HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

ADELAIDE

Tuesday, 17 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

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Indigenous health

ADELAIDE

Tuesday, 17 February 1998

Present

Mr Forrest (Chair)

Mrs Elson	Mr Allan Morris
Mrs Elizabeth Grace	Dr Nelson
Mr Jenkins	Mrs West
Mrs De-Anne Kelly	Mr Quick

The committee met at 9.32 a.m.

Mr Forrest took the chair.

CHAIR—I just might commence with an opening statement. This is actually the third day of public hearings of the committee's inquiry into indigenous health, so we are only really just at the start. This was an inquiry referred to us by the Minister for Health and Family Services, the Hon. Dr Michael Wooldridge, with the support of the Minister for Aboriginal and Torres Strait Islander Affairs, Senator the Hon. John Herron, in June last year. The committee is looking into improved coordination, planning and delivery of indigenous health services against the background that past structures for the delivery of health service to indigenous populations has not resulted in significant improvements to the health status of those communities. It is obvious there still exist barriers for them to access mainstream services.

I would like to say that there is a bipartisan resolve of this committee. We are a standing committee of the parliament. Given that it is 20 years since a federal inquiry was conducted, and there have been some countless inquiries since—in fact I met some Aboriginals in the street last night and they said, 'Oh, not another inquiry'—we do not want that reference to what we are doing. We really want to try and get some national resolve to have a determined assault on the issue. It is considerably frustrating that in 20 years we have still got these statistics that show us up against comparable nations like Canada and New Zealand. So it is not a witch-hunt; it is a resolve the committee has to try and do what it can for what is a significant national problem.

Today's hearing in Adelaide follows a previous hearing in Canberra, which was a hearing to set the scene. We visited Hobart last week and had an opportunity to explore some issues with the South Australian government and others in Aboriginal services. This is the start of our inquiry in Adelaide today. Later on we will be visiting the Nunkuwarrin Yunti, an Aboriginal sobriety group, for a hands-on inspection. We will follow this by being in Perth on Thursday and other capital cities in the next few months. One of the things the committee is intending to do is to visit remote and rural areas of Queensland and central Western Australia where we can gain first-hand experience of some of those awful living conditions that exist out there. I think this is important.

So following a hearing this morning we will be doing a hands-on inspection. As I have indicated on many occasions before, we are seeking to conduct this inquiry in a spirit of collaboration and cooperation with the Aboriginal and Torres Strait Islander people. It is important to consult directly, using the collective experience of so many people we have already spoken to, and the resolve, I hope, to have some acceptance of this, not a groan to say that this is just another inquiry.

[9.35 a.m.]

DIXON, Mr Brian Edward, Executive Director, Aboriginal Health Division, South Australian Health Commission, GPO Box 65, Rundle Mall, Adelaide, South Australia 5000

KNOWLES, Ms Vicki-Lee, Senior Policy and Planning Officer, Aboriginal Health Division, South Australian Health Commission, GPO Box 65, Rundle Mall, Adelaide, South Australia 5000

GOODES, Ms Leanne, State Coordinator, South Australian Aboriginal Health Partnership, c/- Aboriginal Health Division, GPO Box 65, Rundle Mall, Adelaide, South Australia 5000

DIVAKARAN-BROWN, Ms Ceilia, Team Leader, Heritage and Strategic Development, Division of State Aboriginal Affairs, GPO Box 3140, Adelaide, South Australia 5001

CHAIR—I would like to welcome representatives from the South Australian government here this morning. I have a confession to make to you, that I have only just received your written submission this morning. I have not had an opportunity to read it. Some other members of the committee have. We have got an hour and a half to explore some real issues and we are interested to find out some of the good things that are being done here in South Australia. There are a number of good programs. I think that is the key—to find models that work and deliver, and focus on those for the future. Thanks again for coming.

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 the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament. Since the publication of volumes of submissions in connection with the inquiry, the committee has received a submission from the South Australian government dated 13 February 1998. I propose to incorporate this submission into today's transcript of evidence, unless members have any objection. Are there any objections? There being no objection, it is so ordered.

The document read as follows—

CHAIR—Perhaps the way to launch it is to ask Mr Dixon and the representatives present if they might like to make a brief statement to bring us up to speed with an overview of the situation here in South Australia. Please do not be put off if we are flicking through your submission trying to keep up with you. Do not feel the compulsion to read it all. It is already on the public record. We would like to hear your insights and indications of some things that have occurred that you felt had good outcomes. I will leave it in your hands, Mr Dixon, how you want to make the presentation.

Mr Dixon—I am more than happy to make an opening statement. I certainly will not be talking to the submission in front of you there, but I have got a series of points there that I would like to talk to. They provide a background in particular on the South Australian Aboriginal Health Partnership, which we are using as a basis of how we think we should be addressing Aboriginal health in South Australia.

We certainly do not want to dwell on the negative issues, because we are more interested in looking at the positive side of things on how Aboriginal health can be improved in this state in particular. I must say that I share the views in your earlier comments about the large number of reports that have been written about Aboriginal health, and Aboriginal people having been examined to death over the years. And the unfortunate thing about all of that is that we really do not see a huge increase in the health status of Aboriginal people throughout the country.

We believe what is happening in South Australia is a very positive model. We would like to spend most of our time here this morning, if you do not mind, talking about that, and the positive things that have come out of the consultation process here in South Australia. If you would bear with me, I would just like to make a series of points here to set the scene for what we would like to talk about this morning.

There is no doubt that the standing committee here has received a large number of submissions from other states which highlighted the disadvantaged state of Aboriginal health, and the South Australian experience is no different. There is a wide diversity of Aboriginal groups in South Australia, as is the case throughout Australia. There is just as wide a diversity of need: remote, rural, metropolitan, and traditional. The path to improved health for Aboriginal people is often one of untrodden ground, with the need for innovative approaches which strengthen Aboriginal communities' capacities to build healthy environments and promote healthy living.

