coming to some degree of acceptance. I might say Victoria, through the efforts of Premier Kennett and his commitment to indigenous people in that state, is making great inroads. New South Wales, where I come from, is probably the prime example of what bilateral agreements are all about. We are fortunate to have Dr Andrew Refshauge as the Minister for Health and the Minister for Aboriginal Affairs. Dr Andrew Refshauge also previously worked, like Dr Anderson, in an Aboriginal medical service.

We could ask you to have a look at a system whereby we can make these bilateral agreements. I can tell you it does not work very well in Queensland. I can tell you it does not work very well in the Northern Territory and Western Australia. I will say, in support of the Northern Territory health services, that there is a very consolidated effort by the members of the territory health service and the community control sectors. I can allude to that by saying that I am a member of the Central Australian Renal Forum. I do, from time to time, meet the people who are dedicated in the territory health services and it is fairly solid there.

If we are going to have bilateral agreements, it needs to be a bit more than a piece of paper. I was an eyewitness in Sydney when the previous chair of ATSIC, Dr O'Donoghue, and Dr Wooldridge, on behalf of the Commonwealth, Dr Refshauge, on behalf of the state, Sandra Bailey, on behalf of the New South Wales Aboriginal Health Cooperative, and Puggy Hunter, on behalf of the National Aboriginal Community Controlled Health Organisation, all signed that. It is a very meaningful document. In fact, with regard to the partnership that is drawn up there, I, as the person responsible for the ATSIC health portfolio, am a voting member of that partnership.

Until a consolidated agreement comes from around that table, Dr Refshauge will not sign off on anything. Both parties—the Department of Health people and the community controlled sector—have to come to an agreement at that level and then it progresses through the whole department and the community controlled health sector. So I would ask you to have a look at that formula and see if you cannot infiltrate that into the other states and territories, because I think it is a catalyst for all successful bilateral agreements.

As I said before to the committee, we need more health worker training back in the local community and we need that to include specific nutrition, education and hygiene processes. It is going to cost money to do that because the AMSs do not have that capacity at this moment to be able to do that.

We spoke about medical practitioners for rural and remote communities. It is difficult—and understandably so—even in New South Wales, in outback Walgett, to get medical practitioners to spend very much time there. They are having a hell of a time attracting the services of a dentist, because dentists can earn more in Dubbo, which is a

couple of hours drive away, than they could ever expect to earn in Walgett and the surrounds.

I might say, in support of the Aboriginal community controlled medical services, that there is also a service provision aspect there to non-Aboriginal people. We provide services to people in the outback and the remote areas of Australia the same as the other services—the legal services and other situations. I will rest my case there for the time being.

I should just say one thing about money and consolidation, before I get off the subject. I believe—and Naomi or Puggy, or someone like that, will catch up with me later—that the Aboriginal community controlled sector health should remain the responsibility of ATSIC. The reason health was taken away from ATSIC was because of the lack of expertise within ATSIC. ATSIC had about a $1 million a year program which included the primary health advisory sector, community youth support and a few other things, so it was some percentage of $1 million a year. When we go to the Health and Family Services administration budget, we find that in the initial year we have $4.6 million, then it drops down to $3.6 million, and they tell us that in 1999-2000 it is going to be down to $2.6 million. That is double or triple the money that ATSIC had to appropriate this program.

You can ask NACCHO, who are the next witnesses, but I would say that if we had a capacity to develop an overall umbrella structure of experts, people like Dr Anderson, indigenous people from right across Australia could, in my opinion, formulate that sort of overall encompassing authority to make sure that there is expertise within ATSIC. I cannot impress enough upon you that we are talking about all of the things—about housing, infrastructure, sewerage and how to fix up the ills of people in the outback.

If you look at my submission there are a couple of very noted ophthalmologists, one whose name I cannot recall and Professor Hugh Taylor, who alluded to the fact that the answer to eliminating trachoma in those places is water—clean running water. That is going to cost money. We have the Army going in and doing great things in outback Australia—for Aboriginal and non-Aboriginal people, I might add. Somewhere within this capacity we need these things. Dr Anderson very succinctly gave you an interpretation of a culturally appropriate issue. My answer to that is, 'Let's train those local, traditional people.'

I might use the analogy of the current chairperson of ATSIC, Mr Gatjil Djerrkura. We have got people like Gatjil all over Australia in traditional areas who are very adept and articulate on different issues. The developments up in these places were economic, commercial developments and we have experts out there. I can tell you that the likes of Gatjil Djerrkura from remote communities would prefer to work back home with their own people than sitting in a chair here in Canberra.

I just want to emphasise the fact that we do have people out there with the quality, commitment and ability to be able to access professional standards in medical service provision. We spoke earlier about how long it has been and Dr Anderson said since the early 1970s. That was when we had the emergence of Aboriginal community controlled health services and legal services. It did not just occur as a matter of the referendum in 1967; it is a progressive thing.

But if we have a look and do a stocktake of where we are at now, we do have a few people in our communities living to my age. That has increased because of the intense ability of Aboriginal community controlled health services to provide what I consider, in my place, as culturally appropriate to me, and caring and consideration are all part of that. That is in opposition to general practitioners who are a lot like a production line where there is an in door and an out door, they get the Medicare and all of that stuff. But the fact is that Aboriginal medical services provide a much more complete service.

Having done my introduction—and I thank you very much for the opportunity to be able to come and talk to you—I will leave it at that and be open to whatever questions you would like to ask me or the administrative staff.

CHAIR—Without trying to pre-empt where this inquiry might go, because we are right at the start, it seems to me that, even though issues can be very complex, the solution is sometimes a very simple one when you can get ownership. We have talked about this before but it seems to me that, if you could get the ownership and the preventative ethos going amongst the communities, that will be a major step in making progress.

Clearly, from what we have heard in evidence to date, there is an absence of sufficiently trained indigenous people out there actively promoting that. Does ATSIC have a program where it can encourage indigenous Australians to be involved in this sector? Is it something that ATSIC is trying to promote? Starting right back at secondary school level even.

Mr Delaney—It is not just something that ATSIC promotes: it is what Aboriginal and Torres Strait Islander people back in the community would expect. Since the 1967 referendum we have expected big things and we are making inroads. We have professional people in many fields. But the unfortunate part about it is that doctors are swamped up by the health departments. I can tell you that a big mob of Aboriginal doctors work for state or Commonwealth departments. Dr Anderson served his apprenticeship with the AMS in Victoria, and that is fine, but the graduates of medical or legal professions—we have a stack of lawyers out there now—do not work for Aboriginal legal or health services because the need for them in mainstream organisations is so great and they can get more money.

I guess what I am saying is that we should be homing in on communities. The Aboriginal health worker training program which was held in the Aboriginal medical

service Redfern premises—I was working with DEET when we started the thing in about 1987 or 1988, I think it was—went until ATSIC lost control of the medical portfolio. The development of the curricula, the outcomes, the requirements and the accreditation stuff was developed by Aboriginal medical services in New South Wales.

These people came from the communities, and Naomi, if she is here today, might talk about it later when NACCHO is on. People came from all different parts of New South Wales. They came representing the communities. They went through the health worker training and then they went back and worked in their community. We are talking about the big picture stuff here. We need to concentrate on the traditional people of whichever area.

The question was asked about cultural appropriateness. Even with the different language groups, we could have a couple of people in health worker training to start with. This does not just mean every Aboriginal community controlled medical service because there are other community controlled organisations out there where AMSs do not exist and this could be part of their responsibilities also. I would like to think that, holistically, we do not have to hive off things and say, 'That is the AMS and that is the ALS' or whatever it is. We will always come together for some sort of consideration on operating our community.

Certainly, look at the Canadian experience and look at the Maori experience. You can learn a lot from that. But this country has learnt a lot and it does not do anything about it. Reviews after reviews are done on our people and nothing positive happens. I mean, government departments get a few more extra ASL dollars to appropriate these needs but nothing goes to the bottom up approach so that it goes to the community. From my experience that exists not just in health services but right across the board.

We cannot talk about health without talking about housing infrastructure and without talking about sewerage, and we cannot talk about that up in the Top End without talking about the overall infrastructure. Puggy Hunter has always said that we should have some sort of access to the Flying Doctor Service but you have to live near an airstrip to get that. So we need good, consolidated airstrips. We need all of those road situations so that it does not take you three days to drive from Amata to Alice Springs or somewhere like that. The roads need to be accessible to the communities. So it is big picture stuff. This is not just about health; this is about everything that goes into the social wellbeing of Aboriginal and Torres Strait Islander people.

Mr Eldridge—Part of your question related to ATSIC's programs and whether ATSIC actually had program involvement in training in the health area. There is nothing more fundamentally important than health education in the community and the corollary of that is health worker training. The vast bulk of ATSIC's involvement in that area transferred to the Department of Health and Family Services with the transfer of ATSIC's health program.

To the extent that ATSIC had any residual involvement in it, it was largely in three areas. Two of those related to ATSIC's former community training program and ATSIC's former community and youth support program. Both of those programs no longer exist, following 1996 budget cuts. The third area is in ATSIC's CHIP program, the housing and infrastructure program. There is an element of community education in the area of research and development associated with healthy living, the design of housing and essential services in remote communities and that sort of thing. So there is a connection there but it is only in relation to ATSIC's CHIP program that it remains. The vast bulk of any involvement that ATSIC previously had in that area has either transferred or no longer exists.

CHAIR—Colleagues, I am not wanting to hog the action here. Again, I would say that, in terms of the progress of the inquiry, there will be a number of times on which we will want to talk to you; so if we do not cover everything today do not feel that you have not had your opportunity, because we will want to talk to you again.

Mr LIEBERMAN—I would like to ask Commissioner Delaney and his colleagues for their advice on what they would think, if they were responsible for the major final decisions in Aboriginal indigenous health today, would be their top priority for action?

Mr Delaney—I would suggest the top priority for action is that there be action. That is something that has been a delinquent in all of the efforts, to date. Certainly, I believe that there are three sectors of Aboriginal health. Firstly, if we talk about drug abuse, that is infiltrating our community no end. In cities it might be the sophisticated drug problems and in some of the remote areas it is petrol sniffing or glue sniffing. There is a section of those who are chronic users, if you like, who need a carers program to try to bring them back. Then there is a middle tier of people launching into that type of activity, and so we need to concentrate on that sector. And we also need to concentrate on the ones that do not get to that stage. For the younger ones, we need education programs and prevention programs.

We cannot talk about doing action things without dollars but we have myriad advisers out there, and they come from the Aboriginal community. We also have myriad researchers going out there, and they come back and present these things to whichever department or whichever committee they came from. I guess that I would have a look. I would do research, but I would do it through the local community control services—in this case, it would be health. I would also envelop that with a consolidation of other service providers and let them put their case up. No doubt Naomi Mayers and Steven Larkin will tell you in a minute that they have done so time and time again but that it always falls on deaf ears.

As I said in the first place, we need an infusion of cash and resources to be able to do these things back at the community level: education, preventive stuff and carer stuff. We do not have access to that. We still have to struggle with the mainstream, and the

mainstream has not changed too much from when I was a little fellow in Coonabarabran and the Coonabarabran base hospital had three different wards. They had the old tin ward, which was for the blacks; the intermediate ward, which was for the poor whites; and the big flash one, which was for the affluent society of Coonabarabran and surrounds.

We probably need to take a note out of Premier Kennett's book about health provision and who should get it and what it should cost. Whichever way we go, we should have a look at Aboriginal and Islander health problems, because they are exacerbated to a standard such that, when you talk about Third World countries, you could find in suburban Sydney, as well in as rural and remote communities in Australia, Third World conditions that would blow your mind. To answer your question, I would be concentrating on the root of the problem first and get the experts and individual communities to advise me on how they think we can solve the problems by starting at the bottom and working our way up through a process.

Mr LIEBERMAN—Taking that one step further, I take it that you would then suggest that, once the problem has been identified, for getting advice, et cetera, you would favour a model where the community is directly funded and the community itself arranges the service delivery? Is that what you are saying?

Mr Delaney—Yes; and facilities need to be planted there that are required. I want to go through this little paper. Take running water, for goodness' sake. How many of us would understand? One time, when I was a poor little blackfellow on the dole, the water was turned off because I could not pay the bill. I tell you that there is nothing worse than having the water turned off. I had to go and borrow money to pay my water bill, because I was trying to raise a large family as well as my extended family and I could not pay the water bill. That is the first time I realised the problem. I lived on a riverbank in Coonabarabran, so I did not have a water problem. But here, in suburban Sydney, I got the water turned off.

We just take everything for granted, but if you go out into these rural and remote communities or into an urban setting where they cannot afford to pay for the water and they get the water cut off, you will see that the fundamental necessities of life are denied people simply because they do not have the infrastructure. They have to wait for the wet season and follow the track around to wherever they can get water from. Running water should be the right of every citizen of this country.

When you do your tour of places, do not forsake Sydney and New South Wales or Brisbane or Melbourne for remote areas: Senator Richardson went up there a few years ago and cried about the thing. Justice Einfeld went to a place called Toomelah in New South Wales and cried because of the living conditions of Aboriginal people there. I can tell you that not much has been done about that, either. Somewhere along the line we have got to have a really concerted effort and be legitimate about it. Forget about cutting budgets to fill some black hole or whatever; have a look at the real necessities of people

out there. You will find that, if you fix up the Aboriginal and Islander problem, you are going to fix up the problems for a lot of non-Aboriginal people as well, because some of those people suffer the same consequences as we do, because they are interrelated or they are married or they are communal friends of ours.

It is a sort of circle, and the experts will tell you in the next session. It is a vicious circle. Where are you going to start this fix-up? What is more important? Employment? Housing? Health? Education? Which way does it go? The only answer to those questions is go to the community group—to the leaders and to the service providers in the community—and get them to do their own little research in their own paddock and then come back and tell us what they want. Then do something about it: don't sit back and say, 'Let's open up another section of a government department to take care of this matter,' because it does not happen out there.

Mr LIEBERMAN—Commissioner, I have one last question, and it may be that you and your colleagues would like to take it on notice and respond later. I am interested to learn more about the barriers to access to mainstream services for your people in Australia today—not necessarily in the past, although we learn from the past. Would ATSIC be able to give us a briefing on its understanding of the current barriers to indigenous people for mainstream services?

Mr Delaney—Yes, we will do that. I can give you a few of the immediate barriers that come up for an Aboriginal or Islander person in terms of service providers now. We have service charters done by all the departments, like Taxation and DSS. They have all done service charters, but it does not matter when you get back on the ground and you walk in there and you are black. Take the staff in some of these departments: most of the departments are getting more culturally sensitive and have Aboriginal people working in them, but you can stand there waiting for service and, if you are black, for some reason or other—and let me say that some of the people on the other side of the counter are evidence of this being a multicultural country with multicultural departments—you are still at the bottom end of the spectrum for getting the service.

Because it has been 210 years now, we are a little peeved at being subservient to the European, Anglo-Saxon ethnic group who comes in here and still treats us as second- and third-class citizens. It does not matter whether it is at Ramangining or Redfern, we still get the same treatment. So I would say that the greatest mainstream barrier is, first of all, the lack of appropriate community controlled services, whether they be DSS services or health and family services or whatever. You talked about housing. I am trying to infiltrate this housing bilateral agreement too. But wherever we go we still suffer the same consequences.

One of the greatest barriers that Aboriginal and Torres Strait Islander people suffer in this society is being treated endlessly and time and again as second-class citizens, as something other than the indigenous owners of this place. It could be a government

practice or it could be a private practice—if you go to a real estate agent or ring them up on the phone. I experienced this myself when I was looking for a rental property in the flash suburb of West Ryde. I rang a real estate agent and he said, 'Yes, mate, come and see us and sign the contract,' but when I walked in the door, he said, 'That has already been taken.'

So we can speak from our lifetime experiences about all the barriers. I have been on this planet for 64 years and I can tell you about these sorts of things. I try to meld in with the society I live in, but every now and again someone comes up with a very racist issue. They just fob us off and they call us some of these bad names, so it is not going away. I can safely say that the majority of people—you have a problem here in parliament—are honest, down-to-earth people who treat us all equally, but there are sectors of the community that treat us as something else.

Barriers are people's attitudes and we are not going to change that, I suppose. We cannot change the attitudes of parliamentarians, for goodness sake, so what chance do we have in their constituency—of Aboriginal people trying to live a life that is their right? It is wherever you go. If you go to some places to buy a packet of fish and chips, they might not even serve you in that shop. It is reality out there when we walk around the streets of Redfern, Campbelltown or Mount Druitt.

CHAIR—Is that the only barrier?

Mr Delaney—No.

CHAIR—It is the only one you have mentioned so far. What are the other impediments after that one?

Mr Delaney—The impediments are to getting into business enterprises, to getting employment. It is difficult wherever you go to get fair access to employment. All of the things that are accessible to mainstream Australia, such as government services, are not as easily accessible to Aboriginal people. So we suffer these consequences. You can talk to local government and they will say, 'We are a tolerant society,' but if you go in there for a bit of advice on the rates or something you will get something else other than that. People have this big statement here about treating everyone equally, but if you walk into a council in Marrickville—and Anthony Albanese might be able to talk about those places—you get Aboriginal people still at the bottom of the spectrum there, for goodness sake, in multicultural Sydney.