We have a very strong commitment to addressing health in a holistic way, and not just in a variety of medical services as being the total means of solving Aboriginal health problems. Many of the Aboriginal health and health related reports released over recent years recommend cooperative and coordinated approaches if Aboriginal health is to achieve sustainable improvement. To this end, South Australia has entered into a partnership arrangement with the major stakeholders in Aboriginal health at the state level, namely the South Australian Health Commission, the Commonwealth Department of

Health and Family Services, ATSIC, and the Aboriginal Health Council, which is the major advisory health body for Aboriginal people in South Australia.

This partnership was formalised back in July of 1996. One of the first tasks undertaken by the partnership was a regional planning process, which would provide a set of priorities to which the partner organisations would cooperatively work towards achieving. With the multitude of priorities in Aboriginal health, it is often difficult to know where to begin. On every health indicator Aboriginal people experience the worst outcome. The dilemma for funding agencies was how to provide a cohesive and complementary range of service options which would ultimately create change in either health status or health infrastructure.

The regional planning consultation group made a decision to ask individual Aboriginal communities and service providers what they perceived as the health and health related priorities for their region and for the community. We thought it was important to start that consultation process with the Aboriginal community, as opposed to what happens on a lot of other occasions where either government departments or non-Aboriginal organisations are consulted first. We thought that would set the scene in the right cultural way to start Aboriginal health discussions in South Australia.

After a comprehensive consultation, a set of South Australian Aboriginal health regional plans have been developed and endorsed by the partners. It is from this document that Aboriginal health funding and program development will operate over the next 2½ years, which is the life of the partnership structure. From the consultations it became clear that there were health issues specific to particular communities, but that there were several priority areas which would be developed in a strategic and coordinated manner, and which would have a major impact state-wide, as equity in service delivery is a fundamental prerequisite to health advancement.

Issues in relation to Aboriginal health workers were of concern across the state; in particular, the number and gender mix of Aboriginal health workers; the specialisation of health workers; the support, training and development of health workers; and the status not afforded to Aboriginal health workers by other health professionals. We see the Aboriginal health workers as being the cornerstone of Aboriginal health services throughout the state, and in remote communities in particular. We see the status of the health workers, in terms of registration and other issues, is not happening at the moment, and that certainly is a priority.

The increasing of Aboriginal health workers and the provision of a more appropriate gender balance amongst Aboriginal health workers was seen by Aboriginal communities as one of the most culturally appropriate service models that could be afforded to Aboriginal communities. To address these and other Aboriginal health worker issues, the partnership is initiating an Aboriginal health worker review, which would encompass health worker training, support structures, and career pathways. The Aboriginal

health worker forum, which is the forum in South Australia that represents the issues of Aboriginal health workers, is also seen as an important mechanism by which to strengthen the status of Aboriginal health workers and to link them with the mainstream in terms of competencies and accreditation.

The establishment of Aboriginal health advisory committees to advance Aboriginal health at the regional level is another priority for the partnership. The development of these committees will strengthen Aboriginal communities' capacities to be involved in real decision making processes, as they will be directly linked to regional health authorities who have regional funding responsibilities. South Australia is broken up into seven regions that have health responsibilities. There is one Aboriginal person on each of those regional boards, and we think it is very important for that person to be properly supported by an Aboriginal subcommittee in each of those regions, and also by organisations like the Aboriginal health division and the Aboriginal Health Council.

The priorities which relate directly to health status as identified by communities were diabetes, substance and alcohol misuse, and social and emotional wellbeing. There obviously are a whole host of other health problems too, but these three were the three that came out of the extensive consultation that took place. The partners are committed to the development of state-wide strategies to address these issues. As there are many overlapping issues with these health priority areas, it is believed that a strategic and coordinated approach to these issues will ultimately impact on the other health areas.

Once again, the starting point for the development of these state-wide strategies will be Aboriginal communities themselves. Aboriginal health advancement is a longitudinal process, and change will only be achieved over time by the provision of sustainable and strategic responses by government. In South Australia the Aboriginal Health Partnership is committed to working cooperatively towards Aboriginal health advancement. However, the partnership only encompasses the health sector and improvements in Aboriginal health often require a whole of government response.

The South Australian public sector has just undergone a major restructuring, with the result being an amalgamation of many government departments. South Australia now has a Department of Human Services portfolio, which incorporates the South Australian Health Commission and the housing authority, and the Department of Family and Community Services, which provides another opportunity for joint funding, policy development, and program design in the area of Aboriginal affairs.

We see the amalgamation of these three areas in the new Department of Human Services as another positive step towards addressing health issues in a holistic manner. We see it happening in a partnership structure, and we see this new mega-department as providing appropriate support for that coordinated response towards Aboriginal health. A holistic approach to Aboriginal health is vital because this approach encapsulates Aboriginal perceptions of health and wellbeing—that of health being a whole of life

experience which includes issues of land, justice, equity, family, and community.

I guess that development is in line with the old national Aboriginal health strategy report back in 1989 where we talked about the holistic approach towards health, but we now feel that we have a legal document which is signed by the four major jurisdictions which sets the basis for Aboriginal health being addressed in a more appropriate and supportive manner.

CHAIR—Does that have a bottom-up emphasis, or is it top-down?

Mr Dixon—It certainly has the former emphasis. I said earlier on that our consultation process began with the Aboriginal community and with the Aboriginal health workers, and we see that as being the most appropriate way to go.

CHAIR—I omitted to introduce my committee to you. I am sorry about that. Harry Quick is the deputy chairman and the member for Franklin in Tasmania, a rural electorate. De-Anne Kelly is the member for Dawson, Queensland, up around Mackay, a rural electorate. Elizabeth Grace is the member for Lilley, suburban Brisbane. Brendan Nelson is the member for Bradfield in suburban Sydney, and Kay Elson is the member for Forde in suburban Brisbane. There are 14 members in total of the committee. It is difficult to get us all in one spot at every inquiry because of other commitments, but we are spread around Australia. We do not have a South Australian representative, which is no reflection on the state, it is just that members get busy on committees everywhere.

Mr Dixon, would you like each of the other members to make a contribution before we proceed to questions, or how would you like to proceed? We are in your hands.

Ms Knowles—I would just like to first of all comment on the down-up approach. We are very committed to that. What we have seen in the past is policies and directions which have come from Commonwealth and state levels and have had very little relevance on the ground for Aboriginal communities. So we not only made sure that we consulted with Aboriginal health workers and Aboriginal communities, but also have the commitment to work collaboratively with officers within our various jurisdictions, and that is also a bonus. Sometimes you have the policy and the goodwill but it does not always filter through the organisation. So I think that we all are very committed in this state to working collaboratively together towards making a difference.

Ms Goodes—I was one of the people indirectly involved in producing the set of original plans, and myself and two Aboriginal colleagues were the ones that undertook the consultations across the state. Just to follow on from that, I think that the process began as a top-down process. It began because the Commonwealth were the ones that initiated this notion of the agreement on Aboriginal health which has been signed in a number of other states. In some states it has not been signed. So it began as a Commonwealth initiative to try and bring together those organisations in this state that fund Aboriginal health.

But in order for communities to begin to own a new process like an agreement on Aboriginal health—yet another agreement on Aboriginal health—it was really important to be seen to be developing a process that was in fact a bottom-up approach, that was about targeting in the first instance Aboriginal health workers who directly provide health services and who are in the best position to know about the health in their particular communities. The two Aboriginal workers who worked with me were from the field; they were Aboriginal health workers and they already had links with the field and they were known. One had worked at Nunkuwarrin Yunti, where you are going this afternoon, and another had worked in an Aboriginal health team in the mainstream system. So we had an opportunity to develop links in those important ways with people who had actually worked in the field.

The plans are only the first step. They are only a way of producing for the partnership priorities as defined by Aboriginal communities, and it is really just a starting point.

CHAIR—Yes. I have a copy of the South Australian regional plan. It supplements and it is quite comprehensive. Ms Brown?

Ms Divakaran-Brown—Yes, I would just like to make two points, acknowledging what Brian and his team have said. My agency has responsibility to advise the Minister for Aboriginal Affairs in South Australia, so that is the role I am playing here. Whilst we do not focus on the negative aspects of Aboriginal ill health, I think it is important to acknowledge that the impoverished mental health status of the community is of major concern, and that suicides outside of custody is an area that needs some focus. The emphasis on the Royal Commission into Aboriginal Deaths in Custody has mobilised a lot of effort in the area of suicides within custodial institutions, but there are a significant number of deaths happening outside of custody which we need to examine closely.

We use the term 'emotional and social wellbeing' because they cover more than just psychiatric illnesses and include problem social behaviour and psychosocial problems which are not necessarily psychiatric. Some of the experts in the area talk about the lack of useful social roles that creates this opportunity for people to engage in behaviour which carries health risks. In that context the promotion of social roles through economic development opportunities in the community which in some areas is being taken up, including providing employment and keeping people usefully occupied with less excess leisure time and therefore less chances to get involved in health risk behaviour, I think is an area we can promote.

The other point I want to make is that since the early 1980s Aboriginal health services have been established around the country, and we all believed that that would make a significant difference to Aboriginal ill health. I think there have been some major inroads but an important area that is not looked at sufficiently is quality assurance and best practice. The issue of peer review within Aboriginal health services is something that

I think is worth examining. Thank you.

Mr JENKINS—I am from suburban Melbourne. Perhaps you could start by just enlightening me on the operation we are going to see this afternoon at Nunkuwarrin Yunti. Is that an Aboriginal health service centre, and what is conducted there? Are there a whole range of services conducted in one place or is it just focused on one area?

Ms Knowles—Nunkuwarrin Yunti is a community centre. It has a health service where it provides clinical interventions. It also has a holistic model of healing, so it incorporates massage, reiki and a range of things like that. It has an Aboriginal sobriety group housed within it, which is our metropolitan based drug and alcohol service. It houses Kumangka, which is our metropolitan based youth service. It provides a gym to the community. It provides a place for communities to get together and have gatherings and meetings. It provides transport services. So it is very much a community service more than just a health service.

Mr JENKINS—Does social interaction happen there as well, and social support? Often getting people's sense of esteem and wellbeing is part of this, and getting them used to being in a health service and visiting a clinic and so forth. It seems to me that we need to find a clue to encourage that, using sport perhaps, to find that social interaction. Is that what happens down there as well?

Mr Dixon—I think there is quite a lot of that, but I think the overall concept of the development of Aboriginal and private health services is to make the Aboriginal population feel a lot more comfortable in going to a health service under an umbrella of that nature. One of the major issues that arose from the partnership exercise was the need to improve access for Aboriginal people to mainstream services. That is a major problem in some areas of the state.

Ms Divakaran-Brown—It is also one of the few Aboriginal health services that provides narrative therapy sessions, which is an approach that has been showing good success with Aboriginal people with emotional, dysfunctional difficulties.

Ms Knowles—Nunkuwarrin Yunti has also been successful in securing some Commonwealth moneys to develop a health and healing regional centre, which is about developing curricula for Aboriginal health workers around various counselling techniques and healing models, but also, in partnership with the universities, developing curricula for mental health professionals around Aboriginal issues so that they are expanding all the time. Their healing models are not only traditional Western models, but are also looking at ways to strengthen spiritual healing as well.