Mr ALLAN MORRIS—Commissioner Delaney raised a point at the very start of his comments—this is on the same topic but it is going slightly further—about the sectoral connectors, the programs about drugs and alcohol and about health. What you said at the very start of your comments was that one of the problems you had had linking your people into the mainstream was the fact that you needed programs to explain—you

mentioned the breast cancer screening and so on. Clearly, the implication from that is that it is not just the health dollars; it is the dollars between health and the other services.

Mr Delaney—Yes, it is.

Mr ALLAN MORRIS—The complication we have, as a country, is that we have these different departments that look for outcome results. It is very hard to quantify and measure how effective a communication program is between health and a community or between Aboriginal health and other programs.

Can you canvass for a short time the ways we could do that; the ways we could focus that? Who would manage it? Which department should be responsible for linking up drug and alcohol programs with your community people? Obviously you are saying Health has not done it, so who should do it?

Mr Delaney—Let me take you back, Mr Morris, to the New South Wales bilateral agreement.

Mr ALLAN MORRIS—Okay.

Mr Delaney—If you have a look at that, the answer is within that; but there is a bit of imbalance there, given that the Department of Health, albeit with Dr Refshauge's leadership, still has more resources per capita than Aboriginal medical services ever would hope to have. When you talk about dental health and how we approach that, this lady behind me will tell you later on that the dental health in New South Wales was improving to a standard and that those things about education being taken to the communities happen.

We had a mobile health unit. It travelled all over New South Wales and we had the resources to be able to do that. The dental health of our kids was starting to improve, and the same with us older fellas: we were reaping the benefits of that too. So given the resources, and the link between the mainstream providers, they need to refer and reflect on the efforts of the Aboriginal community controlled services.

Mr ALLAN MORRIS—Who should manage the link?

Mr Delaney—Let me talk about the managing of the link now. We spoke to our minister, Senator Herron, and said that within all the Commonwealth-state allocations—we are only talking about Commonwealth money to start with—there should be a condition in there from the federal government that highlights the importance of utilising the local community controlled sector. If we allocate money en masse to New South Wales, for instance, and if we look at the Aboriginal and Islander population in New South Wales and at the mainstream departments that deliver the services and their statistics on how much of that allocation they spend on blacks, I can tell you that they would not be able to tell you.

What is being undertaken in New South Wales now is a cost of government. We are going to try and weed out every little penny that goes to whoever. I happen to be fortunate enough to be on the reference group in New South Wales that can facilitate this and get the results of that. Surprise, surprise: there will be not be much surprise to us about how much the New South Wales government actually spends of what comes from the Commonwealth on state agreements on Aboriginal specific programs in all areas—not just health but all areas. I think we would be a little in front in health, because of the vigilance and alertness of Dr Refshauge; in the other places it would not be evident.

The Commonwealth could have a contractual agreement with the states and territories. We might use the non-signing of Chief Minister Stone of the bilateral agreement on health in the Territory. We understand from the basic statistical information we get from the Bureau of Statistics that Aboriginal and Islander people make up 30 per cent of the population in the Territory. So if we said to the government, 'When you are allocating the Territory money because Shane Stone won't sign it, give us 30 per cent of the total health allocation to the Territory.' We can take care of everything with that much money. When the crumbs are handed out to Aboriginal community controlled health services in this case, but to community controlled services in all aspects, we are supposed to do the best we can with the communities with the crumbs we get.

Let me take you back to the Territory health section. In the renal forum I am on we put up a proposition to infiltrate the problem of renal diseases up there and to have all of the facilities to take care of that. In a $250,000 proposal, it was $50,000. It was in no-man's land. Shane Stone's responsibility was not there and Dr Wooldridge's responsibility was not there. This was a collaborative approach from the community controlled organisations there and the Territory health services, without signing any agreement. They wanted to do this. While it would not have taken care of the problem up there, at least it would have been the beginning of taking care of it. It was fifty thousand bloody dollars out of $250,000! It was for a piece of machinery that was essential to the whole of the operation; without that $50,000 machinery the thing could not go. That is the sort of petty issue we have to deal with, in health particularly.

Mr ALLAN MORRIS—I have a further question on a similar tack. In an inquiry on home and community care by this committee, in a previous parliament, one of our concerns was access by indigenous communities, and particularly remote communities of all kinds, to home based support. That is technically not medical; it is for frail aged and people with disabilities and so on. We found some real problems with that as to who was responsible, who provided the money and how you classified it—and I do not doubt that that is still the same now. Do you have any observations about HACC? It was originally run by Aboriginal communities, it was then mainstreamed and we had a fair bit of criticism about the fact that the mainstream system was not—

Mr Delaney—I will just cast my mind back to the Campbelltown session. I attended that one; I was before that committee.

Mr ALLAN MORRIS—That is right, I recall that.

Mr Delaney—We said then that you have got to pay homage to the community controlled sector. Someone took notice of us and the community controlled organisation was given this HACC program. But the stringency of the program, the stringency of the departmental provisions that you had to adhere to, made it almost impossible.

I am on the threshold of being a user of the service. Naomi can tell you later on that I probably owe the extension of my life—I have gone past the use-by date—to the Aboriginal medical services, for goodness sake. If you had an hour and a half to sit down and listen to me, I would tell you all about it.

But the fact of the matter is that, with the HACC program, we wanted to get the community controlled organisation to take it over, then we wanted to establish a committee of aged people to take care of their own business, but because that flew in the face of the policy procedural stuff we were not allowed to do that. We wanted a lump sum to give to us old fellas in Campbelltown and we could have taken care of everything, but we had to comply with all these requirements—you have got to do this, you have got to do that. That is where there is a lot of restriction on Aboriginal communities being able to do things. It comes with provisos: 'Here's the money, or here's the Toyota, but these are the conditions you have got to use it under.' And they are very stringent conditions, right across the board. But thanks for raising HACC, because we gave you a fairly comprehensive view of how we assessed that.

Mr ALLAN MORRIS—No change since then?

Mr Delaney—Things have got a little bit hairier now than they were then, but they are still working on it. That needs to be readdressed and there needs to be a very strong component of community control. It needs to be totally community controlled and for us to be given a lump sum. Don't say, 'This is for petrol, this is for the phone bill, this is for the rent.' Just give us the lump sum and we will do that ourselves in compliance with the needs of our communities and not necessarily unrealistic financial requirements or standards.

Mr JENKINS—Mr Chairman, what Commissioner Delaney has illustrated in that answer goes to something that has been mentioned in ATSIC's submission, which is that there is a need for looking at the wellbeing of the community rather than just the management of the individual's health needs, whether it is the direct provision of health services or the allied types of things that can be done under a HACC program.

Has there been progress towards change in people's thinking about dealing with indigenous communities in enabling them to put that philosophy into practice, that the type of services that are provided are taking that holistic approach? I think that is something that mainstream health services should have as a principle just as much as services for

indigenous people.

Mr Delaney—Yes. We spoke again about cultural appropriateness. It does not apply only to traditional people today; it applies to all of us. I have got certain cultural aspects that I always infiltrate into organisations I belong to, both Aboriginal and non-Aboriginal. We are all interested in influencing Lions and Apex clubs, and all of those sorts of things. We need to infiltrate and give a sense of recognition that an identified problem needs a bit more activity to take care of it. The sensitivity involved in some of the illnesses our people suffer is such that they will not even elaborate upon them to mainstream practitioners. I have found that nine times out of 10 they do not get an opportunity to say what is wrong with them. They do all this analysis and come up with a 'take this and go home'. Before you know it, you have got a drawer full of pills and you are doing something. You do not get that succinct personal service from mainstream.

I can understand that being a private practitioner you have got to keep a production line going to make a quid for yourself. In an appropriate community controlled environment then we get to the root of the thing. I think that I mentioned previously my emerging stroke syndrome which mainstream medical practitioners or processes could not identify. They did not have the understanding to ask me about my family tree, which was the first question the doctor at the Aboriginal medical service asked me when I was getting all these headaches. For goodness sake, what is happening to me? I had read something and bang, bang, bang. It was getting a bit embarrassing going and asking the doctor for a sick note. They got used to me and had the sick note out as soon as they saw I was on the agenda. I would be in there, wham bam and gone, and I would have a sick note.

The Aboriginal medical service clearly gave me a more consultative understanding. How can you tell whether someone has got a headache just by looking at them? So I went back a little bit and told the doctor that my father and my uncles had debilitating strokes before they were 50 years of age. My father lived as a vegetable for the last 20 years of his life because of the stroke. I found out through consultation with the doctor that I could take one of these cardiprins a day now, just a bit of aspirin that does not cost a fortune and I do not have to get diagnosed regularly. I just get that.

As I said, if I tell you about my personal stuff, it would take me an hour and half and you do not have the time. But the fact of the matter is the consolidation of community control. It does not matter where you go—and I think that Dr Anderson illustrated the importance of his time at the Aboriginal medical service in Victoria and what can apply there that he could better comment on. Maybe the question you need to ask him is about the difference between the provision of services and his understanding of how it was to be there at an Aboriginal medical service and be here with OATSIHS now. We are fortunate that OATSIHS has a man of his experience and expertise on there because it makes us feel a little bit more comfortable about that section of health and family services.

The questions you raise are very pertinent, but because of our life experiences we

have very succinct and direct answers to those things. We can tell from our life experiences, and you do not have to have all this documentation written down to put your life experience to the committee.

Mr JENKINS—Mr Chairman, I have two questions, but I understand the time, so I am going to overlook one which was to ask Commissioner Delaney to comment more specifically on what Mr Kennett actually does. He might say more kind words about Premier Kennett, so I can do away with that one.

Mr Delaney—Just on that, my experts are the Aboriginal people of Victoria, not the Premier.

Mr JENKINS—No. I take on board that it probably will be worthwhile for us to explore what does happen in Victoria and give credit where credit is due. I am being very bipartisan in that comment.

Specifically, I would like to ask a question about the ATSIC-army community assistance program and get ATSIC's view of the success, or otherwise, of that program and what lessons were learnt that might be transferable to an ongoing program of this ilk. In particular, can I just add for comment whether the success of that was that it was the defence forces that were involved, or would it possibly have been as successful if we had a—and I do not know what to call it—a peace corps type element? We have got Green Corps working with the environment. If we had another program that took the principles of this one, could it also have positive outcomes?

Mr Delaney—I will just make a comment then I will hand over to these fellows here because they are closer on a daily basis. The main thing that came to mind was looking at army personnel who had been there and how they treated our people. They treated our people with dignity and as fellow Australians. The problem with the state service deliverers is, firstly, they do not go out there—and it is their responsibility. But I think the main success—and it is not the physical success of the operation—is the attitude of those personnel in the army towards our people. I think that is great and it speaks volumes for that organisation. I wish that Commonwealth and state authorities could treat Aboriginal people in communities the same way as these professional army people do.

Mr Plowman—To date we think the ATSIC-army initiative has been reasonably successful—remembering that it is only halfway through. The six projects are probably going to become seven—we are doing some negotiations with another community in Queensland. Basically, the army in association with some private sector has been delivering some power, water and sewerage—those essential elements—to a number of communities. The one that most media attention has been on so far is the community of Bula, which is west of Katherine. It was good. The army went in there and provided some essential infrastructure. They provided some additional medical and dog health work for the community. They assisted community members to be trained. The community

members were very happy with what they learnt through their training at Batchelor College and on the job with the army. Generally it has worked very well.

I think the main lesson so far is about the complexity of delivering housing infrastructure in remote Australia. We had a steering committee with the army towards the end of the year and one of the things they were saying to us—and, remember, it is ourselves and Health and Family Services that have put money into this—is that it is very hard to effectively deliver quality housing infrastructure remote from capital cities. They had some private sector involvement at Bulla and even through a tender process in selecting the good quality people to do it, it required significant additional resources from the army to actually deliver the project on time and within quality.

We have got a lot of housing infrastructure projects throughout Australia either being constructed, as we speak, or in planning. It is a very difficult job to make sure, firstly, that communities get the outcomes that they should get out of these projects which are health related and, secondly, that they are delivered at appropriate quality. Thirdly, it is important that they are delivered in an appropriate time, so that communities get the benefits as soon as possible, and so that they get those other employment and training benefits that can come from these things. Fourthly, it is also important that the projects are properly maintained so that there are not only short-term health benefits but also overall long-term benefits. It is extremely complex, and the army, I think, are recognising that as well, despite the large level of resources they have put into these particular projects. We have been very happy, and I think Health and Family Services have been as well—although I cannot speak for them, of course—with the attitude of the army, in particular, and the willingness and the commitment to doing a good job. We have obviously got more detailed work in the next six to nine months and I think that all of the communities will benefit.

Mr Eldridge—Mr Chairman, may I add something there? For fear that the AACP program is regarded as something that has never happened before, and something entirely new, a notion which we have never actually had before: that is not, of course, true. ATSIC has in place a HIPP program that takes a holistic approach to the housing and essential services needs of communities—primarily, but not exclusively—and addresses community needs on a project basis.

AACAP is an offspring of that approach that involves the army. One of the key additions that comes with the use of the army is the fact that we can access some of the multidisciplinary resources of the army. I do not want to take anything away from the army. This approach does work, but that benefit we should also be able to achieve through intersectoral collaboration with the primary health services, for example, and with other service areas. We hope to achieve that as the HIPP program evolves over time.

Mr Plowman—We have about 150 projects planned nationally up to the year 2000 which will involve about $353 million.

Mr ALLAN MORRIS—Is that documented in the report?

Mr Plowman—Yes, we have provided that information. We have a map here which details where some of them are. With these projects that the army is doing, some of these were already planned. But, of course, normal private sector contractors do not have vets.

Mr JENKINS—That was the point that I wanted to explore. Under HIPP, would there have been the opportunity for not only the logistic infrastructure support but also medical personnel or allied health people to go in to do the training, or the vets to do that work?

Mr Plowman—With employment and training, yes. We have a significant input in dealing with the Department of Employment, Education, Training and Youth Affairs on employment and training.

Mr JENKINS—As part of HIPP?

Mr Plowman—Yes. One of the benefits we try to ensure with HIPP and NAHS, with all our large capital projects, is to get the maximum employment and training that is possible and that the community wants in terms of that particular project. That is a key element. It is something that we insist that our program and project managers input.

As for vets and individual medical officers, normal private sector contractors do not have that sort of capacity, although what we do with all of these is try to ensure that the local health authorities, and Aboriginal medical services where appropriate, are aware. We try to ensure that there are linkages at the time that the projects are on and for the period after the project has finished. That is much more complex when it is not part of a delivery mechanism such as with the army.

Mr Eldridge—Perhaps I can go a step further and point out that the actual process of project selection under HIPP involves a health impact assessment. This is undertaken by a national or state based program manager. It measures the impact on the health of the community of the proposed project. In the process of assessing that, there will be links with other needs, other disciplines, other services. We expect that the program manager will look to make those linkages.

This is the process of intersectoral collaboration that I was talking about before. It is an element of the MOU that exists currently between ATSIC and the Department of Health and Family Services, and it is something that we want to develop over time. It is very clearly an element of the HIPP program as it stands. The point I wanted to make is that AACP is an offshoot of HIPP that happens to involve the army as the service deliverer.

Mr Plowman—For instance, in the Northern Territory, Western Australia and New South Wales, there are environmental health working parties which involve state agencies, health agencies, and ATSIC. Our program managers are involved from time to time to make sure that the health benefits flow on when we are doing these projects. So all agencies, state and local, are aware of these projects and can put in as much additional effort as is possible because they have got a health objective.

CHAIR—We need to wrap it up there. Thank you, Commissioner, for bringing your team along for this preliminary discussion. If you are willing to liaise with the secretariat, there might be some of those projects very worthwhile for us to visit later in the year. I am referring to pending projects and a successful one.

Mr ALLAN MORRIS—Are there spare copies of this map we have been given?

Mr Plowman—Two more. I am just in the process of getting the map updated. There are about 20 or 30 more projects to go on. When we get all the projects on, I will send you copies of it, if you like.

CHAIR—Could you do that?

Mr Plowman—Yes.

CHAIR—With some advice perhaps about what could be suitable projects for inspection?

Mr Plowman—Absolutely. We can provide you some advice on that.

CHAIR—Thank you very much. We look forward to further consultation.

[11.45 a.m.]

LARKIN, Mr Steven Raymond, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation, 2/4 Phipps Close, Deakin, Australian Capital Territory 2600

MAYERS, Ms Naomi, Vice-Chairperson, National Aboriginal Community Controlled Health Organisation, 2/4 Phipps Close, Deakin, Australian Capital Territory 2600

CHAIR—Welcome. Before we proceed I need to point out that, while this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament.

Your submission has been incorporated in published volumes and distributed as part of the inquiry. What I am interested in is an exchange of information and ideas at this very preliminary stage of our inquiry—this is the first day of hearings—to steer the committee in the right direction in terms of ultimately making some strong recommendations for progress. You may wish to make some preliminary remarks. We have read your submission. We will then proceed to some questions.

Ms Mayers—First I want to explain I have been quite a long time in Aboriginal affairs—almost 30 years. I also have to say that this is about the 15th inquiry that we have participated in. We have also participated in a very big major report called *The national Aboriginal health strategy* and then the review of that report, the major finding of which was that it had never been implemented. For all the inquiries that have taken place to date, the majority of the recommendations have always been the same, but they have never been implemented.

One of the major recommendations of the national health strategy was to work out better intersectoral collaboration between all the services: between state, federal and the Aboriginal community and also the primary, secondary and tertiary levels of care, plus between all the funding bodies relating to various programs. There was also a recommendation to have Aboriginal health worked out in a more holistic way rather than splitting us up into body parts with funding coming from all different directions.

For instance, we were funded for a diabetes pilot program. That is one of the major health problems in the Aboriginal community, yet we were only funded for a pilot scheme for 12 months. It took quite a long time to get our programs into action and to get everybody coming and really working out the program, then the funding stopped. We were funded because they were funding the white community, but it is not suitable to fund the Aboriginal health services that way because we do that on a daily basis and see all these things on a daily basis.

The other one was cervical cancer screening and then breast cancer screening. They had two teams going in different directions. They could have saved resources. If they had given it to the medical service, we could have done all that as part of our normal ongoing services to our communities. The better the intersectoral collaboration, the better is the non-submission based funding. You do not just send out a letter and ask people to put in a submission because that is how all those remote communities have missed out.

Another major recommendation of the national health strategy was a proper base to work from and the knowledge of what is needed in each community—across-the-board with water, sewerage, whatever—be done in a properly organised way. But we have not yet got to that either. We are still doing it submission based. Communities are still missing out because it is submission based, when it should be done on a proper plan that everybody works to. Would you like to say something further to that, Steven?

Mr Larkin—No.

CHAIR—I can see some frustration in your submission about the fact that a lot of work is done to formulate a national strategy and then you perceive a lack of progress. We are determined to try and break through some of that. As someone who represents a significant number of Aboriginals, coming as I do from Swan Hill in northern Victoria, I am encouraged by what I see happening in the community in a preventative sense, for instance in child care, and in an integration of all of the activities: housing, employment, all coordinated at community level. I have a determination to encourage that because I have seen it in my own community. But it still needs that ownership sense. This is what you would probably call a provincial community. Swan Hill has got a population of about 12,000 people. Maybe that is a model that works there, but it may not work out in the remote regions where the problems are even more desperate. Is that a fair enough observation? We need models. I think you have said it in your submission and again in what you have just said that each community is going to be slightly different and therefore the models need to reflect that. Is that a fair observation?

Ms Mayers—Yes. There is also a need for better coordination along the Murray River in New South Wales-Victoria—and we are talking about Swan Hill. Some of the people that live on the New South Wales side are tending to their health needs through the health system on the New South Wales side and yet they have to go down to Melbourne to a hospital or to Adelaide, and that is in the northern part of the Murray River.

We have been trying for quite a few years now to get a meeting between all of those bodies that have the responsibility for the borders—not only that border but also the border of New South Wales, Queensland, Northern Territory and so on. It has never really happened even though it was put to AHM council as a recommendation of the national health strategy and even state wide inquiries. It comes up all the time in our meetings with the state government that they have to organise it at that level because they are the ones with the money to be able to sort that out on both sides of the borders.

CHAIR—That is not just a problem in your activities. It is a problem across the board in regard to health. To go back to my question: is it realistic to say that the model that I observe working in my community will work in the remote regions of Australia?

Ms Mayers—In some communities, it is already working but, on the whole, all those agencies that exist in some of those communities are not working together—local government, housing and so on—and that is what the problem is. That is one of the things—the intersectoral collaboration is not taking place.

CHAIR—If I was to say to you that you are Queen for the day—

Mr ALLAN MORRIS—Make her our President, please!

Mr LIEBERMAN—They have got no powers; they are only ceremonial.

CHAIR—If you were Queen for a day, you would have the cheque book and all the powers. What would you like to see done to get the urgency, to get the roll-out, in a nutshell?

Ms Mayers—What I would want to do could not be done in a day, because you would have to do a proper profile on all those Aboriginal communities and assess what the needs are in all areas, housing and so on, on anything that impacts on health. It would take more than a day. I would set up the process in a day to start that, so that you would then have a proper plan to work to and everybody could work to it.

CHAIR—But could you document, in terms of all the communities around the nation, what the needs of each community are? Would you be confident that the department or—

Ms Mayers—During the national health strategy, the consultation that took place with the national health strategy was the most comprehensive consultation that ever took place in an Aboriginal report—more than the employment strategy, or whatever, that Mick Miller did. We did compile the consultations in Queensland that gave a really good profile of all the needs of those communities in Queensland. A person from the secretariat, a state government employee plus one from NACCHO actually went around and saw all those communities. They did it everywhere in Western Australia and the Northern Territory. The only strategy that was printed up, and that we got the money to print up, was from Queensland, so that they had that on record and had something to work to. But they would not give the extra money to print up those other reports. So that is where it fell down. They would have had a base to work from. Of course, on top of that, a lot of it was never implemented.

CHAIR—Is that information still available?

Ms Mayers—I have got one report at Redfern; I would have to go through our archives to dig it out. The people who did it from the state government there, the state health department plus the Aboriginal person, Les Collins, who is the secretary of QUAIF—the community control health program in Queensland—would have one.

CHAIR—We might try to track that down. It sort of relates to the question that Mr Lieberman asked earlier. It is documented and it exists; you do not have to go and re-invent it.

Ms Mayers—Yes and all the other reports on the consultations, although they are not compiled into one book, are in the archives. ATSIC was DAA at the time, and apparently they are in the archives of DAA. They are all the reports of all the consultations that took place with the national Aboriginal health strategy.

Mr LIEBERMAN—I read your submission with great interest and you have crystallised a lot of issues for me. Could you help me clear up what I think is a bit of a misconception that some people have in relation to the call of indigenous people for local community organisations to provide the services? This is a strong recommendation, I think, of all the work you do, is not it?

Ms Mayers—Yes.

Mr LIEBERMAN—Some people say, 'But that will, of necessity, as those local indigenous health organisations start to grow, cause duplication with mainstream services.' You have heard that proposition put?

Ms Mayers—Yes.

Mr LIEBERMAN—I would like to give you the opportunity to perhaps crack the egg open and talk a bit more about the model which you see would foster local community indigenous health management, but which would be in partnership with mainstream services where appropriate. Do you envisage that it would be that sort of concept or are you saying—and I do not think you are but I need to establish it for the record—'No, the local indigenous service should provide exclusively and not plug into, when needed, mainstream services'? Would you like to talk about that?

Ms Mayers—At the moment, our services, for instance, the one in Redfern—and I know this is multiplied around the country, in Perth and wherever there is a big Aboriginal health service that has been going for a number of years as ours has—are already working in partnership with the hospitals in the area. We are referring our patients to those hospitals where people live for the treatment that we cannot give at our service. They are also working in with us. For instance, we found that a lot of the patients could not get to one of the hospitals for hearing tests and so on. So the hospital decided that the best thing to do was to come and deliver that service at our service, because it was easier for the

patients to get to our service for different reasons.

That has been going now for the past four years. They have also decided that the better way to do it would be to train Aboriginal health workers to do hearing tests. We have that program in place, and they actually do that at our services. There are a whole lot of things like that, that we do in partnership with each other. In New South Wales we have an actual partnership arrangement and agreement with all the area health services, where the Aboriginal community works in partnership with them. We sit down and decide together what should happen about this or that problem.

One of the main things with community control health services is that we know our community. If some of the patients were going to private doctors, the doctors would not—as John mentioned before—know the tie-ups with the family. Also, they usually treat only what somebody presents for. They do not look at the whole person and say, 'We know about Aboriginal health. There are usually several things wrong, so go and test for those things or look at those things.' We usually have the family history, anyway. We are also easily able to trace people around the country, between our services.

The other major thing is that Aboriginal people use our service for all kinds of things: assistance with housing, assistance with social security and other things like that that they would not get at a hospital or private doctor's surgery or whatever. But they are all things that impact on the improvement of people's health. They come to us as Aboriginal people. They know that if they go to hospital, for instance, the first thing they sometimes confront is racism. We have put a lot of those cases to the tribunal in New South Wales. But Aboriginal people know that they can make a complaint to us about various aspects, if they are sent somewhere to get treated at a hospital and so on. It makes a big different to a person's confidence that they can come and do that, and we can handle that for them: take them there, or do whatever.

If Aboriginal health is going to be improved, there has to be a partnership where everybody is working together to improve it. It has to go across the board on all the things that impact on the improvement of Aboriginal health.

Mr LIEBERMAN—Are there any copies of those partnership agreements? Perhaps a couple of samples could be made available to the committee to look at.

Ms Mayers—We could get copies of the New South Wales agreement to the committee, but there are also some in the other states.

Mr Larkin—I would also like to respond to what you were saying about who is duplicating whom. Historically, the concept of community health and community health centres that the mainstream is now utilising has actually come from the creation of women's health centres and our medical services. In fact, they are duplicating us.

Mr LIEBERMAN—Do you mean they are copying you?

Mr Larkin—They have borrowed the model.

Mr LIEBERMAN—Yes; they are not 'duplicating', as such.

Mr Larkin—It is a matter of words. The other thing you probably heard reference to this morning and this afternoon is other countries where indigenous health has undergone a significant improvement. What you are probably likely to hear is that the cornerstone of those improvements has been the fairly high level of indigenous community control over those processes. If we are going to be looking internationally. we need to be taking those sorts of lessons on board here in our own country. People are voting with their feet: Aboriginal people are coming to our services in the first instance a lot more than they present in the mainstream. The reasons for that, in terms of barriers, have been discussed, and I do not think I need go into all of them.

The other thing to remember is that in a number of our services a fairly significant proportion of our clients are non-Aboriginal. In some areas, up to 40 per cent of users of our service are non-Aboriginal people, and they are not turned away. What we are about is complementarity: we cannot, as a community controlled sector, address and resolve Aboriginal health issues or other problems on our own. We need to work with the states and with the Commonwealth. We each have our strengths and weaknesses and we need to be looking for complementarity so that what we do complements what the states and others do. The most important thing for us is to ensure that our people have access to our service.

Mr LIEBERMAN—On the 40 per cent non-indigenous use of your services, would you have some data and information that you could make available to the committee of where that is and what sort of services are involved?

Mr Larkin—Sure.

Mr LIEBERMAN—That is obviously an area that the committee should be looking at—not to block it off but to understand what is going on and why, and whether that impinges on your scarce budgetary resources. That is the reason. I have got no motive for asking, other than that.

Ms Mayers—Can I go back to the question that you asked me about being President for the day? One of the major things that would probably fix everything is if you were to pay the last 208 years of rent, and then we would be independent.

Mr LIEBERMAN—Do you want to be independent?

Ms Mayers—Yes.

Mr LIEBERMAN—Of what?

Ms Mayers—We want to be independent of asking for handouts from the government. We want to be able to do our own thing and plan our own lives without coming to the government with cap in hand. If you paid the last 208 or 209 years of rent, we would be there. I do not know whether you know that the NACCHO position on Aboriginal land rights is that we never ceded the land: it is all ours. Pay the rent, and that would have a major impact on the improvement of Aboriginal health.

Mr LIEBERMAN—That means you will have to provide my health services, then.

Ms Mayers—We could do that, and better than probably it is being provided now.

Mr LIEBERMAN—Better than someone else: it is an interesting proposition.

CHAIR—Yes; and paying for it, too. One of the things that I was impressed with in your submission is at page 11, where you talk about the need to shift the emphasis from problem description to problem solving. That is obviously where you are at, because of the nature of your organisation and its direct link. There needs to be an emphasis on the problems, because when you make the comparisons with some of those other countries that you have already made reference to, Mr Larkin, Australia's record stands out worse than a sore thumb—and I notice that Mr Jenkins has got one of those! It is almost outrageous that we perform so badly in comparison with other countries.

Ms Mayers—One of the reasons is what we call the 'Follies'. We are sitting here and then a new government comes in and sacks all the public servants, and we get a new lot in. Then they proceed to put in programs with what they think is going to cure us or be better for us or whatever. The next minute, that lot changes and the next lot comes in. We have been, and we still are, sitting here. I have been waiting to improve Aboriginal health now for about 30 years, and we do not seem to be getting anywhere. We seem to take six steps forward and about 10 back all the time, and it has got worse in the past couple of years. It is because of the change: nobody ever sticks to a plan.

Everybody who has the power to fund this or that or to do this or that report has got all their own ideas. They are not working to any plan. They just come up with a good idea. It does not matter whether we say to them, 'Listen, we already did this 10 years ago. It didn't work. We have already done it.' They just go ahead and do it. We never seem to get anywhere. Nobody is working to a plan. No matter who is in government, in OATSIHS, in ATSIC, or whatever, they should still go ahead. This is the master plan, and that is the way to go.

Mr Larkin—You have a plan; the national aboriginal health strategy document is still valid today.

Mr LIEBERMAN—Was that 1992?

Ms Mayers—No, 1987-88.

Mr LIEBERMAN—The agreement to implement it was then.

Ms Mayers—It was completed in 1989. But it was never meant to be the be-all and end-all of everything. It was supposed to be a growing document, to be added to and whatever. But that was never done.

Mr LIEBERMAN—A framework.

Ms Mayers—Yes. One of the major things that was set up as a recommendation out of that was the advisory body, the Council of Aboriginal Health. That council had high level state government people on it—health people—and Aboriginal community people, members of NACCHO, plus people at the Commonwealth level.

There are different views as to what happened to make it collapse. We only had about two meetings. There was really strong opposition to it from public servants who had worked in the Department of Aboriginal Affairs before and had gone over to ATSIC.

One of the problems that happened with ATSIC is that we had a board of commissioners coming in and we had 65 regional councils across the country. Nobody had read the report. We offered to workshop it, but it was not workshopped with any of the regional councils. So ATSIC just went on with funding the normal ongoing stuff, as people were making decisions. It was still the bureaucracy that was making the decisions in regards to Aboriginal health. There was also a national organisation that they could have asked advice from, but not once were we ever asked advice by ATSIC at the level that the decisions were being made.

We also had a health minister who said he was not responsible for Aboriginal health during that time, and all the blame was put on to ATSIC. It was not put on to the bureaucracy in ATSIC; it was put on to the commissioners and to the elected Aboriginal members, but they did not have a say over the money, even though they were supposed to have a say. The last say was from the bureaucrats within ATSIC who had the okay to say yea or nay to funding. They could override the board of commissioners, so that is where it fell down.

Then everybody woke up and the minister, Senator Richardson, woke up. He had said at one time to reporters that yes, he was the Minister for Health for all Australians, and a reporter had said to him, ‘Except Aborigines’. That was because they were all saying that it was ATSIC’s responsibility and that of nobody else, not even the Minister for Aboriginal Affairs. That was the kind of thinking at that time when the national health strategy was put to the government.

CHAIR—You have had this difficulty of getting your ideas through about community driven programs, though, even when ATSIC had the jurisdiction, haven't you? It is not a new thing for you.

Ms Mayers—I was on the regional council, and I can tell you that we found out within a week that we did not have any power to make decisions in regards to funding anything. It took us a week to find that out, and we were the first elected regional council in Sydney. They are on to their third or fourth one now, but on that first regional council we found out then and there that we really did not have any power.

The other thing is that there is a lot of misinformation about Aboriginal health services out there: people think that we are getting all this money and that we are not really spending it in the right way, or that it is taxpayers' money and we are not accounting for it, and things like that. We have the most stringent accounting. In the past 12 months it has got worse, and it has really got to the stage where it is discriminating against Aboriginal organisations, because the funds that go to white agencies or NGOs do not have the same kinds of rules. It is really discriminating against Aboriginal health services and organisations.

Mr LIEBERMAN—Would you, on notice, be able to give the committee a letter setting out some of the accounting provisions that you believe are onerous or unnecessary and that are in particular, from your broad knowledge, additional to what other mainstream health services are required to deliver? Thank you. I apologise for cutting in there.

Ms Mayers—Yes, I will.

Mr ALLAN MORRIS—I want to talk you a bit more about the technical things. I think you said that you have 100 organisations and that the Aboriginal medical services are part of your organisation. What level of penetration is there across the Aboriginal communities? How much of the Aboriginal community has access to medical services? Is it 10 per cent or 20 per cent?

Mr Larkin—I am sorry, I do not really follow the question.

Mr ALLAN MORRIS—I am trying to get some sense of your reach and provision. I think you mentioned earlier, or in your submission, that there are 100 agencies that are part of your organisation. What coverage of the indigenous community does that give? What does it provide?

Mr Larkin—That is fairly difficult to answer. In the locations where they are, of course, it is full coverage. But not all communities control the health service. Those ones would be under state provision.

Mr ALLAN MORRIS—Would it be possible to get some idea at some stage? It is

very hard for us sitting here to try and get a sense as to how much access Aboriginal people have to their own services. Is it 20 per cent or 40 per cent or 10 per cent? You do not have to answer it now but I would like you to think about that.

Ms Mayers—We can get that. But I must point out that in Sydney, for instance, we are not funded to handle all of the Aboriginal community in Sydney. We do not have the resources to do that. We would need far more resource to handle the whole of the Aboriginal community in Sydney.

Mr ALLAN MORRIS—We hear about your services but we have no idea of how to quantify just what they are. If you could think about that and perhaps give us a guesstimate or perhaps do it by states. I want to ask about the intersection of yourselves and the state services. We heard Commissioner Delaney talking earlier about coordination and that sounded very positive. But when we look at the areas of north Queensland and parts of the Northern Territory there appears to be none.

Ms Mayers—There are none.

Mr ALLAN MORRIS—In the states where you have Aboriginal medical services and state services, often not together, how do you intersect? Is there a good working relationship? What kind of relationship is there between your organisations and the state providers?

Mr Larkin—It varies from state to state and region to region. Certainly, we are encouraged by developments in New South Wales with the partnership agreement and our member organisations in Victoria are reporting that it seems to be working well there too. But across the rest of the country it starts to deteriorate. Essentially, the best way to describe the relations between our sector and the state at the moment, in general terms, is that of rivalry, of competition and probably animosity.