Mr QUICK—Mr Dixon, when you were talking about the submission you mentioned three I guess basic Aboriginal groups, the urban, the rural and remote, and what you called the traditional Aboriginals. Do you think we need to develop a specific model

for each of those rather than perhaps have a blanket cover to include everybody that is categorised as an indigenous Australian? Would it be far more effective to say, 'Okay, for the Pitjantjatjara people who wander across three state boundaries we need something specific,' and we then set up appropriate goals and monitor and evaluate for that group, and likewise for the people who want to live at Port Augusta who are half in and half out, if you like—and I used to live up there—and then perhaps the ones who are living in the Redferns and perhaps the central part of Adelaide? I would like your views on that, if you could.

Mr Dixon—There certainly is not a global answer to fixing up Aboriginal health in every part of Australia. Each region or each group needs to be examined in an individual way to take into consideration the types of issues and the lifestyles of the various clans in each of those groups. That varies from place to place and state to state. We have to take into consideration environmental issues that surround the living areas of the various groups. So, yes, there needs to be individual consideration given to each of the various regions and groups in the state.

That is borne out in the plans, the documents that you have there, that there are specific ways in which Aboriginal health ought to be addressed in each of those different regions. If that is not done we are not going to succeed. You will find that in the AP lands that you have just referred to there is an Aboriginal-run health service up there known as the Nganampa Health Council who have specific responsibility for looking after Aboriginal health issues in that traditional area of South Australia.

Mr QUICK—In the development of the regional plans is there a priority set which says, for example, that the more remote the region the quicker the issues need to be addressed—and that they are more manageable, say, in the Adelaide environs because we can say, 'They're six blocks this way and 14 blocks that way, and basically we know how many there are and we can access them or they can access us,' and they will be easier than perhaps the remote parts of South Australia where transport is a big issue? Flowing on from that, is the incidence of some of the health issues like diabetes and substance abuse any greater or any less in any of those areas? If so, as part of this strategy, are you saying, 'The incidence of diabetes in the Pitjantjatjara tribe is 10 times that of the indigenous people in Adelaide so we need to prioritise and spend more money there and develop better linkages,' and that sort of thing?

Ms Knowles—We have not got statistical data which really separate the urban situation out from our country and rural and remote areas, so really the data suggest that the health status of Aboriginal people is as poor whether you live in metropolitan Adelaide or whether you live in our more remote regions. That is for very different reasons, though, and it is all about access, but different reasons for access. In our rural, remote areas, naturally access is about the provision of a service, or the time travelling to a service, and the availability of specialist medical care. In the metropolitan situation this is what provides us with the challenge, because you might have Aboriginal groups who live right

next door to one of the best hospitals in Australia, yet they are not utilising that particular service or that particular community health service.

So the issues around access are very different, and we have to look at what are those barriers which prevent Aboriginal people from accessing the mainstream services when you are living in metropolitan Adelaide and there is a plethora of services available to you, not only health, but welfare and housing. The statistics do not separate it out for us, although some statistics actually highlight that some health indicators are worse in metropolitan Adelaide.

What we have decided to do is this. Whilst we have developed this state-wide Aboriginal health regional plan, and we will be developing a state-wide strategy, the state-wide strategies around those various areas will have broad areas which each region, regardless of where you live, should be having. How you do that will be developed at the regional level. We have an absolute commitment, as the plans highlight, to the regional development of Aboriginal communities, strengthening their capacities to drive health at the local level.

Mr QUICK—So region A has X number of indigenous people, so they will be looked at, and will they be brought in through a focal point to say, 'Okay, we've got 1,827 in area A and substance abuse is one in whatever it is compared to something else.' Are we going to have those sorts of figures? To me, irrespective of what Commonwealth or state government we are involved in, if there are problems to be solved, unless we know specifics, you know, that is a guesstimate and we are throwing money around. So is part of the plan that we can say, 'Look, there are within the Adelaide area X number of indigenous people and substance abuse is 10 per cent'? Whose responsibility is it? Is it yours? Is it the Minister for Aboriginal Affairs?

You say in your submission that networking at the service provider level is fractured and limited. I would also suggest that is so within the education department, because a lot of the manifestations are in the education system, and the housing system is something to contribute towards it.

Ms Knowles—The whole issue of sharing of information and the collection of data is a huge national priority, and the ability to be able to really pinpoint in a statistical way the incidence of various diseases or social causes in the community is quite difficult at the moment. What we rely on is anecdotal evidence from Aboriginal health workers. For instance, we have a HACC program here in South Australia where, anecdotally, staff are saying that of 190 clients 168 experience diabetes. We do not have stats which are fed into a central place where we can pull all of that out. We have individual service statistics. So it is about developing a process whereby we not only plan and fund together, but collect data and share that information across the various agencies. There are very traditional boundaries that have to be broken down before that will happen.

Mr QUICK—So how do you go about saying to the Aboriginal community, 'There is a huge problem with our young people with substance abuse, and we need to do something to stop it, to put something place now; otherwise this generation is going to disappear, and it's going to have a huge impact on us culturally'?

Ms Knowles—In actual fact, our communities are coming to us and telling us, as government bodies, 'We have young people dying from drugs and alcohol. We have the older people dying at a rate of knots, and our babies dying. What are you going to do?' So I do not think it is about having to know how to approach the community to discuss these issues. They are actually talking to us and saying, 'What are you doing about the problems?'

Mr QUICK—So when people raise this cultural sensitivity thing, is it more of an urban myth than we white people think, or is it easily bridged?

Ms Knowles—It depends on the issue. For instance, child abuse is not a subject at the moment which is openly discussed in our communities. We know it is a huge problem. The statistics that are available highlight that. But it is not an area where we are focusing attention. The same could be said for domestic violence. Ten years ago we were not talking about it. Now, through a range of women and men deciding that these are important issues, and being respected in communities and creating debate within communities, we have got a recognition that these are issues that we need to be dealing with. Communities are now giving us the mandate, if you like, to address them. So it is about also waiting for communities.