I think it goes back to that earlier point I made about complementarity. I think our sector has a legitimate place in the delivery of Aboriginal health care. These same state departments, if you happen to peruse their corporate plans, their business plans, you will see under their principles, goals and objectives that they will have community control of health. I am not sure whether that means control of the community or community based or community control, as we understand it.

At the same time, we remain firmly and deeply committed to the framework for bilateral agreements. We sign them in good faith and in good spirit. We want to see reform. As far as we are concerned, the door is always open in terms of working closely with the states. I think we need to depoliticise Aboriginal health somewhat in those relations and those arrangements.

Mr ALLAN MORRIS—Perhaps you might, some time after today, give us some

information about the number of people who are engaged within your services. I think from recollection—and this is getting onto service provision a bit—that, in many cases, your doctors can bulk-bill or can bill through Medicare; can't they?

Ms Mayers—Yes.

Mr ALLAN MORRIS—Do you have any breakdowns of your overall revenue which is Medicare funded or fee-for-service funded as contrasted with grant funded? Is that available to any extent at all?

Ms Mayers—Yes, that would be available through the OATSIHS office.

Mr ALLAN MORRIS—Okay. The next question I want to ask is about pharmaceuticals. In the old days state governments used to provide people with drugs. Let us say you went to outpatients at the Royal Newcastle Hospital. If you had a condition, the hospital would give you the medication as part of that visit and there was no charge for it. We have now moved into the system where you get a script, you go to the chemist and you get it separately. I think we all share the concern that you have about access to PBS being a major impediment to Aboriginal health improvement. One of the options would be for Aboriginal medical services to be able to provide to people medications that were needed as part of their treatment.

Ms Mayers—Most of our services do.

Mr ALLAN MORRIS—So they do that?

Ms Mayers—Yes.

Mr ALLAN MORRIS—Who funds those pharmaceuticals?

Ms Mayers—It is funded through our general grants from OATSIHS. I think the problem is in the remote areas where they do not have chemists and they do not have access to the drugs. I think Puggy Hunter sits on that pharmaceutical thing. They have big problems up in the Kimberley and some of those remote areas in that regard. Our service gets funded for pharmaceuticals, for people who are in need of them.

Mr ALLAN MORRIS—Is that by the PBS or is that by a separate grant?

Ms Mayers—It is by a separate grant and we also have a pharmacy. We order stuff through the hospital system—Prince Alfred, Prince Henry, and so on, in Sydney so we get it cheap.

Mr ALLAN MORRIS—But you still pay for it and not the PBS?

Ms Mayers—We pay for it.

Mr ALLAN MORRIS—In other words, you save the PBS money? If they went to a chemist and paid their $3.20, the PBS would pay for it?

Ms Mayers—We also have a set-up with the chemist so that we send a script to the chemist and we pay that account. We also give out medication. We buy it ourselves and give it out but there are ones for whom we cannot do that. I think there are laws pertaining to what you can prescribe and what you cannot.

Mr ALLAN MORRIS—Mr Chairman, could the secretariat at some stage liaise with NACCHO to get clarity on whether they are subsidising the PBS out of their own grants to pay for drugs that PBS would normally provide? I am more than supportive of the concept of you paying the up-front fees so that you get access because there is a real barrier, and I think the point you make in your submission about the $3.20 being a barrier to good health is of great value to us. But if your way around it is for you to buy the drugs yourself rather than get them through the PBS then that would be a misuse of your funds.

Ms Mayers—That is the better way.

Mr ALLAN MORRIS—I mean, the PBS should provide the funds for those drugs. If your grant provides the $3.20 that is fine, but perhaps we might be able to liaise with the secretariat and just clarify how that works because I think it is part of our inquiries.

Ms Mayers—Yes, we can do that.

CHAIR—The department has indicated that it can supply us with that so that is another one on notice.

Mr ALLAN MORRIS—We are visiting states, and we will be talking to state departments and state governments so it would be helpful to know about those relationships between the states and yourselves. It would mean that we would have some idea of the background of your relationships within those states. In that way, we could bring to the public arena some of the issues that you think we should be aware of.

Ms Mayers—Yes. There is a partnership meeting four times a year. It would be a good idea for you to attend those because you would see the partnership in action.

Mr ALLAN MORRIS—I would not be averse to it but whether that is possible would depend on the participants. I think we are here because we are interested and hope to learn. I would be happy to do that but I will leave it with the chairman to liaise with you on that.

You have told us about a lot of the reports and we are aware of many of those. One of the questions we will be asking the federal departments, as we go around the states, is why. We do not know as much as you know, so if you can give us any feedback or background as to particular issues in particular states, then we may be able to help get some answers in the public arena which might help.

Rather than being president for a day, I think the question would be: if you were on this committee, what questions would you be asking in each state? That may be a more useful question. It would be very useful if you were sitting where we are, asking some of the state or Commonwealth departments the questions that you think are appropriate. That would be helpful, I think.

Ms Mayers—Yes. Do you want us to prepare something?

Mr ALLAN MORRIS—I was just thinking—

Ms Mayers—Yes, we could do that.

Mr ALLAN MORRIS—Yes. If you could just give us some issues that you think we should be canvassing in each state, or with the committee department, that would be helpful. You have told us about a lot of the issues and the submission has been very valuable to us. Imagine that you are sitting at this table in Queensland or in Perth, asking the state departmental officials some of those questions. We may well ask questions—we will no doubt ask intelligent and sensible questions—but you may be able to give us some more appropriate ones.

Ms Mayers—We could do that.

Mr JENKINS—Can I just go to the question of how much the Aboriginal community controlled health services are involved in those sort of intersectoral things, say, provision of infrastructure, housing, water, things like that? How much can you reach out from health care, primary care role into being involved in the provision of those things that are fairly essential to improving the overall state of indigenous health?

Ms Mayers—In New South Wales because of the partnership, we are involved a lot. It varies across the country. In some states, we are not involved at all—there is no intersectoral collaboration between the health services and the state bodies that deliver local governments state housing programs, and so on.

You should know that when we first came into the partnership and started to do intersectoral stuff in regards to the housing, we tried to find out how many houses there were in New South Wales that had been bought with money that had been allocated for Aboriginal housing. The housing department could not tell us. They did not have any idea about how many houses had been bought with Aboriginal money, whether they were what

they call HFA houses—houses for Aborigines—or whether Department of Aboriginal Affairs money had been given to the state governments. They could not even tell us where the houses were because they had bought a house and an Aboriginal family moved in, then, when the family moved out, they put a white family in. That was one of the major complaints all around when we were doing our consultations about the national health strategy: that all the houses had slowly moved over to the white community. That is why there should be intersectoral collaboration between the health services, housing and local government just to make sure that those things that impact on the improvement of Aboriginal health are done properly.

I know that ATSIC has improved those kinds of things in the communities in the last two or three years with the army going in, and so on. Some of those things have been improved, but it is still a problem with some of the state governments in those areas in the Northern Territory.

Mr Larkin—I suppose that, firstly, at the community level, medical services have always been coordinating care of people who come in. That includes ensuring that there is effective access, where appropriate and when needed, to secondary and other services that the medical service itself cannot provide, for example, providing access to specialists or, again, advocating on behalf of people for accommodation and housing issues, Social Security, and that sort of thing.

In terms of impacting on other sectors at the community level, it is not uncommon to find that in our services, which are governed by a board of directors elected from the community, that a number of those people will also sit on other community organisation boards, or be employed by those organisations. At the broad community level there is a cross-fertilisation, I suppose, of people being involved in different sectors of activity within the community that relate to health.

On the broader level across, say, states and territories, I do not think that we have had all that much impact on the policies that are run by the states and the services provided by them particularly, as you say, in housing. There are probably a number of reasons for that, but certainly the separation of those sorts of functions and distinct departments does not lead to—and is probably symptomatic of not working into—a broader health plan which Naomi has referred to before.

But, these sorts of activities tend to take place in isolation and not with any reference to a broader plan that encompasses health aspects, environmental health, and that sort of thing. That is why we are committed to that framework agreement process. We think that that provides an opportunity to get those issues put on the table. It recognises the particular expertise that we can bring in a health area and also provides for regional forums to be established to ensure that that information is fed into those sorts of programs.

Mr JENKINS—Mr Chairman, I have got one question and, given that there is an

element of controversy, I apologise to you because you were wanting to finish up pretty quickly. The question of the foregone rent over the past 210 years is an economic angle to that. But there is a serious question that we have skirted so far today about the importance of a proper reconciliation between indigenous people and non-indigenous Australians. Mr Chairman, these witnesses will be the last appropriate witnesses to put this to about the importance of reaching that reconciliation, whether it concerns Aboriginal health or a whole host of matters, to enable us to go forward and have progress from a sensible base.

Mr Larkin—Personally, I think that a successful reconciliation process means that in the health area—specifically where I work—greater attention and recognition are given to the disproportionately high level of disadvantage. We all know the statistics. We know the Governor-General's release of the report last year. Yet I find that in our organisation we continue to struggle to get those sorts of things on the agenda and receive adequate and appropriate levels of resourcing to undertake the tasks and activities we know we have to do to fix them up.

It is quite frustrating having those statistics showing it is the worst in Australia and in some cases the worst in the world. Yet we still have to fight a legitimacy problem with our organisations in this country. We still have to jostle and bustle and compete with other organisations and departments just to get a fair and equitable share of resources to deliver a health service. Personally, a successful reconciliation would mean that there is at least a meeting of minds across the sectors about what needs to be done and who is best to do it. That is what it means for me.

CHAIR—Thank you for that. We would be very interested in some ongoing discussion. We are coming to Sydney, I think, in June. There might be some of those projects we could arrange to have a look at. We appreciate your comments today and your frankness, too. I very much appreciate it. I think that it is very much the secret to finding the key in the question that Mr Jenkins has asked.

I feel very reconciled to my indigenous Australians in my home town because they are getting access to a service that they actually own themselves. But I am just worried that that model will not work in remote areas because there is not that infrastructure around it with a good hospital and everything else.

Mr Larkin—When you get a community controlled service, it does not mean you necessarily have to have your own accompanying paranoia. We are not going to turn into a land council or the Black Panthers, or something like that. All we want to do is to deliver the service in the most culturally appropriate, cost effective, cost efficient way, and not to the exclusion of others.

CHAIR—Thank you for your submission and your time. I will be talking to you some more. We will adjourn now for lunch.

Proceedings suspended from 12.35 p.m. to 1.39 p.m.

[1.39 p.m.]

ADAMS, Professor Tony, Life Member, Public Health Association, PO Box 319, Curtin, Australian Capital Territory 2605

BALDWIN-JONES, Ms Marjorie, Public Health Association, PO Box 319, Curtin, Australian Capital Territory 2605

FLEMMING, Ms Lynne, Executive Director, Public Health Association, PO Box 319, Curtin, Australian Capital Territory 2605

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Prof. Adams—I am from the Australian National University. I am deputising for the president of the Public Health Association, Professor Stephen Leeder, who is unable to be here at this time.

Ms Baldwin-Jones—I am an activist and represent an Aboriginal contingent of the Public Health Association.

CHAIR—Before we proceed, I wish to point out that, whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament. Your submission has been incorporated in the published volumes and distributed as part of the inquiry. I would like to offer you an opportunity to speak to your submission in an opening statement before we proceed to questions.

Prof. Adams—The Public Health Association is an organisation of some 2,000 professionals involved in the area of public health. These include medical practitioners, nurses, public health and environmental health people—a whole range of various professionals concerned about the state of population health in this country. The association has been in operation for about 30 years, but only in the last 10 years has it been voicing its concern about the state of indigenous health in this country, which really is the biggest public health challenge facing this nation. As previous speakers this morning have said, it is our biggest health disgrace in comparison with the situation in other countries with indigenous populations.

Included in our submission is the public health policy on indigenous health, which was updated last year at the time that Chris Sidoti addressed the annual conference on the stolen generation report. Included in the statement on page 107 is the apology on behalf of the association to the indigenous people of Australia, also recognising that we, as professional public health people, have been negligent in the last 20 years or so in

bringing this matter to our own concern and to the concern of the population. Maybe we have not been as vocal as we should have been.

Having said that, we certainly maintain that the situation with indigenous health needs to be tackled as the nation's No. 1 health problem. We would echo the excellent things that have been said this morning by the Department of Health and Family Services, ATSIC and NACCHO about the things that need to be done and about the commitment and attitude changes that are needed, the approaches that Naomi Mayers was saying that the original NAHS—national Aboriginal health strategy—report put in its initial submission by looking at the communities throughout Australia.

I personally have always been of the view—and I said this to Senator Richardson when I accompanied him on that somewhat ill-fated tour of his—that we are dealing, in terms of rural remote peoples living in situations worse than those of people in rural conditions in places like India and Third World countries, with no more than what would be a grand final football crowd in Melbourne of probably 100,000 maximum. If this country cannot fix the living conditions working with those communities, there is something really wrong with us.

I believe that Naomi's approach would be something that we could recommend that needed to be dusted off again. It would be possible to go through the communities one by one throughout each state and ATSIC region to say what needs to be fixed in terms of the housing, access to nutritional food, access to telephones and transport. Going around a place called Mudiwah Loop, near Hall's Creek, I was appalled to talk to mothers about where they took their kids when they got sick. They said that in the middle of the night they would have to walk five kilometres into the town because there are no phones to call anybody, there is no transport provided. Even to get food they had to walk into town because the hawkers laws in Western Australia prohibited the local supermarkets from transporting food in a van around to sell it to the community.

Another thing that I think the Public Health Association would support us in saying is that some of the legislative barriers to the delivery of health services really need to be looked at. I know the public health partnership, the national movement, at the moment is looking at legislation. But the sorts of things that have come up from time to time are where local government acts have been unable to force shire councils to provide water supplies to Aboriginal communities, through some loophole in legislation, and where Aboriginal communities on ex-mission stations have not been covered either by public health acts at the state level or by local government acts. There is a whole lot of legal duckshoving that goes on which prevents people from getting access to health services, to basic dust control, housing, water supplies, garbage removal, sewerage and so on. We would recommend that public health legislation is something that might be looked at in terms of your inquiry.

The president of the Public Health Association, yesterday or the day before, put out

a press release supporting all the calls from everybody that more resources ought to go into indigenous health. Even though many people say that access to health services is the key thing, our definition of health services—as was echoed this morning—is beyond just access to clinical medicine in the primary health setting; it is access to fundamental nutritional programs, to environmental health programs, to anti-smoking campaigns and to injury prevention services—services tailored to the needs of the community. We would like to emphasise that public health is more than just the provision of clinical medical services, important as they are. As an opening statement, I hope that is sufficient. I could ask my colleagues if they would like to add anything.

Ms Baldwin-Jones—I am like Naomi; I have been around for many years in health. I was one of the nursing sisters who helped to commence the first Aboriginal medical service in Sydney—I worked with Professor Hollows for three years and I went to every waterhole. We have been coming to meetings and doing all the things that Naomi said this morning, but this is 1998 and I feel that we need to get agreements by all parties—government, non-government and Aboriginal people—and to work on that framework to make sure not only of accountability for the medical services but also of accountability for the states and government departments.

I think it is also important for non-Aboriginal people, whether they work in health or whether they are in government, to understand health for Aboriginal people. We see our health in the context of body, land and spirit. Firstly, there is the land issue. Of course people who are sitting on their land do have health problems, but spiritually they are not dead and do not see health as the priority that non-Aboriginal health professionals do. For example, some of the people have said to me, 'Girlie, we are not sick; we are on our land.'

In other words, they are saying, 'You white fellas measure health by morbidity and mortality statistics, but there are other ways to measure the health of Aboriginal people.' The perfect example is written in the submission by the church people. It is clearly stated on page 21. It is written by the Uniting Church and it is in a box. It says that Aboriginal health organisations see land, stress, grief, trauma and dispossession. That is about the stolen generation of people who have been removed from their mothers, their people and their land.

I am talking from my own experience and lifestyle. I have been out in those communities and have seen shops that do not have products suitable for diabetics. They sell treacle and jam, things that people were taught to eat a long time ago, and we are still forced to eat it. Some shops do not have fresh fruit and vegetables. Also, there are alcohol and drug problems, things that the communities have to work out. Although I like my alcohol, I do not drink in excess. Somehow we all have to learn to be moderate.

Commonwealth officers, as you can see, talk about cardiovascular disease. They talk also about heart problems, cancers, mental health and injury. To me, what I am saying

is very clear.

CHAIR—Thank you for that. You have probably seen from reading the submissions that there is something of a debate in respect to the concept of empowering local communities to drive and control their own health care delivery. What is your association's view of that and how important is it? Does it have a high priority? Is it the single most important disincentive for progress?

There is a debate. There is one debate that says, 'Yes, they need to be consulted, but actually handing over control is another question.' I would be interested in Ms Baldwin-Jones's comment on that, given that you have seen a lot of inquiries. You have probably come to this one thinking, 'Here we go again.' Let me say that as a committee we are determined that the outcome will be positive.

Ms Baldwin-Jones—As I have said, we have to be fair dinkum. All workers who are interested and who want to be involved with Aboriginal health, must be dedicated. I am still, despite my years, very positive in thinking that we have to do it because we all have to do it if we want all in our society to live together.