We have a whole range of statistical evidence which points to this, this and this, and that is why we chose in this instance to ask communities what they see as their priority areas in the first instance. So if we can begin to address some of the things that they see as priorities, ultimately we will be able to address the things that we see as priorities. It is a give and take situation. It is about community empowerment.

CHAIR—Regarding the comment that there is no global answer on a national basis, obviously there is not even a global answer on a regional basis, because each region is going to be different as well.

Mr Dixon—I think I was referring to a regional basis. The same could be said as far as a national answer is concerned, but I was referring to a global regional answer or a global state answer for Aboriginal health business in South Australia.

CHAIR—There could be some clues for our recommendation resulting from the model being developed, which is referred to on page 2, which talks about with ministerial arrangements being in place as a way to get decisions ratified much more quickly, with some sort of performance monitoring in place to try and get a quick response to it. There was an initiative. Did it deliver? If it did not, then let us try something else. If it did, let

us enhance it. What is the time frame for some of that? How on earth have you been able to put good monitoring in place when really, even identifying Aboriginals in mainstream health records, we have discovered, is not well coordinated either, because of the sensitivity about even asking questions, I suppose, and the issues of privacy. Could you run us through some plans for that model and details of how it operates?

Ms Knowles—I think that offers the government probably one of the greatest challenges, because what is an outcome, and by whom is it determined? We have not even got to a point of really discussing that. From a government point of view there is an expected outcome, but is that the same outcome as is expected at the community level? So I think that is the challenge. But Ceilia has been working, I would think, without those sorts of things, from MACATSIA.

Ms Divakaran-Brown—Yes. It used to be the department of state aboriginal affairs, and now it is the division. We have a role of ensuring that the expenditure of state government funds meets the best outcome for Aboriginal people. In that context we had proposed this model of ministerial agreements, which each respective minister signs off with the Minister for Aboriginal Affairs, in terms of their given budget and their targeted outcomes. Interestingly enough, the previous government, prior to the December 1993 state elections, approved this model, but when the current government took over, they were reluctant to introduce the model. The thinking in government is that these arrangements should be done at the departmental level.

So state Aboriginal Affairs have been negotiating a forum called the Aboriginal Programs Cooperative Council, which was the forum through which we would engender more integrated planning and synergistic arrangements to arrive at these best outcomes. Personally I was surprised, but that was actually referred to in the submission by the Premier and cabinet, because that was in the previous government's endorsement which we had not secured in the current term.

Mr QUICK—So is there a person within each of the key areas like education, health, and community welfare, who can suddenly say, 'We've got a really serious domestic violence thing. There's no adequate housing. Just give them house A in Glenelg' or who can respond quickly? Or do you have to go through the bureaucracy and category 1, category 2—'What level are they?'—with a public servant shoving paper around when a decision needs to be made today because that family is in a crisis situation? Have you got, as you say, that synergistic thing operating where public servants can make a quick decision and the paperwork is done tomorrow?

Ms Divakaran-Brown—No, I do not believe so, which is why the health partnership really is the sort of mechanism in which there would be more dialogue between agencies. Often there is an overlap, and the experience is that the squeaky wheel gets the most funding. It is not the person with the greatest need, but those who can in fact write attractive submissions who get the funding. I just wanted to add a point to what

Vicki was saying earlier—a clue into this business of access and availability of services. When you examine the mortality and morbidity data, what you find is that there is a disjunction between the reasons that Aboriginal people present to hospitals, and the reasons they are dying. People are dying from heart conditions, but the number of times they attend a health service or a hospital for that condition is not at the same prevalence. That is because these barriers exist—the barriers that Vicki was talking about. I think that is a hard piece of data that we can rely on.

CHAIR—So if just go back to this proposed model again, it is not what it is cracked up to be. Is that what you are saying?

Ms Divakaran-Brown—It is a model that we certainly support, and would like implemented. At this point in time we have not cabinet endorsement to do so.

CHAIR—With respect to the question of identifiers, and identifying and getting good data, do you feel you are better progressed in that compared to the rest of the nation, as we have discovered?

Ms Divakaran-Brown—Yes, South Australia is far more advanced in terms of Aboriginal identifiers, both in vital stats and health patterns.

CHAIR—I think someone made the comment earlier that even urban-dwelling Aboriginals in South Australia suffer worse health outcomes, but can you make the distinction on a regional basis—for example, how many Aboriginal people live in region 7, that there are a certain number of diabetes sufferers, and then comparing that with the urban location. How comprehensive is the data?

Ms Goodes—The data does not indicate how many people have specific illnesses in a particular region, and make a comparison between a rural or remote setting and an urban setting, because we do not have the data to support that. That is the truth. What the data gives you in the plans is the number of Aboriginal people living there, the number of people that are employed, and the sorts of housing conditions. So it sets the scene for how Aboriginal people are living across a series of indicators, because we have only got hospital statistics or mortality and morbidity data. That is what we have got. So what Ceilia is saying about the number of people who present at a health service and then what they are dying of in a hospital is really true—that there is a big bridge between those two things, and there is a range of inferences that can be drawn about why that is.

Ms Knowles—What we can do, though, through hospital separation data, is highlight that Aboriginal people at a regional level are going to hospital for the acute end of their diseases, and at greater rates than their non-Aboriginal counterparts in the region. So we can do some comparisons that way. But we cannot get a picture of the incidence of particular diseases in the community. When you go to hospital, it might be the diabetes which is the issue, but you get diagnosed with a sore finger or whatever. So we are doing

a lot of work at the state level around the identification of Aboriginality and the collection of performance indicators at the national level to feed into a national process for the Australian health ministers advisory council.