CHAIR—Do you see that as a partnership or—

Ms Baldwin-Jones—A partnership, yes, but as one of the members said this morning, it is all very well talking about a partnership but from my experience you have got to have it on paper so that we are all accountable. We can be criticised and asked questions such as, 'Why isn't this done?' We can then go to governments and ask the same thing. But we have to be honest about it because it is just not going to get us anywhere.

Prof. Adams—If I can add to what Majorie Baldwin-Jones has said, the association is fully committed to having community ownership of services both in advisory and in some executive roles. Advisory is one thing, but they need to have some control over budgets and so on.

I know Dr Sibthorpe is going to talk later on about the number of trained people who are available to assist. There is a number now but there needs to be a great many more trained people to assist communities understand some of the technical things about how public health programs should be run most effectively. They must work with the community. To answer your question, we would say definitely community controlled, but receiving advice from associations like ours and from the AMA and from the professional colleges.

One of the things that has impressed me as I have gone around some of the Aboriginal medical services was that they are so busy doing clinical work that they cannot get their heads above the water to look at community problems and all these things that

Marjorie has been talking about on a population basis.

Just to add to what she said, just last week at the executive board meeting of the World Health Organisation, a decision was taken to change the definition of health, which has been not merely the absence of disease but also the complete social, mental and physical wellbeing. They are going to add spiritual wellbeing, largely due to pressure from 300 million indigenous people around the world. Spiritual wellbeing is an interesting addition to the definition of health. Did we answer your question?

CHAIR—Yes. As a follow up to that question, are you satisfied with the progress that is being achieved in ensuring that there are adequately trained nurses, medico support and Aboriginal doctors? Are you satisfied with progress on that front?

Prof. Adams—Not at all, I think it has been an absolute disgrace. It is wonderful that we now have 28 medical graduates of indigenous background. As for the number of nurses, I do not know what the figure is at the present time but it was going backwards. I remember a colleague of ours, Sally Goold, commenting on that. Aboriginal health workers are another issue. I know Dr Sibthorpe is going to talk about that and I agree with what she is going to say about the fact that there are as yet no indigenous medical specialists in gynaecology, opthalmology, et cetera. There is a great need. Compare things here with the Maori situation and the situation in Canada and so on. I was working in the United States 30 years ago in a medical school which was training Navaho Indian doctors at that stage.

Ms Flemming—I support what my colleagues have said, but I want to clarify one point. When we were talking with Marjorie the other day about the most important issues we wanted to get across here today, Marjorie made a comment that was very telling. She said that after 20 years of working as a health activist in Aboriginal health, she is fed up with being on advisory committees.

That is a very important point, that we still have not yet moved on to giving Aboriginal control of executive functions in terms of dealing with Commonwealth and state jurisdictions. They are still advisory, particularly the committees. They are asked to participate and represent the community sector on committees that advise the minister, but they still do not have control. They might have control over running a primary health care service in a community, but that does not give control over the policy agenda.

CHAIR—On that statistic of nursing, would you be able to perhaps take that on notice? That is a good question. That is very much a proactive preventative role working in communities—active, culturally related nursing staff.

Prof. Adams—The Department of Health might have some statistics on their work force area or the latest figures. Certainly between the two of us we could find that out.

CHAIR—Mr Morris, the first question to you.

Mr ALLAN MORRIS—Thank you, Mr Chairman, I am very appreciative. On the intersection question—as the PHA is a fairly broad church—it seems to me that there are complications with the intersection of service funding and provision between the Aboriginal communities, between the state governments, between private providers, like doctors and, of course, the Commonwealth. Have you any comments to offer as to ways in which we can improve the intersectional gaps, if you like? There are clearly conflicts. I think one of the words used earlier was perhaps animosity between state health departments and some of the Aboriginal controlled organisations. That whole area of cooperation, coordination and complementarity seems to be a vexatious one. From your standpoint, you are probably a good observer of that because I think you cover all of them in a way.

Prof. Adams—I think we would echo some of the statements that have been made. We are sort of living in hope that these framework agreements the department mentioned earlier this morning and the partnerships that Naomi Myers was talking about in New South Wales are at least forcing people to come together and they have some performance agreements. It will push them together. It depends so much on an attitude change in the individuals concerned.

Mr ALLAN MORRIS—How can we help that? What would your advice be to us to help expedite, facilitate or make that more effective?

Prof. Adams—I think the whole solution is going to depend on people working together. In a place like Wilcannia the local water supply people or the housing people have not been talking to the medical service and so on. In the Western Desert we are trying to do something about water supplies, but the Northern Territory government is saying that if we are going to do something about water supplies that means they can cop out and wash their hands of it and leave. To start, the first process seems to be in certain of these—

Mr ALLAN MORRIS—There has to be framework and partnership. How do we ensure that they are effective and not simply tokenism?

Ms Flemming—The answer is the one that everybody keeps coming back with all the time in this context. It needs more money. You will always have conflict and rivalry between various service providers when they are competing with each other for a limited budget. One of the best and most effective ways to overcome that big barrier of competition between different providers and jurisdictions is for there to be enough money for everybody to be able to make the contribution they want to be able to make, to do the work and to put in the effort that is required. It reduces animosity.

Mr ALLAN MORRIS—There is a coordinated care trial at Wilcannia but one could argue that giving them more money does not necessarily make them more coordinated; it makes them fight even harder because they have more resources to fight

with or for and it creates the boundaries between them.

The coordinated care trial was an attempt to pool funds from the various sectors and manage them as a common operation. Are you monitoring that to any degree yourselves, as an organisation, or do you have members who are in any way involved? I am looking for the feedback you may get as a broad church without a vested interest. Are you following those developments because coordinated care seems to be a good model in the sense of a conceptual model in practice?

Prof. Adams—Is that within the strictly medical area?

Mr ALLAN MORRIS—No. Coordinated care incorporates things like frail aged and home and community care so it is not strictly medical.

Prof. Adams—Not water supplies and housing?

Mr ALLAN MORRIS—It is a bit broader than strictly medical but there is a danger that it may be strictly medical if it is done wrong.

Prof. Adams—Yes. I can say there are members including Dr Sibthorpe who is keeping a close eye on coordinated care and she may want to comment during her presentation later on.

Mr JENKINS—I do not know if I really have a question but I would like to say to Ms Baldwin-Jones that I think that she has been very helpful to give us an understanding of the way in which this, as yet another inquiry, must look at it not through, as she put it, the white fella notions and things like that. I think, whilst this is early in what we are deliberating, that that is a very important piece of advice for us and it underscores the complexity of this as an issue. Whilst before lunch I asked the question about the importance of reconciliation on it, I think she stressed those sorts of concepts of spirit and things like that as being very important. How we actually go about that within the frameworks that we understand, I think, is going to be our great challenge.

I looked through some of the evidence that refers to past inquiries and it refers to the national Aboriginal health strategy back in 1989. Those concepts are mentioned but it has taken so long to move on. I suppose this inquiry comes at a time when, in a more overall sense, the relationship between indigenous and non-indigenous people is being highlighted and preconceived notions are being challenged. I actually apologise for not having a question.

CHAIR—I think, from my own personal perspective, I agree with the sentiment about the spiritual connection. People should feel good about themselves—not just indigenous Australians but our whole society. When you look at our youth drug problem it is all because people do not feel good about themselves. That is a connection that I am

very much encouraged to see becoming part of the public debate. It might have some good impacts right across our society. That probably satisfies us for the moment. I imagine we might want to talk to your group later on in the inquiry.

Mr ALLAN MORRIS—You may see things occurring in the inquiry that you think we might want to know about. Hindsight is a wonderful thing.

CHAIR—I would encourage you to keep in close contact with our secretariat, Mr Nordin and Mr Kennedy. We would be interested to talk to you later, once we have a better handle on the situation.

Prof. Adams—Any help we can give we will be delighted to.

CHAIR—Thank you very much.

Ms Flemming—Thank you.

[2.08 p.m.]

HINDLE, Professor Don, National Director, Australian Healthcare Association, 42 Thesiger Court, Deakin, Australian Capital Territory 2600

CHAIR—Welcome. Before proceeding, I wish to point out that whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the proceedings of the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament.

We have a submission from the association which is already part of the public record and has been distributed as part of the activities of the inquiry. Would you like to make a brief opening statement by condensing your submission and making some salient points before we proceed to questions?

Prof. Hindle—Thank you. I would like to make six brief points. Firstly, nearly everyone gives the same diagnosis. The gap in health status is wide and we seem to be making little progress compared with similar minorities in similar countries. It may be that our problem is harder or that we have not been as effective in dealing with it. It is probably a bit of both. In passing, I caution against assuming that the problem is the same but, more importantly, we need to solve it whether it is harder or easier.

Secondly, there are many shared views about what needs to be done. This is reflected in frequent use of similar terms: primary care, community focus, health promotion, illness prevention, cultural sensitivity, multi-sectoral, more money, more education, long-term empowerment, cohesion, commitment—and I could go on for a little while but I will not. I take the chairman's comment, earlier on, that some of these terms are apparently conflicting. In summary, most people believe we need short-term action to ameliorate the symptoms, but just about everybody believes we need long-term action in respect of structural change.

Thirdly, the AHA wishes to emphasise the need for renewed effort. Our dissatisfaction with progress should be used as a reason to work smarter, not necessarily harder, but certainly not to give up. Fourthly, the differences in health status between indigenous and other Australians are a community responsibility. I know the committee is aware of this but I will say it anyway: it is socially unacceptable and unscientific to state, suggest or imply that the disadvantaged are to blame in any way.

Fifthly, we cannot just keep on with our previous strategies which have been dominated by partial solutions, rushed planning and simple ideas about a change of direction. For example, at one time we will centralise for efficiency in technical sophistication and then, next year or in the next parliament, we will decentralise for community involvement. Then we will centralise again, and so on. I will use an analogy

here. It is as if we are planning a moon landing and we keep switching between pointed and blunt-ended rockets as a substitute for doing hard work. We have to accept that there are not any simple answers and that progress will be made only through the design of a highly complicated approach involving sophisticated ideas and models. This means we need to improve the capabilities of involved parties to manage complexity, where it is needed, rather than trying to avoid it.

Finally, I have a firm recommendation that a task force be formed and given the resources and time to ensure actions are taken which improve the situation. The commitment needs to be to use as many resources as necessary to produce a workable strategy, rather than just to do what is possible with a pre-determined set of resources. Incidentally, the AHA does not believe it is expensive to spend five times as much on planning, given the amount of money that we have spent on implementing rather poor plans.

CHAIR—Your submission mentioned that one of the principal impediments has been the absence of an effective national strategy but we do have a national strategy. I suppose the adjective ‘effective’ is probably what you would talk about in response to my question. But we have a national strategy which is both developed and evolving. Why isn’t it delivering, in a nutshell?

Prof. Hindle—Because it is not a good national strategy. Let me make three assertions. The first one is that the problems which remain to be solved in the Australian health care system have one attribute in common. It is that they are at the intersection of a whole set of subsystems. That is, the reason why they remain to be solved is that we cannot chop them up into little bits and solve them by themselves. They have a high degree of interconnectedness with everything else. All of the literature that has been presented at this inquiry, and in subsequent inquiries, demonstrates that everybody recognises that you cannot deal with problem A unless you consider problem B, and so on. What we have got is a large number of really good people designing parts of a good system. When we have got those parts in working order, we try to assemble them and they do not fit together. I would argue that there is a discipline, known as brain surgery, and you need some training in order to be able to master it. Some people would disagree with that, but I firmly believe it to be the case.

Might it be possible that there is a discipline which we need to apply which requires some training which is to do with solving fundamentally complicated problems? That is, is there a science which deals with complicated problems? Is there a bag of techniques which equates to the bag of techniques which are relevant to brain surgery? The answer to that question is yes. There is a set of techniques which come broadly under a term which is 50 years old called ‘systems analysis’. The term has been recently updated and made more sophisticated. An example is soft systems technology, which is designed to deal with complicated problems. That technology is well known, it is widely applied. I would challenge each of us to ask: at what time on previous occasions have we chosen to

pick up the expert knowledge in respect of a technique which is not the solution, but is part of the process for solving a particular problem that we face?

CHAIR—What is your feeling about the direction that this must come from—the top down driving or motivating from the bottom up?

Prof. Hindle—One of the features of complicated problems—person-machine problems, as the literature calls them—is that no single answer is sufficient by itself. It is like the pointless debate between centralisation and decentralisation. The answer is that neither one is preferable to the other and we need both. The issue is whether or not we apply centralisation where it is appropriate and continue to apply decentralisation where that is appropriate too. It seems to me to be quite obvious that action has to be rooted in structural change which is driven by the community. That is without question a fundamental element of the right strategy. However, by itself it is not sufficient.

If we say we will rely exclusively on community initiative, we will rely exclusively on primary care and we will not institute any structural changes to facilitate that community action taking place, then it will be insufficient by itself. Clearly, top down will not work by itself. The same is true for community participation. It will work but not to the extent that we would like it to work. We need a mixed model, a mixed strategy. We need to blend together all of the good ideas and use them in a judicious combination rather than trying to work out which of one or two ideas is the most important and should be used in exclusion.

CHAIR—Your submission does not go as far as others have with respect to the empowerment question of community involvement. Others argue that it is time to empower and give complete autonomy to community groups. Your solution is still very much consultation and so forth but not complete control in terms of implementation management. Is there a reason for that?

Prof. Hindle—Probably accident, omission or ignorance on the part of the people who wrote it, including me. Can I respond to the comment you made by picking up the point that was made by the coordinated care trials. Let me say that the idea of the coordinated care trials is fundamentally sound. Delivering services in an integrated way to the whole community and having the service delivery process dominated by and driven by the community's expectations is a fundamentally sound idea. The difficulty is not in respect of the idea; the difficulty is that we never created the environment in which that idea could be proven to deliver in the best way possible. That is, we rushed the coordinated care trials—they must start on 1 July, or whatever it is. We did not do the advance planning. We tried to involve people but we did not do it very well.

There is absolutely no doubt that health care is driven by the expectations and input of the communities that are supposed to be the recipients. That is, without question, an inherent requirement of an effective system. By itself, it will not work. It is not

sufficient simply to say, 'We have found the answer. It is empowerment. Let us go out and empower.' What we have got to do is create the circumstance, the environment, the culture, the broad setting within which empowerment will be able to reach its full potential.

Mr ALLAN MORRIS—That is a bit like the chicken and egg, though, isn't it? That is a bit of a circular argument. I guess it would apply to virtually every aspect of everybody's life. As a systems analyst I guess I should probably say that the more important point is that the quality of the analysis determines the quality of the design that comes out of it. So, whilst the ideas put forward to date may have been excellent, they have not necessarily been for the right problem. For example, with Aboriginality, leaving out the spirituality, land has obviously been a major system failure. So I guess I would probably take it the other way and say the chicken is actually the analysis of the design.

In all of that stuff, in all systems analysis or system design, the really difficult part is how you measure, how you monitor, how you know whether or not you have got the right design. We say now that the community was not ready for coordinated trials. Some thought they were; you are now saying that practice shows they were not. How do we know, firstly, that that is the appropriate design? Secondly, how do we know it is actually working or not, without waiting another ten years and saying, 'I am sorry, but we made a mistake?' How do you build into this system a monitoring and evaluating assessment process and be confident that that is actually accurate and reliable?

Prof. Hindle—It was not my intention to say that the community was not ready to run with coordinated care trials.

Mr ALLAN MORRIS—No; I was taking a slight liberty.

Prof. Hindle—The point I am trying to make is that coordinated care trials are an important component, but that one must make sure that the places within which that component will fit are also given consideration at the same time. I am saying that the coordinated care trials would have produced more rapid and beneficial results if we had spent a little more time planning in an effective way.

Mr ALLAN MORRIS—My point is this: how do we measure that the planning is adequate? I see a kind of 'chicken and egg' problem: how do we build into any design, firstly, a capacity to know that it is appropriate and, secondly, an assessing process? All the way through, we talked to people when I was a parliamentarian on committees and we were being told, 'These things are okay,' but a year later we find that they were not.

Prof. Hindle—There is a difference in views about the objective of a planning exercise. One view is that the purpose is to find the right answer. The systems technology view is, some people would say, a commonsense view that, even if we knew what the right answer was for 1998, it would not be the right answer for the year 2000. What we

are interested in doing is creating a purposeful system, a system that continually learns from its experiences and that has the power to change and to improve on a continuous basis. What we tend to do now is to say that the right answer is X rather than to focus on saying that the right process is Y.

In the sense of evaluation of the effectiveness of the intervention, I realise there are huge difficulties in measuring many things that we will be particularly interested in measuring. But, ultimately, we have a very simple single measure of performance of our health care system in respect of indigenous Australians. It is in the statistics that are widely known and widely published, and some excellent summaries are in the documentation. That is, we know that the current system is not working well. It would be possible for us relatively easily to note that the trends between Maori health and indigenous US communities' health and the Australian indigenous population's health are moving together, but what we can see from relatively crude measures of performance is that they are not. We do not need to worry about the degree of sophistication of our measuring instrument.

Mr ALLAN MORRIS—Yes, but we do need to worry about the likeness of samples, in the sense of isolation and remoteness from airports and from infrastructure facilities and so on of the equivalent community. So there are in fact, built into that, some difficulties in terms of equating them. Secondly, as was pointed out to us this morning by Dr Anderson, the improvements in postnatal care mean that many children survive who then have subsequent serious illness; so, in effect when you succeed at one end, you may end up creating a difference at the other. So just comparing them can be difficult. I am not being disagreeable; I guess I am just trying to come to terms with the complexity of the task. I agree with your approach: the process is more important than the content, in my view, most times. But my difficulty is how we can be sure the process is correct in advance. It is always afterwards that you find out it was the wrong one anyhow.

Prof. Hindle—I am suggesting that it is not necessary to know that the process was right and that we were correct when we started off. It is necessary to know that we have built into the system the ability for it to be able to learn from its own experience. What we are talking about are purposeful systems; that is, systems that have the power within themselves for self-correction.

Mr ALLAN MORRIS—That is a fair enough answer. Thank you.

Mr LIEBERMAN—Professor, I notice that your association represents 80 per cent of public hospitals and health services throughout Australia. In that context, you would have heard this morning the very sad indication in the discussions from Commissioner John Delaney of ATSIC, and also from Naomi Mayers, from the National Aboriginal Community Controlled Health Organisation, about obstacles to accessing mainstream services and their reference to the feeling and experiences of their people that they are being discriminated against and demeaned when they go to some mainstream facilities.

Without wanting to find that those claims are right or wrong, obviously they trouble me greatly. As a senior spokesman for mainstream services, are you aware of any contemporary, vigorous strategy of management in hospitals and the like to address this problem, to train staff to eliminate it and to ensure that any improper or ignorant behaviour is dealt with quickly and severely? Or do you deny that it exists at all?

Prof. Hindle—No, absolutely definitely not. It certainly exists, and to a much greater extent than any of us would wish to see. Certainly, much more can and should be done in terms of making the formal health care provider system more knowledgeable of and sensitive to the needs of all kinds of consumers. I would argue that we are doing something but not enough in respect of, say, the broad set of concerns in terms of responding to and involving the consumers in the services that they receive; and a lot of work is being done in that respect. But in a sense the same kinds of problems exist in respect of that smaller problem as in the larger problem that is the subject of this inquiry: that is, if we were only to focus on the issue of improving the way in which the mainstream health services respond to all clients of whatever type in a culturally sensitive way, we would not have moved significantly in terms of addressing the more fundamental problem of health status among indigenous Australians.

It would seem to me that, for example, large numbers of episodes of care delivered at hospitals are avoidable, and I deprecate the fact that when service is delivered it is not delivered in an appropriate way. But I suggest that a broader and more important concern is whether we should allow the health of indigenous Australians to reach the stage where it is necessary to receive services from hospitals in the ways that indigenous Australians do receive them for preventable illnesses.

Mr LIEBERMAN—Professor, just going back to the core question and your acknowledgment that regrettably there is truth in what we were told this morning, would you be able to come back to the committee with a supplementary submission of advice as to an action plan that might be considered for adoption urgently in public institutions and mainstream health organisations across Australia?

Prof. Hindle—I would be delighted to do that and I thank you for the opportunity to contribute in that way.

Mr LIEBERMAN—Professor, the chairman and I were also very interested in your matrix development concept, which I think we might have touched on in questioning earlier today with others. We have asked the department to give us this. One of the witnesses said, ‘You want a matrix, Mr Lieberman,’ and I said yes. Time is getting on, but could you over a couple of minutes quickly expand on the concept of matrix strategic management and planning, in the context of indigenous health?

Prof. Hindle—If we are dealing with a complicated problem, the main reason for its complexity is the high degree of interconnectedness, and I made that point before. One

of the problems we have is that we find it very difficult to draw diagrams of complicated problems. If you have got a whiteboard, you can draw a picture of some things but you cannot draw a picture of the problem of Aboriginal health status on a whiteboard; there are too many dimensions. The idea of systems analysis in its broader sense, and the use of matrix techniques in a much narrower sense, is that one will need to develop techniques for depicting more dimensions than are possible on a single sheet of paper. What we are talking about is a more sophisticated way of representing the nature of the problem so that we can understand and begin to analyse and begin to test optional solutions.

CHAIR—Time is against us, Professor, but I imagine there will be ongoing contact. This is the first day of our inquiry, so we are still at the stage of assembling information. We will look forward to that contact. If you could respond to Mr Lieberman's question and liaise with the secretariat, that would be very helpful. Thank you very much for taking the time and the trouble to make a submission and attend here today.

[2.32 p.m.]

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NOSSAL, Emeritus Professor Sir Gustav, President, Australian Academy of Science, and Member, Panel on Indigenous Health, Australian Medical Association, 42 Macquarie Street, Barton, Australian Capital Territory 2600

RING, Professor Ian, Head, School of Public Health and Tropical Medicine, James Cook University, Townsville, Queensland

WOOLLARD, Dr Keith Victor, Federal President, Australian Medical Association, 42 Macquarie Street, Barton, Australian Capital Territory 2600

CHAIR—Welcome. I understand that this is the AMA's expert panel on indigenous health. We are very pleased that you have been able to find the time to talk to us today. Do any of you have any comment of the capacity in which you appear before the committee?

Dr Woollard—Yes. I am chairman of the group, which represents both the AMA and the Public Health Association.

Prof. Sir Gustav Nossal—I am here wearing two hats: firstly, as the president of the Australian Academy of Science; and, secondly, as the recently elected deputy chairman of the Aboriginal Reconciliation Council.

Dr Hetzel—I have a background in public health and am a life member of the Public Health Association, and I am currently Chancellor of the University of South Australia, which has particular commitments in the field of Aboriginal welfare education.

CHAIR—Professor Adams was deputising for you in the earlier submission we heard: is that right? Yes. Before we proceed I need to point out that, whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament.

The submissions that you made are already part of the published volumes of the inquiry and have been distributed in that respect, and so you need not feel a compulsion to read completely into the record, as it is already there. I would like to invite Dr Woollard, as the chairman of the group, to make an opening statement—or, indeed, any other member of the panel may—before proceeding to questions from the committee.

Dr Woollard—Thank you, Mr Chairman. With your indulgence, each of us would like to make a short opening statement. We all have specific areas of expertise, and I would ask Professor Stephen Leeder to lead off.

Prof. Leeder—Thank you. The basic awareness that we bring to this is that many other countries have done very well in solving the kind of problem that confronts us with regard to Aboriginal health. We will speak a little further in the proceedings about why that is so. Certainly the achievements of Canada and the United States with indigenous populations and New Zealand with regard to Maori are landmarks that suggest it is fully possible to confront and deal with issues of wide disparity in health between indigenous groups and groups such as white Australians. The task is not impossible. We are here to express a measure of optimism that these problems are not insoluble, that others have solved them, and that it is therefore within our current range of capacity to address these and deal with them.

Our second principal contention is that there are three areas where we could direct our energy with very considerable outcome. The first is in regard to the development of the Aboriginal health work force, where many gains could be made. The second is that there are several specific areas where currently available preventive programs in common use in Australia could be targeted and applied with benefit to such things as pneumonia through pneumococcal vaccine, reduction in heart disease and diabetes, early treatment of diabetic complications and reduction of injury.

It is a matter of great pride in Australia that heart disease and injury death rates, especially from road trauma, have fallen by well over 50 per cent since 1966. We have the capacity to handle and tackle those problems. The third element would be the creation of a truly effective health service network among Aboriginal people, building on what has been achieved through such things as the community controlled Aboriginal health services, but ensuring that that program is implemented with appropriate expedition and built upon.

Those are some of the key elements within programs that concern us. Given the interests of the group, those of us who have a concern about public health look at the various factions within the Aboriginal health scene and say, 'Here is something not dissimilar in style to what faced us when first we began to respond to HIV-AIDS.' The organisational response that we mounted at that time, bringing all of the different groups together around a table and funding an initiative adequately, put Australia right at the forefront of the global battle against HIV-AIDS. That was so much so that we were able to host an Asian and Pacific conference around that theme. We had visitors from the US

and other places who came to see how it was done. To build on what Professor Nossal said, there are elements in the health inequality setting which, if we were to tackle them technically, could really begin to bulldoze a practical pathway towards effective reconciliation.

The last area that I believe important to put on the record is what research might contribute toward the resolution of these problems. We work in this area with relatively little by way of insight into what works and what does not. We have not chronicled our successes. We put in a lot of money, but it is often said anecdotally that that does not achieve what we intend. Yet the information that we gather back to give us a basis for determining cost-effectiveness and accountability is missing. There is a lot still to be done in the field of biological and medical research that could be highly appropriate in reducing those disparities.

All of those, put together, suggest to us that with goodwill or the polity of the sort that I have described, and additional funding of the order of $20 million to $40 million a year, we could make steady progress. That is a bit of an overview of what we would like to discuss with you in terms of further detail. From the public health perspective, which we define as the response of society through societal efforts to deal with its health, there is a great deal that could be contributed even now without further ado.

CHAIR—Thank you.

Prof. Ring—Mr Chairman, the circumstances and the level of Aboriginal health is well known and we do not propose to take up your time in telling you things that you are well aware of. Suffice it to say that the most recent information that we have indicates that there is little evidence of any significant improvement in Aboriginal health in this country, at least over the past two decades. That is reasonably unique on a world scale. There are few, if any, countries around the world, no matter what their disease pattern or political system, where that is true and the countries that we think of as being most like this country—that is, New Zealand, Canada and the United States—have a very different experience in terms of indigenous health.

There are two implications of that. The first is that it puts an onus on this country to do the kinds of things which similar countries have been able to do. The second implication is that we are talking about something which is quite doable. No-one is saying it is easy, but we are saying that it is doable.

It is important to note that there is nothing that is really unique about the Australian indigenous history and experience. The issues of forcible dispossession, of children being removed from their families, the disease pattern, the remoteness are all important, but none is unique to this country. It is important to recognise that and to notice that these are things which those countries like us have been able to deal with successfully.

We think there is no particular mystery about what has to be done. We are not saying it is easy to do, but we are saying that the directions are clear and involve three main aspects. The first has to do with some effective process of reconciliation which further defines the life of Aboriginal people within Australian society. The second is a set of health services that work and are delivered in a way which is appropriate and acceptable to Aboriginal people. The third is to deal with the fundamental infrastructure issues of housing, water, environment, education, economic development, land and so forth.

Our point is that we applaud much of what the government is doing. The directions, we think, are fundamentally in the right direction. But, in our view, the issue is one of scale, that we could continue on those directions for many decades to come without necessarily making any measurable impact in the health circumstances of indigenous people. It is our feeling that this is an issue the country needs to grab hold of and to bring about the kinds of changes which we believe can occur in as short a period as a decade. This is based on what has happened elsewhere. This is not never-never stuff; an effective approach can produce sizeable changes in the short term.

The scale issue has to do with money. The popular perception is that all this money has been thrown at Aboriginal health, that there has been little or no improvement, therefore the money must have been incompetently used, corruptly used, eaten up by a bloated bureaucracy, or the like. The critical issue, however, is how much is spent on Aboriginal people in relation to how much is spent on the population as a whole.

The best information that we have is that the excess spending on Aboriginal people is of the order of 10 per cent. If Aboriginal people were only 10 per cent sicker, that would be fine. The reality is that they are three times as sick. And the effect of that is that there is not enough money out there at the moment even to treat the level of illness which is out there, let alone to provide those services which are necessary to break the cycle.

We do not pretend that we can say exactly what kind of money is required, but by now I think we have a reasonable idea of the order of magnitude. We believe that the sums of money, though large, are well within the scale of possible in terms of budgeting. We are recommending and urging an additional $20 million to $40 million—genuine new money, not rebadged old money—for each of the next five years. This could be put in context, I suppose, with other areas of government spending or, indeed, the recently announced infrastructure spending in Bougainville.

What would the money be for? We suggest that the money could and should be used for three principal purposes. You cannot provide any services at all unless there is an effective infrastructure to deliver services and we believe that at the moment that is, at best, patchy, incomplete and fragmented. So strengthening the infrastructure for delivering health services throughout the country is the first point.

The second point is that there needs to be a national training program. At the moment our work force consists essentially of one- and two-year trained health workers plus white doctors and nurses thrown in at the deep end with little preparation for very onerous tasks. We believe that there is a whole range of health professions required in indigenous health, as is required for the health of the population as a whole. A national training program is very important.

The third element in our recommendations is that those things which are important need to receive major effort. About three or four conditions between them account for something of the order of 60 to 70 per cent of the excess deaths. These are cardiovascular disease, respiratory disease, injury and diabetes. We are not saying this is the whole event. But, whatever else we do, we must be able to develop and mount effective programs for those issues which are causing so much of the burden of excess deaths. At the moment our service delivery patterns are dictated by funding mechanisms—that is, you have funds for a certain line of activity, therefore you do it—rather than saying, 'These are the things that need to be done,' and having funding mechanisms which support those things which are important.

We think it is very important to start to develop appropriate models of service delivery which measure how well services are working, their cost and performance, which have that kind of element to them, as is increasingly the case for health services of all kinds throughout the country. This is a concept of a teaching health centre which starts to develop a set of services which collectively address those issues which are important throughout the country and for individual communities. The development of these services needs to be linked to highly practical methods of training in terms of the national training program.

We need to come back to the final point, that health services are our particular area of expertise and are particularly important but that they need to go hand in hand with issues and approaches which deal with matters of housing, education, water, sanitation, jobs, income, and the like. We think there is a real opportunity now for this country, in terms of affordable sums of money, to do what has not occurred before and to initiate a series of practical measures which can really, for the first time, bring about the kinds of improvements in indigenous health which are possible and long overdue.

CHAIR—I must say that, in your contribution, you are pre-empting many of our questions—but that is good, too. Dr Hetzel.

Dr Hetzel—I would like to speak briefly in support of what Ian Ring has said. There are some good things that are happening, and I refer particularly to the Aboriginal health worker training programs.

There is an excellent training program in the Northern Territory with what could be called professional recognition of the Aboriginal health worker, which has not happened

elsewhere in Australia. I suggest that this should be developed and expanded so that we have an increasing number of Aboriginal professionals who take pride in their work, who are recognised for their work, so that their professional development is fostered in ways that are quite familiar to people in other professional areas—with a national journal, national meetings, a state journal and state meetings—to lift the horizons and get people focused on the good things that are happening in Aboriginal health and stimulated to what I would call a higher quality of leadership. That is the first point that I would make.

The second point that I would make is in support of the infrastructure issue. The problem is multisectoral which means that it is not just a matter of health services. It includes the whole environment; it includes education. This is the reason that no more improvement has occurred in spite of expansion of the health services in the last 25 years. I have been involved with this problem originally from 25 years ago. The health indices, I regret to say, as has been pointed out by my colleagues, have not improved significantly in 25 years, and that is what we are so worried about.

Improvement requires what is a multisectoral approach and, if there is one thing that is more important than anything else, it is education, and education of women. In developing countries around the world, it is recognised that educating women is the single most valuable thing you can do for health, to improve the health of families, to improve the health of these communities. If you take a subject like heart disease or diabetes, it is terribly true that there is gross ignorance in the Aboriginal communities where there is common knowledge in the rest of the Australian population, and that gap has to be bridged.

Dr Brown—I would like to speak in support of Professor Hetzel. As one of the small but growing number of Aboriginal doctors in Australia today, I think it is imperative that indigenous people are trained to work at all levels in the health care profession, be that as Aboriginal health workers in the territory, as nurses, dentists or doctors in primary health care. I feel that not only is it important in terms of self-determination but also it is important to perpetuate and support community controlled initiatives. Training indigenous people as health workers is important because they are community members. Therefore, they would be sensitive to the needs and the expectations of the communities and, in turn, you would expect them to make their decisions, give advice and provide information or training based on an insight that would provide something that is both professionally and culturally appropriate.

The difficult part is how we put that into action. I agree that education is very important. We need to get indigenous children to school and keep them there. We need to encourage them to stay at high school. We need to encourage them to pursue further education in whatever field they so desire. In terms of the health profession, that is where that would tie in with the national training strategy, so that we could identify and perhaps stream potential applicants for health jobs when they are still at high school. In regard to those who may have left high school or who may be unprepared for tertiary studies, it is a

big leap for people from an Aboriginal community to study in the city or at other tertiary institutions, and perhaps we could think about bridging courses of one to two years to prepare them for study.

Once they begin their studies, it is very important that we support them throughout. It is often one of the major hurdles that indigenous people face when they have actually commenced tertiary education. In that way, we can raise the profile of indigenous people, which I feel is important, and also raise their self-image and their expectations for the future.

Prof. Sir Gustav Nossal—Thank you for the privilege of allowing me to take part in these proceedings which I think are exceedingly important. I will be very brief. I want to pick up on two points that Professor Leeder made: the two words 'reconciliation' and 'research'. This country will be the focus of world attention twice in the near future. In the year 2000, there will be 200 or more cameras pointed towards the opening of the Olympic Games. In the year 2001, certainly all of the Commonwealth countries, and I dare say many other countries, will be looking at the centenary of our Federation.

If reconciliation is not a done deal by that time, we will be diminished in a serious way, to the detriment of all of the Australian people at that time. Reconciliation unfortunately has become mired in party politics, in a way that was never hoped for or intended. The two aspects of reconciliation that are uppermost in the minds of the Aboriginal people are land rights and reparation for the stolen generation, and what flows from the stolen generation report. I hardly have to tell you that those two issues are currently enormously contentious, divisive and difficult.

I believe, whatever happens about this arena which we, as a group, cannot influence—although you can—we have to grope for other elements in the reconciliation spectrum and what better place to start than health. Health is non-controversial: there is no division between the political parties about the shameful state of Aboriginal health; there is no division about the need urgently to address it. I think that gives this group enormous leverage to press on and make the kinds of financial demands which we are making. That would be my first point: health as a tool of a non-controversial sort and doable towards reconciliation.