We are also working collaboratively with the Aboriginal health organisations in the state to look at how we share data amongst ourselves, because they have amazing amounts of data about their local community which we are not sharing for a range of reasons, including confidentiality, ownership and other ethical reasons. So those are strategies which we will develop and work through as part of the partnership.

CHAIR—You mentioned this question of the definition of Aboriginality, a very delicate question, certainly in Tasmania. Is it a delicate question in South Australia?

Ms Knowles—Not to my knowledge. Not particularly, no.

CHAIR—How have you progressed the issue of identification of Aboriginality?

Ms Knowles—We are developing a strategy around making sure that all administrative data collections have an Aboriginality field—that for all community health services and hospitals, and not only just in terms of interaction with the health service, but also in terms of employment statistics within a particular health service. In some instances that is strategic. We have to change forms and we have to change computing technology. We are in the process of developing a new way of collecting data from our community health centres. That is longitudinal.

But also I think one of the key things we need to do in the state, or nationally, is develop an in-service training module for counter staff as to why they need to ask the Aboriginality question, and it needs to be mandatory, and asked by every single person who presents at a service. I think we also need to develop a promotional campaign which targets the Aboriginal community, as to why they are constantly asked about their Aboriginal status.

CHAIR—Yes.

Ms Knowles—I would like a campaign which says, ‘Stand up and be counted. Don’t wait to be asked. Be proud.’ But the community needs to know why they are constantly asked this question. It needs to be tied to funding. It needs to be tied to better outcomes, those sorts of things, so that there is a dual process that needs to happen before we get the hundred percentile, if that is ever possible.

CHAIR—Yes. Actually, I think that mainstream Australia needs to know why the question is asked as well.

Ms Knowles—Absolutely.

Ms Goodes—Every single person that presents for a service needs to be asked this question, because otherwise you are not going to find those Aboriginal people that do not look overtly Aboriginal. So everyone needs to know why that question is being asked across the board.

CHAIR—Precisely, yes.

Ms Divakaran-Brown—As a matter of interest, when you present in hospital, the question is not, 'Are you an Aboriginal or Torres Strait Islander, yes or no?'. Rather, there are four options—'Caucasian, Australian Aboriginal, Asian, or Other'—and those questions were in fact framed for the health staff to ascertain risks associated with particular conditions. So there is a misunderstanding in the community that the question is 'Are you Aboriginal or not?' but certainly in other collection systems the question is just, 'Are you Aboriginal or Torres Strait Islander? Yes or no?'

Mr Dixon—It is also part and parcel of the need for the Aboriginal cross-culture training program to be conducted in mainstream services. I mentioned earlier that one of the major problems is access to those types of operations, and the more non-Aboriginal staff are made aware of Aboriginal culture and issues of that nature and being trained accordingly, we believe that will also be a large stepping stone towards addressing the types of issues we are talking about with respect to identification, et cetera.

Mrs GRACE—You mentioned in your submission about Aboriginal hospital liaison officers. The theory sounds great, because it is making people aware of the cultural differences and how things can be different. Are they actually in existence? If so, what do they do now?

Ms Knowles—We have hospital liaisons based in most of our major metropolitan based hospitals. Their role is to provide smooth pathways through the hospital system for Aboriginal clients. How effectively that operates is really up to individual health units and hospitals actually. But, overall, I think that hospitals appreciate the role that AHLOs provide. Particularly remote patients who come down from the remote regions appreciate that service too, because it is about dealing with unfamiliar environments. They pick people up from the hospital and take them to the hospital, help them through the admission process, do some welfare work, link them to other services within the hospital and other allied health professionals. So they are a valuable tool within the hospital system. But unfortunately, like anything else, there are not enough of them.

Mrs GRACE—That is probably where I am heading with my questioning. If you expanded this role, what would you see them also doing? Or can't you see any expansion in that role?

Ms Knowles—That is really big question, isn't it? I think that there could be teams of Aboriginal professionals within a hospital setting providing a range of services—

for instance a specific transport person who does all of that transport-type work, not just to and from hospitals, but to the hostels after release from hospital, and for outpatient appointments. I think there is always a role for AHLOs. For instance, our Queen Elizabeth hospital has a renal unit which has a lot of our Aboriginal clients, so that hospital needs to have some specialised type Aboriginal hospital liaison people. So we need the generic one that visits anybody, and one with a specific renal focus who can focus on specific issues for renal unit clients, because they generally have to relocate to come down, and those sorts of things.

You need to have people who direct policy. You cannot have a service delivery level and no policy level, I think, because often it does not match. You need to have people who work in the staff development unit around cross-cultural issues, in the health promotion unit, making sure that all health information material generated by hospitals has an Aboriginal focus, and also an Aboriginal targeted area for specific diseases which are relevant to that hospital, which can be pulled from the hospital statistics and the hospital separation data.

Mrs GRACE—Has there been any encouragement for this to develop from the state government? Are they moving towards perhaps developing these teams, even if on a small scale? Or is still staying just with your liaison officer where you can find one?

Mr QUICK—And following on from that, shouldn't you change to Aboriginal health liaison officer, and have a TAFE course of say two years in which you get some accreditation? You come in at one end just basically being a 'counsellor' and use this as a stepping stone through the health—not necessarily hospital—system. The education department can say, 'We're doing our bit for health by having a nationally accredited TAFE course,' and at the end of two years you can get your associate diploma, and if you want to go to university there is the next stepping stone, but there is this synergy between departments.

Ms Knowles—We were actually just talking about that earlier this morning in relation to Aboriginal health workers. What we are seeing with the Aboriginal primary health care certificate, which is offered in the state here to Aboriginal health workers through the TAFE system, is that Aboriginal people are undertaking the course, are going out and getting a few years experience in the field as Aboriginal health workers, and are now wanting to take the next leap into nursing or allied health professional areas. So the same could be done for the Aboriginal hospital liaison officers, providing career pathways for them.

Last year an Aboriginal hospital liaison officer review was initiated by the Aboriginal health division and the Aboriginal Health Council. A series of recommendations was put forward looking at issues around training and development of Aboriginal hospital liaisons, and career development in terms of maybe some of our AHLOs here going to work in the Alice Springs hospital for a while and learning about

that type of setting, and vice versa, because I think there is miscommunication between hospitals about roles and functions of AHLOs. That is about to be implemented over the next couple of months. But I think the Aboriginal health worker review which Brian highlighted before will actually encompass a lot of those issues around training development, support, career structures, and pathways.

Mr QUICK—Are you aware of what other states are doing? Is it a similar thing, or are you totally unaware of what they are doing?

Ms Knowles—I do not know that much about what other people are doing.

Mr QUICK—Do you have the best model? There is Western Australia and Queensland. Does anyone know? We have this Commonwealth-state agreement. It all sounds wonderful, but if South Australia is going to develop the best model and no-one else knows that it is going on, and it has already done all the hard work and introduced this TAFE course, and Western Australia goes through the same stupid, reinvent the wheel process—

Ms Goodes—I think the idea of a review of the Aboriginal health worker training—primary health care training—would encompass the fact that you would be looking across the country to see what is happening in other states as well. It is really clear that it is a major area of need. I just wanted to make the point about Aboriginal hospital liaison officers that often their ability to be able to perform their role is commensurate with the sort of support they are getting from within a large institution like the hospital anyway. What we have found via the plans and consultation is that when there is high-level management support for the work of Aboriginal hospital liaison officers, or an acknowledgment of the issues for Aboriginal people entering a hospital, then it is more likely to be those hospitals that support the work of Aboriginal health workers. There are all sorts of layers in there.

Mr QUICK—So if we said to you, 'Can you tell us which hospital in South Australia is best practice, the best?', can you tell us?

Ms Knowles—Yes.

Mr QUICK—Well, can you tell us, because we would like perhaps to go and visit it. If I suddenly found myself in this hospital, how would I know this person existed? Does he or she have a badge or a different uniform, or what? Tell us the hospital; I would love to know. We are not casting aspersions on one against the other, but tell us what you think is the best.

Mr Dixon—I would say the most appropriate hospital to meet with would be the Women's and Children's in Adelaide if you want to see an effective and appropriate model that supports the role of the Aboriginal liaison officer.

Ms Goodes—And the other community health support that works in with the Women's and Children's Hospital is the community health centre, Adelaide Central Community Health Service. That has a team of Aboriginal health workers that have developed over the last four or five years. They have their own separately incorporated Aboriginal-only committee that oversees and is in partnership with the mainstream health service that employs the Aboriginal health workers. They work quite closely with the outreach services from the Women's and Children's Hospital. So it is a model of the way in which, at a metropolitan level, community health and a major teaching hospital are working together. It is worth a look.

Mrs GRACE—Have you enough people to do these jobs or are you really scratching to find people willing to do these jobs? I am not just talking about hospital liaison officers. You were talking about training health workers and reviewing the health work program. Are there enough people out there willing to start or willing to be educated and trained up, or is it a real case of having to go out and try and find recruits?

Ms Knowles—I do not know the numbers, but I know that we have got a pool of Aboriginal people who have undertaken the primary health care certificate who are just waiting for an employment opportunity. So I think we have a nice tidy group of people. We just have not got positions and/or the funding to place them, which I think is the sad thing.

Mrs GRACE—Yes.

Ms Knowles—You encourage people to undertake training and education, and are not providing opportunities at the other end of that.

Mr Dixon—I think one of the most important things along those lines is the need for us to promote the role and responsibility of the Aboriginal health worker and the Aboriginal liaison officer, who ought to be seen and respected and understood as being an integral part of an Aboriginal health service. It ought to be supported accordingly by a worthwhile employment package that recognises the role and importance of an Aboriginal health worker in the system, whether it be in the mainstream system or with an Aboriginal health service.

Mrs GRACE—My last question then is in relation to the health workers and your liaison officers working across your cultural differences, because within your own community there are huge cultural differences. Is there an acceptance that, 'I'm a health worker, so regardless of my cultural background I'm accepted by other areas of the community'? Or is there this barrier still that 'Hey, I'm from this area; therefore I can't work with that person from that area'? Do you know what I am trying to say?

Ms Knowles—Yes.

Mrs GRACE—I know that is a problem you have within your own community.

Ms Knowles—I will just talk from an Aboriginal hospital liaison point of view. What we found through the review was in fact that it was one of the greatest dilemmas experienced by Aboriginal hospital liaison officers, particularly women who had to work with traditional Aboriginal men who came down from our remote regions. It put them in a culturally compromising situation, and there was in many instances no acknowledgment from the organisation that they were in fact putting the AHLO in a culturally compromising position. What we need to look at is not only numbers of Aboriginal people but appropriate gender balances, and even appropriate age balances, because it might not be appropriate for a young Aboriginal man or boy to be doing certain things with a traditional Aboriginal man. So the cultural dilemmas are huge.

I do not think it is so great in terms of Aboriginal health worker work, although I do know that there is the gender difference, too—that it is not seen as appropriate for Aboriginal women to work in the realm of Aboriginal men's health business, and vice versa. These are important considerations when we are thinking about work force development.

CHAIR—What you are saying is that there are barriers to encouraging those health workers to work in the mainstream sector where there is heaps of funding. Is it impossible that it could work that way?