My second point is research. There are some aspects of my own trade of biomedical research which could be helpful. Just to mention one, a streptococcal vaccine, or perhaps a more polyvalent vaccine against streptococci and other major respiratory organisms to prevent the terrible deafness which afflicts 50 per cent of kiddies in school in some remote Aboriginal areas. They get recurrent middle ear infections. From the middle ear infections, they get perforated drums and because the perforated ear drums are not looked after they go deaf and that means they cannot learn and their schooling is wasted. That is just one small thing: to get behind those at the University of Canberra, in the Menzies Centre in Darwin and in the Queensland Institute of Medical Research where

they are developing a vaccine against streps in young kids.

There is a second dimension of research, and I will close on this note. One of the first things that I learnt in the cancer game was that you cannot fight an enemy until you know your enemy in quantitative terms. I am therefore putting in a plea for public health and health services research and for epidemiological research that will give us better knowledge than we currently have about the dimension of the problem. We have a reasonably good idea, but we need a more precise idea because only then will we be able to divide any extra health dollars in the most appropriate way.

Dr Woollard—I would like to say a few words at the end. I really cannot add much. I am surrounded by eminent people. I am a simple medical politician and I am sure you know what the second part of that term means. Perhaps as a medical politician, it does seem to me that this is an achievable aim. We have community acceptance of this issue that something needs to be done.

I think you have heard today that there are some clearly definable, positive steps that will make an impact, that can be done at a cost which the community and the government could afford if they had the intention to do so and, more importantly, that we have the basic building blocks in place. We do need development of the infrastructure. Out there in the Aboriginal communities where I go there are some wonderful people just waiting for the resources. There are dedicated people who want to get on with this program. We just need to put the tools in their hands to make it happen. Thank you.

CHAIR—I will proceed immediately to questions. I appreciate that we have before us quite an accumulation of people from the profession. You say you are a simple medical politician: we are just simple politicians. I invite you to read my opening statement. We have a committed resolve which is bipartisan in our committee. We punched through quite a few good reports last year to make sure that we had the time to do this one well. We do not want it described later as 'just another one.' We are hoping to drive some reform.

Mr ALLAN MORRIS—I will comment on three things that I think are very important. Firstly, if you look at the departmental submission, pages 13 and 14, you will see that there have been some substantial improvements in Aboriginal health in particular areas. That is not well understood and not well known, and that in itself is a tragedy. The fact that there have been improvements and that we think the opposite is really unfortunate.

Secondly, the ATSIC submission quotes a 1989 study from the University of Queensland where 90 per cent of medical undergraduates believed that Aboriginals were to blame for their own problems. Those people are obviously out there now as doctors but the fact that they saw Aboriginal health problems as being the fault of Aboriginals is an incredibly insightful comment and observation to all of us.

The third point is that those figures of 10 per cent extra are unweighted. In fact, we just asked the department that this morning. But when you take into account that 30 per cent of the population are living in remote areas, contrasted to three per cent of the non-indigenous population, it is very likely that they are getting less per capita than every other Australian. On a weighted basis, it is probable and no-one has ever bothered doing the sums.

So there are three perceptions out there which we all are aware of. I might suggest that as your organisation plays such a fundamental role that you could help to correct some of those perceptions and perhaps help drive some of the changes that we may come up with. I may have to encourage you to stay involved in the inquiry. We are going to be bipartisan, and we will try to get some answers but it will not matter unless organisations like yours are actively in there afterwards helping make the answers work.

So I think today is the start of a process. As a parliamentary committee, we have dealt with you as an organisation over many years and I have always been grateful for that. But this is perhaps the greatest challenge for both of us. I think those three perceptions are just incredibly important and I think it indicates that we can all get it so wrong, so easily. It is disturbing that we simple politicians, simple medical politicians, and very experienced professionals across the field, seem to be so poorly informed about ourselves as a country. It says a great deal I think, as Dr Leeder was saying, about our lack of statistics or lack of data, if nothing else.

How can we so poorly understand? Is it the statistics or is it the state-Commonwealth lack of communication? Is it the lack of definition of data? What is the answer to that part of it? You are all involved in public health in some way or another; how can such an educated society be so poorly informed?

Prof. Leeder—Allan, if responding to you I could just offer one view, it is probably to go to the second of those points you raised about medical practitioner attitudes. We are here in a very congenial group today. But our encounters, even among other groups of parliamentarians that we have met, show that those attitudes are not restricted to the medical profession. There is an awful lot of people out there who believe that they have had enough or too much. It is their problem. One politician said to us ‘They live with dogs. Until they get rid of the dogs, nothing will happen’. This is part of a cultural set of attitudes that certainly are there. I have not done any recent polls, but I would imagine that our medical colleagues would probably have a view that is not radically different to the general population.

Mr ALLAN MORRIS—I am saying that I am agreeing with you in thinking that if we are so—

Prof. Leeder—Yes, how can we fix it? My own view is that the University of Newcastle has gone down the right track there. They can talk more about that than I can

from first-hand experience. I was at the early stages of that. The impact of those students on the other students was profound. At the end of the year, the evaluation was, 'We have learnt heaps about this by virtue of these colleagues'. Looking at medical education, which is the only bit of it that most of us can control, I would say the more that the Newcastle model can be emulated—and fortunately other places are doing so—you might begin to influence that set of behaviours.

Mr ALLAN MORRIS—We hope to visit and look at the medical effort at Newcastle.

Dr Woollard—From the broader picture point of view, obviously within the medical profession we are a reflection of society to some extent and hopefully better informed. In society in general, one of the reasons this group was formed was to provide that sort of advice to the community and to use the public relations expertise we have to get those messages out to the community. We are keen to continue promoting exactly the views you are putting forward there about this thing.

The concept of blame is unacceptable. The diseases they suffer from and die from are exactly the same diseases that your families and your relatives die from. They are heart disease, diabetes, road traffic accidents and injuries. They are exactly the same group of diseases. We do not go around blaming people with heart attacks because they happen to smoke, nor should we use blame as any part of the management of the problem in Aboriginal people as well.

Prof. Ring—Essentially we are saying we are here to help. We are not here, and never have been here, in any kind of adversarial capacity or in any party political capacity. If there are things that we can do—I am sure I speak for the whole group in saying this—that is our real purpose. If there are things that you think that we could usefully do, we would be more than willing to do whatever we can.

Mr ALLAN MORRIS—That is what I was hoping to hear.

Prof. Ring—In terms of just two of the things that you mentioned, there have been success stories. There are improvements in some areas. We can say that globally, when you look at all causes combined, there is no significant improvement. What that means is that the areas of improvement are offset by other areas that are getting worse. In terms of the cost issues, I can only agree with you. We have taken a very cautious approach in describing that as 10 per cent. We agree with you that, when you look at a weighted basis, it comes back much nearer one. One reason is that it is assumed that all people using dedicated Aboriginal medical services are Aboriginal when about 30 per cent are Aboriginal. That works in the same way.

The only other point I did not mention before, which I think we would all want to make very strongly, is that we absolutely believe in the principle of self-determination in

terms of delivery of health services. We are really at a loss to understand why the issue of community control in delivery of health services is still sometimes a topic of debate. It is time we moved on beyond that and looked at what we would need to do to further strengthen the capacity of all services, be they government or community controlled, to do the job. The issue is not what sort of service they are, but do they work, and what we have to do to make it work better.

Mr LIEBERMAN—I would like to thank you all. I have listened very carefully to your submissions. I think they are wonderfully inspiring submissions and spot-on in what we need to do.

Professor Ring, the self-determination issue, and we just touched on it then, is one of my great passions. Perhaps in a supplementary submission, or in another discussion, your group may be able to help us to consider an appropriate model of self-determination which helps us tackle some issues. Firstly, there is the fiction that self-determination leads to needless duplication and bypassing of existing services, for example, mainstream services. That is a perception a lot of people have.

Secondly, there is the issue of how a partnership can be best fostered between mainstream and self-determining community groups to maximise all the talent and money that we have got and to avoid the pitfalls. That would help me a lot to take on some of the challenges that are coming out of what we are talking about.

Thirdly, and with no attempt to diminish the importance of the land issue, particularly on reconciliation, it is ironic that while you have said this nation needs to put between $20 million to $40 million extra per year into indigenous health over the next five years, perhaps $100 million to $200 million of extra funds, in the last four years this nation has spent $100 million on legal aid in arguing cases which have not yet been determined. I am not saying they are not important to argue, they are, but it is ironic.

I would like to open up, without getting into party politics—because that is not what I want to do—the debate that is going on now. It is a very important debate but I feel very sad that not enough emphasis is being given by the community to the importance of tackling health problems, and how much benefit we can gain by doing it properly. Could we get some advice and comments from your panel on how we might expand the debate without diminishing the importance of land and other issues?

Dr Hetzel—We have discussed this, and we refer in the submission to the need for a whole of government approach. Spelling that out, that means that we need a national authority which would have responsibility for Aboriginal health. It would be able to educate the community, and as we have already pointed out, whose ignorance is abysmal. It would be multi-sectoral. It would have authority to assist with environmental changes. Health is a multi-sectoral thing, you cannot localise it to health service. It depends on a multi-sectoral approach which goes across the whole lifestyle of the community.

Obviously, it involves employment, education, environment, water supply, food supply and so on, which are desperate problems in Aboriginal communities in this country, as I think you are well aware.

An authority which was able to attack the problem in this way is what is required. Twenty five years ago these statistics were the same as they are now. This has been observed in other countries and other countries have improved their situation. A major factor in this change involves a multi-sectoral approach so that the environment, education, water supply and so on are all attended to. Those things have been attended to. This is well documented in the literature. There is a limit to what you can do with just health services.

That is the point we now have to recognise in this country. We could expand on this if you wished. There has to be some form of authority. It has to have political support that is dedicated to facing this problem at a national level with education of the community so people understand the statistics in the way they understand statistics on heart disease and traffic crashes in this country. The same principle applies.

Prof. Sir Gustav Nossal—Mr Lieberman, I have just had the privilege of spending a day and a half with Ms Evelyn Scott, the new chairperson of the Aboriginal Reconciliation Council. We have been developing a point of view that we wish to put to the first meeting of the new council which will take place on 7 and 8 March. It goes as follows: with reconciliation there is a spiritual dimension which is largely about land rights and the acknowledgment of the separate culture, and maybe some general sense of sorrow, not to use the word 'apology' which has been excluded for reasons that we all know about. There is a spiritual dimension that is enormously important. But there is also a practical dimension where the mainstream Australian community can link arms with the indigenous community and push forward in very practical areas of which Evelyn Scott believes education and health are the two most important.

I think we will be very much thrusting in the very direction that you want. We, of course, cannot and do not want to influence the political debate. That will play itself out as it will. We are going to be sticking to the basic principles and, hopefully, the high moral ground.

Mr LIEBERMAN—Thank you, that is encouraging.

CHAIR—I want to take Mr Lieberman's question a little further. The submission referred to the establishment of a commission. I do not know whether that means another commission. I must confess I am a little bit reluctant to accept that. That seems to me like saying, 'We've got this problem so let's form another committee to address it.' That has some difficulties. It is another bureaucratic organisation imposed from above when we are hearing loud and clear the need for community driven programs. What do you believe a new commission will achieve?

Prof. Sir Gustav Nossal—If I can leap in, it may be that in this whole issue there may not be consensus in our group just yet. Professor Hetzel has steadfastly, from the very beginning, expressed his belief that an authority or a commission of some sort would be the way to go. However, I have equally steadfastly, from the beginning, espoused the point of view that you have just enunciated, that I do not think that is the way to go. So, on that point we have a friendly disagreement. But if that is the only disagreement in a group as diverse as this, we are doing pretty well!

Prof. Leeder—I am stuck somewhere in the middle in the sense that what Australia did with regard to HIV, I do not know whether you call it a commission or what you call it—

Mr LIEBERMAN—A strategy.

Prof. Leeder—There was a bit more to it than that because it really brought together all the key people—the professionals, the interest groups, the immunologists and the public health people—and sat them around a table and said, 'We have a mutual problem. Stop punching each other in the nose and let us settle down and find a solution.'

At the moment with Aboriginal health you have the community control people saying, 'We are the way to go', and you have other groups saying, 'No, you are not'. I guess it is that that motivates the feeling that has expressed itself in different ways in our group. It is much more akin to what Gus is doing with the reconciliation group, in a sense, by bringing people together around a table to say, 'How can we pool our resources?'

I have met with Aboriginal groups who have said to me, 'Public health! You are a public health person. You have nothing to contribute to this debate.' Actually, I have, and so have they, but there is no mechanism at the moment to bring us together. I have my conversation there and they have their conversation there and never the twain shall meet. That is a regrettable real element in the Gestalt of this thing as it stands at the moment. Somehow or other we have to break through. The combination of bringing people together in a group and giving them additional resources is the genius behind HIV.

I think it is that style of approach which we are saying is necessary for a problem of this magnitude. Whether you use phrases like 'whole of government', 'committee', 'strategy', 'convention' or whatever it is, that is what we would like to see it achieve.

Prof. Ring—Very briefly, our submission refers to a commission in relation to education. I suppose it is simply a way of emphasising the central role of education. We have also tried to capture the notion that there needs to be some way of harnessing a national effort across a broad range of related activities. We are not specific about how best that might be done. I think what is in all of our minds is that we do have an example in the AIDS strategy which may, at least, have elements of a successful model because that is an issue this country has shown it has done as well as anywhere in the world. But,

in some way or other, these are broad national issues and there has to be some means of drawing that together and harnessing a national effort. We are not specific in recommending any particular way about how that might best be done.

Mr LIEBERMAN—It is certainly a strategy with an implementation mechanism for a project team to deliver and someone to coordinate it. They are the sorts of things you are talking about, are you not?

Dr Woollard—I think that is the model we are discussing. We are not talking about setting up a new government department and I think that is perhaps what has scared the horses over there.

CHAIR—I understand that—a rose by any other name. One more question from Mr Jenkins, and then I propose a brief break.

Mr ALLAN MORRIS—I have a question as well.

CHAIR—All right, two then.

Mr JENKINS—I think that my questions have probably been answered by the discussion and I am left with observations. I am very grateful that Professor Nossal had the opportunity to explain the relationship he sees between the reconciliation process and putting forward not only Aboriginal health but Aboriginal education as being very important. I suppose until that fuller explanation I was left with a bit of a chicken and egg thing. I make the observation that the reason we have the reconciliation council is to try to perhaps get the politicians out of the process and to give it that sort of eminence that it needs to have in the eyes of the Australian public. If the type of body that you are talking about only had that role, which was to give this particular issue the sort of status that would have the wider Australian public thinking about it properly, I think that would be an understandable and worthwhile aim.

The other observation I make is that a lot of these things we will only achieve over generational change. Medicine was previously taught differently until the likes of Dr Hetzel had units of community and preventative medicine set up in some of the larger institutions and now these units exist in a number of the newer universities that have taken up the teaching of medicine. That was something that took a while to really get through and to change the way in which we prepared our medicos to go out into the world but it is now in the mainstream. So were the efforts that have been made to involve indigenous Australians in those educational opportunities. I note the comments that you have made about the experience in New Zealand and a number of the elements that we are to explore such as the relationship that Maori people have had with the sort of social and governmental fabric, even though the anniversary of the Treaty of Waitangi is still a controversial element but at least they have had the opportunity to be in there and discuss. That is why this reconciliation process is just so important.

Like my colleagues, all I can say is that I think the fact that you as a group can come before us indicates that there is a willingness to try to push home solutions to this. If it is only $20 million or $40 million a year, that should be an easier ask than a lot of other problems that we confront. I suppose the thing that I still am not clear about is how we go about gaining the sensitivity or that wider understanding of not just the cultural differences but, as I am trying to come to grips with, the way of life difference, this association with the land that is a very deep and spiritual thing.

I have an electorate with a high migrant population. I think that I know about living in a multicultural society, but the sort of cultural issues that I am talking about I do not necessarily think have that spiritual dimension that we really will have to confront here.

Mr ALLAN MORRIS—I think both my comments you may respond to afterwards. Firstly, Mr Lieberman asked earlier if you could provide perhaps subsequently some more information about self-determination. The point he made was that we get told this is duplication and it is misuse and all the rest of it. The fact that you are putting it forward as a given is extremely important and we would appreciate any words you can offer later to help explain why you see that as being so relevant.

The second part is that it is coming through in the submissions and came through certainly today in the hearings that a communication problem exists between the mainstream health system and ancillary health and the Aboriginal community and its members. It does not necessarily involve the actual precise medical thing, but the understanding and the education of those ancillaries. Apparently they are some of the areas where funding cuts are more easily made because they are less tangible. If you have got any thoughts on how this committee in its recommendations to take back to the parliament can help improve that communication of health and related issues in an Aboriginal context, I think it would probably be helpful to us.

In conclusion, these inquiries have a life of their own. They are very much determined by the people who make contributions to us and the ongoing contributions, so I really want to encourage you as much as possible to watch what we are doing and if anything comes to mind that you think is important, please let us know. Single submissions are not enough, because when you made yours, you had not read all the others. After you have read all the others, observations would be very much appreciated by all of us. Thank you, Mr Chair.

CHAIR—Thank you very much, Dr Woollard and your group, for coming along today and for your submission. If you are able to put some resources to responding to what Mr Lieberman has requested we will be grateful. I would also be interested in your insights with respect to the training program you referred to in the Northern Territory and we will pursue that and get a department comment. But that is a good model; your insights as to how it has worked well we would be very interested in. We look forward to

ongoing contact during the course of this inquiry. Thank you very much.

Dr Woollard—Thank you and we wish you well with your inquiry.

[3.32 p.m.]

SIBTHORPE, Dr Beverly Margaret, Fellow, National Centre for Epidemiology and Population Health, Australian National University, Australian Capital Territory 0200

CHAIR—Welcome. Before we proceed I need to point out that, whilst this committee does not swear its witnesses, the proceedings today are formal proceedings of the parliament and warrant the same respect as the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament.

We have your submission before us, which we have all read, but would invite you to make some comments in respect of that. Do not feel the need to read it all out. Your insights from a perspective of someone involved in the delivery of health care is what we are after. This is the first hearing of this inquiry so we are at the stage where we are looking for the insights to point us in the right direction as to where we take it for the rest of the year.

Dr Sibthorpe—Thank you. I would like to expand on four of the points that I made in my submission. The first relates to the training of an indigenous health work force. We have heard a lot about training needs today and I want to make three comments about that.

Firstly, I continue to be surprised by the low level at which people set their horizons for indigenous health training. For example, looking at the submissions from the medical specialist colleges in Australia, I think I am correct in saying that not one of them mentions training indigenous specialists as members of their colleges. We heard earlier from Professor Leeder about the impact at Newcastle University on non-Aboriginal medical students of having indigenous people as equals and colleagues in those settings in terms of attitudes.

We are a graduate training centre and we have spent the last couple of years establishing a Master of Applied Epidemiology for indigenous health professionals at NCEPH, which is a graduate training program. It is quite an expensive program because we are training public health specialists and we pay a stipend to the students that is equivalent to a medical registrar's training.

I have to say that the Office for Aboriginal and Torres Strait Islander Health Services have been extremely supportive of that initiative and seen it as fitting in with their broader upper level training strategy. The same cannot be said for DEETYA. There is a problem at the moment with DEETYA coming on board in many indigenous health training areas. One of the issues is that typically anything innovative—and we are agreed very broadly that innovation is something that we could do with in the sector—does not fit within their program guidelines. We are constantly frustrated by that.

My final comment in the training area is about health workers. This comes out of my experience working as a researcher currently in a community controlled health service. There needs to be attention paid to something that is currently very ambiguous and difficult about their role, which is that they are typically seen as cultural brokers not only by the communities but by themselves. As a result, they have some difficulties operating as health professionals. This reflects itself most markedly in the difficulty that they have broaching difficult subjects with their client populations. There needs to be some thinking done about how that role is developed, so they really can participate as health professionals, and not as Aboriginal people first and health professionals second. I will come back to that point in a moment.

I raise the issue about hypersensitivity to cultural difference. I believe that the elaboration of cultural difference has become a barrier to the inclusion of Aboriginal people in many mainstream health programs and processes. I will give you just the one example with which I am most familiar. In the area of alcohol intervention for Aboriginal people, we have put resources into prevention and very late stage treatment of people who basically are alcoholics. We have done virtually nothing in the medical area of early intervention, yet there are tools available, tested all over the world. Trials run by the WHO in the late 1980s looked at brief intervention, for example, as a tool for early intervention for alcohol use. That has never been picked up in Australia for indigenous people though it is in widespread use for non-indigenous people.

The paralysis around picking up on those tried and tested programs often revolves around the fact that Aboriginal people are so different and their needs are so different. Cultural issues are so important that we cannot actually go about implementing the expertise that we have available to us. I think Dr Anderson touched this morning on the real corner issue. That is that, if you accept cultural sensitivity as an openness to learning from your clients, you can adopt and adapt many mainstream health programs and processes for Aboriginal people without a lot of effort and imagination.

Data quality is a real major issue. I agree with the comment about the large amount of research done in Aboriginal communities. I know that is something they feel very sensitive about, but in the public health area there are huge data quality gaps. I am going to give you an example just from cervical cancer. The incidence of cervical cancer is in the lower third for indigenous people on an international comparative basis, but mortality seems to be higher than anywhere else in the world. At the same time, we do not have good state data on the incidence and mortality for more than two or three states in this country. We have no data on geographical differences in the distribution of cervical cancer. We have virtually no data on the social distribution of risk behaviours. We have very little information on utilisation of preventive services and preferences for modes of care. That is an area, obviously, where research is needed.

We cannot hope to intervene between a relatively low incidence and an incredibly high mortality unless we understand the processes that run between those. Professor

Nossal touched on a really important issue in relation to that, which is that public health research and health services research have always been the poor relations of the health research agenda in Australia. The need for Aboriginal health research is really most focused in those areas. I think they have been poor relations, along with that relatively low standing of public health research.

Before I go off the subject of research, I raise in my submission the issue of indigenous identification in administrative data collections. There is a lot of work going on in that area, but it is still a national disgrace. Those administrative data collections provide the basis on which a lot of funding decisions are made; and yet, to take the example I quote in my submission of a large public hospital, if only 20 per cent of Aboriginal babies and sick children admitted to that hospital are accurately identified as indigenous, then we have big problems—both with the funding relativities that flow from that Aboriginal up-take of services and also with the flow-on planning. They obviously were not adequately referred to the local Aboriginal medical service for follow-up and so forth; so lots of consequences for public health flow from that poor identification of indigenous people in administrative data collections.

My final expanded point is about research. There is a worrying tendency for research to be shutting down in many aspects in Aboriginal communities, because of extraordinary rights and controls that Aboriginal people are requesting over the handling of information. I have personal experience of trying to establish a collaborative research arrangement, where the request was that any member of the Aboriginal community—not defined—in the area where the research was being undertaken would have total veto rights over any publication which should emerge from that research. Those are conditions under which research basically cannot be conducted. So I guess I am quite keen for this committee to look at the whole issue of reasonable safeguards and proper partnerships being developed around research, but not at a proliferation of extraordinary controls that are going to set the public health research agenda for indigenous people back a long, long way. Thank you very much.

CHAIR—Thank you. The committee has wrestled before with this problem of data identification, in two previous reports we have submitted to the parliament. The impediment is the privacy one, but would you feel this is often overstated, if there is a benefit that can be demonstrated and we can get a good handle on the research?

Dr Sibthorpe—In the past, Aboriginal people quite rightly had sensitivities around identifying as Aboriginal, with all this stuff about licensing and movement controls and things that impacted on Aboriginal people's lives by virtue of them identifying as Aboriginal. I think they realise now that standing up and being counted is important. I guess there is the Australian Health Care Association, but I think there is an appalling lack of a concerted effort at the interface between Aboriginal people and health services, in terms of accurately collecting that data.

It is often argued that it is to do with embarrassment on the part of clerks booking people, et cetera, and about asking people for information. There are international standards for collecting information. It can be done by self-report, as a routine thing. If you hand somebody something over the counter and ask them to tick the box, you do not have to enter into a dialogue about it. There are many ways that you could go about improving that situation, and I do not think that there has been a concerted effort to do that, to date.

CHAIR—Just before I hand over to colleagues, your submission is very strong on training. I imagine I already know the answer to my question: I imagine you are really going to say 'everywhere'. But, to get a good start, is there one particular element of the whole health care sector—nursing or GP or what—which we could focus on and score well with, rather than the lot?

Dr Sibthorpe—It is very hard for me to answer that without reflecting an institutional and professional bias. I do believe that the major health problems confronting Aboriginal people are public health problems. The largely non-resourced area of training has been in public health. The survey that I mentioned in my submission, where we looked at people operating in public health—it is in the record there—showed that 70 per cent of non-indigenous people have basic degrees and three per cent of indigenous people do. If you look at the expertise of the people who are currently trying to implement population health and primary care—both very complex constructs—in Aboriginal health, either at the community controlled or the state Aboriginal health policy unit level, there is an absolutely alarming paucity of public health training amongst those people. That would be my answer.

CHAIR—Yes; we will wrestle with that.

Mr JENKINS—I would like some clarification on a point where you had some comments about the ill-defined role for Aboriginal health workers. You used a term, 'cultural broker', that completely threw me, I am sorry. Can you expand on what you were trying to convey?

Dr Sibthorpe—There are many definitions and understandings of what health workers do, and I am sure you are aware of them. One of the key roles that they have played—and I think it was the key role that underpinned the development of such things as an Aboriginal health worker—was that there was a need for someone to broker the access of indigenous people to health services, those health services being almost always non-indigenous. The health worker really was the person who managed that interface and in a sense was a cultural broker, if you like, across the divide between Aboriginal understandings and needs and health service understandings and needs.

Growing up with that was an expectation by communities that those people were Aboriginal people first and health workers second. That has created a dilemma in the

current context as to how they allow themselves, and feel that the community allows them, to broach the difficult issues that you might not broach if you were wearing an Aboriginal person's hat but that you would have to broach if you were wearing a health professional's hat. Two good examples of issues that I am very familiar with are alcohol use and sexually transmitted diseases. Since they play such a key role, there is some important work to be done in how Aboriginal health workers can more effectively operate across that interface.

I will give you a clear example. I have just interviewed an Aboriginal health worker about a drinking program, because we are trying to understand this barrier. I said, 'Does it make you uncomfortable to ask people about their drinking?' and he said to me, 'It does; but if I do that I hope that they are thinking that I am a health worker and not an Aborigine'—which beautifully summed up the dilemma they face.

Mr JENKINS—In your submission you make the comment that in some places Aboriginal health workers are non-numerate and illiterate but are expected to deliver the primary health care. In what proportion of cases is that the situation? How successful are the more formal courses? Dr Hetzel or somebody said that they were moving to giving accreditation for those courses; but, from that piece of evidence from you, there was obviously a number of communities where there would not be a pool with sufficient education to go on. Whilst we have what we think is a good idea from afar, when it gets down to the ground, it would be difficult to put in place unless we had another step where we trained up people who can then go on to the full training.

Dr Sibthorpe—Firstly, I have to say I am not an expert on Aboriginal health worker training. I do not know what the figures are in relation to current competencies. You will be aware that there is a lot of work being done in the area of health worker competencies.

In answer to your second point, that continuum is currently happening. There are one-year, two-year and three-year programs which now build on each other in a sequential kind of way so that you can start with getting an associate diploma and then a diploma, and go on to higher levels of qualification. I think that people with that lower level of training have had inordinate expectations put on them about what they can achieve in terms of health care delivery. I do not think that any other country in the world places such expectations on people with that level of training.

Public health is a really complicated thing in, for example, just the issue of understanding failure to thrive, or when to intervene when a child has a fever. They require quite complicated understandings of mathematical concepts. It is just completely unreasonable to expect people with very limited training and often very limited English to take on responsibility for achieving health gains in those areas with that level of training.

Mr JENKINS—I guess that one of the problems is that there are insufficient

indigenous students who actually matriculate—in the old sense of the word 'matriculate'. In one of the submissions that we had earlier on, in New Zealand—I do not know whether they are thinking of it, or implementing it—they identify talent and give a bridging course to open up those opportunities. Do you think that that is something that we should be looking at?

Dr Sibthorpe—Absolutely, yes. I was recently involved in a review of the graduate entry medical program at an Australian university. This is the new four-year postgraduate training. They have a commitment to encouraging indigenous uptake of that course and have to date not done at all well. One of the things that we suggested to them was that they needed to think about the issue of bridging courses. I think that we are so far behind in this issue that the concept of indigenous training of health professionals has to start—as was mentioned earlier this morning—right back at school and we have got to nurture that process along the way. We cannot sit back in tertiary institutions and just expect that after a time of wonder all these indigenous people will be lining up at the door to undertake training. The expectations of indigenous students; their treatment in various sectors leading up to those times; demands on them in terms of their communities, and many other factors, make that a very unlikely reality, unless we put a lot of energy into facilitating the whole process.

Mr JENKINS—I want to try and make sure that I understand the notion of this problem of cultural hypersensitivity. Am I right that what you are really saying is that it is one of those perception things, and the more we talk about it—and we tend to talk it up—the more people think that it is just too big a problem, and they do not even try? I would hate to be talking about being culture receptive and asking questions that way and contributing to making this such a mountain that nobody wants to try to climb over it. I was interested when you put that notion to us, that sometimes it seems insurmountable, so people move on and do not try.

Dr Sibthorpe—That is why many mainstream health strategies, programs and policies have excluded Aboriginal people because people have got frightened away by the idea that Aboriginal people are so different, and they are going to make such a stuff-up that it is not worth trying.

Another example is in the area of health assessment that I am familiar with. I feel that it is extremely important that we try to get good comparative data about Aboriginal and non-Aboriginal people around a whole lot of health areas. If you start from the position that Aboriginal people's concept of good health care, their own health and the health of their communities, is so different from ours then you tend to want to give up before you even start trying to find comparable instruments.

There is an instrument called the SF-36 that is currently being used widely in Australia. It was included in the last national health survey, which for the first time, I should stress, oversampled Aboriginal people so that we actually will have a decent

statistical sample of Aboriginal people. It has a question about self-assessed health which was also in the national Aboriginal and Torres Strait Islander health survey.

We have looked at responses by Aboriginal people to that question, which just says, 'Do you think your health is excellent, very good, good, fair, poor?' When you look at it statistically, the things that predict whether or not they will say that their health is poor are the very same things that would predict it in the mainstream community—that would make us say that our health was poor. They have lots of self-reported chronic medical conditions; they have a disability; they are unemployed; they have been to a health service recently. There were no surprises about anything in that that would mean that we cannot start to try to develop shared understandings, shared instruments and shared approaches to dealing with what are fundamentally human problems about health and wellbeing.

Mr ALLAN MORRIS—But the hardest thing seems to be that—and it is to some degree understandable—when they get data published on a particular community, it looks so tilted towards failure, or however you want to put it. It looks like blame; it looks like victimisation. So I can understand their hypersensitivity. I think it requires perhaps a bit more sophistication on all of our parts to work our way through that.

I wanted to ask you a question about cultural appropriateness. Is it possible that our educational systems, being so competitively based as they are from a very early age, may in fact be incompatible, to some degree, with Aboriginal cultural mores? Are Aboriginal children as competitive in terms of beating each other in marks in class? Have you done any work on that?

Dr Sibthorpe—No.

Mr ALLAN MORRIS—I am not sure. I have been in some schools where all the students are Aboriginal but where the mood seemed to be different. I just wonder whether or not we drive a cultural process which is westernised, whereas their culture is much more cooperative and much less possession based and personal superiority based than ours.

Dr Sibthorpe—I cannot comment on that. I understand what you are saying. If what you are saying is true, that would impact on the extent to which indigenous people present themselves, for example, for tertiary education, because they have not incorporated that kind of competitive process. But having said that, that is not to say that educational processes need to be predicated on the idea that success is somehow a competitive process.

Mr ALLAN MORRIS—I know. Does it mean that we need to adapt our educative processes or our curriculum process or our measurement? We are moving away from exam based learning anyhow—we have been for quite some years, but slowly. It

may be that this has an impact in schools where there is a high proportion of Aboriginal students—or even an impact when there is a low proportion. We may need to understand better that that may be incompatible.

Dr Sibthorpe—Yes, I agree with the question you are raising. I cannot comment on it.

Mr ALLAN MORRIS—It is going to be hard to find people who have answers to these things, isn't it.

Dr Sibthorpe—There are people doing work in the education area on this very issue.

Mr ALLAN MORRIS—Yes, but they will not come to us normally.

Dr Sibthorpe—Yes, but maybe you need to go to them.

Mr ALLAN MORRIS—Yes, we may have to. A previous report—and I may be able to fish it out and circulate it—ran up against a similar problem on this question of identification by people from non-English speaking backgrounds, where people did not identify this in the Public Service, in hospital or in other ways. That was a problem, as a general question, about people not liking to be labelled as something. It was not just people from Aboriginal backgrounds; it was actually people from non-English speaking backgrounds and from other backgrounds who did not want to have themselves identified.

Dr Sibthorpe—It is a very complicated issue, I agree.

Mr ALLAN MORRIS—There was the need to establish protocols about that, and we did actually canvass that in a previous report.

CHAIR—We regularly revisit this. There is a need to identify data so that it can be advanced and used better, but there is this privacy problem. We have managed to find, and we are currently testing, some models in other areas of health care in reports that we have already submitted, so it will be interesting to see how much progress that makes. It may provide some keys to the issue you have raised.

Dr Sibthorpe—The National Centre for Aboriginal and Torres Strait Islander Health Statistics, which is a joint AIHW-ABS initiative in Darwin—and I notice they have not made a submission—would be important to contact in this regard. They have done a lot of work recently on—

CHAIR—Yes, they are on our list and we will be talking to them through the progress of the inquiry. We thank you for the trouble you have taken. I imagine that, as we proceed, we will probably want some ongoing dialogue with you. We would appreciate

your willingness to share your wisdom.

Dr Sibthorpe—Okay, thank you.

CHAIR—Thank you very much to those witnesses who have stuck with us for the hearing. Thank you very much to *Hansard* staff and to the secretariat, Bjarne Nordin and Jim Kennedy. Our appreciation now is on the record.

Resolved (on motion by **Mr Allan Morris**, seconded by **Mr Jenkins**):

That, pursuant to the power conferred by section 2(2) of the Parliamentary Papers Act 1908, this committee authorises publication of the evidence given before it at public hearing this day.

Committee adjourned at 4.01 p.m.