Ms Knowles—I think what needs to happen is that there needs to be organisational recognition that just because you are an Aboriginal person does not mean that you are culturally appropriate, and that Aboriginal interaction is very much about relationships, so it goes deeper than just having Aboriginal people employed. You have to think very strategically. Looking at, for instance, the Royal Adelaide Hospital, in 1995-96 it had 1,100 Aboriginal hospital separations and 700 of those were Aboriginal men. So you might need to be thinking about this hospital's particular need to have male hospital liaison officers, young and old, whereas in another hospital, the Women's and Children's for instance, it is the balance of older and younger women too. It is not just gender, but age, which is very important.

CHAIR—It is not impossible though, is it?

Ms Knowles—No, I do not think so.

CHAIR—I wanted just to explore it, but I will defer to you guys. It is not impossible though, is it?

Ms Knowles—It is about the cross-cultural training that Brian was talking about, ensuring that the health system, the health sector, gets comprehensive cross-cultural understanding about those cultural implications in terms of service delivery to our

communities.

Mr Dixon—Just on that point, too, it is also the attitude of the hierarchy in the mainstream services, understanding, accepting, and respecting that there are these important cultural issues that affect the appropriate treatment of an Aboriginal person who comes into a mainstream service. It is not impossible; however there are going to be funding issues that are going to be talked about, as they always are, and it is a matter of working out the priorities in the eyes of people who have that responsibility in weighing up these issues that we have outlined and the funding responsibilities, and the overall priorities within the mainstream health system. We are arguing that for Aboriginal people those things ought to be considered and addressed accordingly.

Dr NELSON—I have a series of questions, some of which are provocative. Firstly, is there yet a national accreditation system for Aboriginal health workers?

Ms Knowles—No, there is not. Actually last year a national Aboriginal health worker conference was held in Sydney, the first one in 20 years, and one of the major recommendations that came out of that conference was in fact the development of a national accreditation board. I know that the Aboriginal health worker forum at the state level is looking at ways to become accredited, and they are looking at the Northern Territory model and looking at ways to link themselves to other health professional accreditation auspices.

So it has not happened as yet but it is definitely in line with the national competency standards which have been developed for Aboriginal and Torres Strait Islander health workers and in line with some of the work force initiative strategies that have been developed at the Commonwealth level. National accreditation is definitely something that Aboriginal health workers themselves are asking for.

Dr NELSON—Is that something that you think we should be recommending to the Commonwealth government to pursue, to implement?

Ms Knowles—Personally I think, yes.

Ms Goodes—Yes, indeed.

Ms Knowles—Because I think one of the big barriers we have found with Aboriginal health workers and their work with other non-Aboriginal health professionals is the status they are afforded, and the credibility they are afforded, and all of those sorts of issues. So we think that by having an accreditation board which is along the same standards as doctors and nurses have actually creates a measure of professional credibility, and that might raise the status of Aboriginal health workers in other health professionals' eyes.

Dr NELSON—The second thing is liaison officers in the hospitals. Is there any kind of orientation in South Australia to new medical and nursing staff who come to work in the hospitals about Aboriginal related issues? Is there any program that has been established to ensure that the new doctors who come to work in the hospitals actually understand Aboriginal issues, or at least have a modicum of understanding?

Ms Knowles—The division over the last two years has been working with the Adelaide University and Flinders University to deliver a one-day workshop with sixth-year medical students around culturally appropriate health care practices for Aboriginal clients. Isn't that a mouthful? It has been very successful. It is only one day, but what we do is take the medical students through a journey. Aboriginal people always talk about knowing our history, so we do a brief overview of history. Then we talk about how that history might impact on interactions with health professionals. Then we look at processes within hospitals that we might be able to utilise to address them, that is AHLOs, the social and welfare department, and also personal things that you can do about knowing networks within communities, for instance Nunkuwarrin Yunti, various metropolitan based Aboriginal medical services around. So whilst it is not as comprehensive as we would want, and probably not enshrined in concrete, we have a pretty good relationship with those two universities to ensure that sixth-year medical students at least get one day.

Dr NELSON—What about during the orientation week for nurses and interns and all that?

Ms Knowles—No.

Dr NELSON—Should that be the case?

Ms Knowles—Absolutely.

Mr Dixon—It certainly should be, and again I do not doubt that the hospitals have their own orientation programs, but I would imagine that the Aboriginal content would be limited. We have just employed a cross-cultural training person to begin cross-cultural training program development within the mainstream services, and we are certainly hoping that that will form a large part of this orientation program for non-Aboriginal personnel within the health system.

Dr NELSON—I realise that there are some individuals who, in a philanthropic sense, go out to provide services to Aboriginal communities. Is there a formal program running in South Australia where doctors, and specialists in particular, are visiting remote and rural communities and providing educational and clinical services? If so, in what way could the Commonwealth further support that?

Ms Goodes—The Commonwealth program for the delivery of eye health services has just undergone a review last year, and the outcomes of that review are being looked at

in South Australia in the next couple of weeks. In that particular program, ophthalmologists, through the Eye Health Committee here in South Australia, were regularly visiting remote Aboriginal communities in the north and west of South Australia. In most cases, in answer to your question, it happens in an ad hoc way dependent on historical or whatever kind of arrangements where specialist doctors do go. Nothing happens really in a formal sense, and the whole issue of specialist services to remote communities is a big issue.

Dr NELSON—I presume from what you are saying, though, that there ought to be a formal process—and not just for Aboriginal communities, by the way—or program established that builds on the preparedness of those specialists who are prepared to do that.

Ms Knowles—Yes.

Ms Divakaran-Brown—Dr Nelson, to add to that, it also has to do with the attitude of the community controlled health services to access those facilities. I know personally of specialists who have made offers to go out gratis, and those offers have not been taken up. I think that is an important matter.

Dr NELSON—Yes, thank you. I appreciate that. There was a housing for health project which ran in South Australia I think about three or four years ago, the outcome of which suggested that health indicators improved where people were building their own housing and so on. I think it was in the Pitjantjatjara group. Is there any program like that continuing on an ongoing basis? Related to that, if there is overcrowding or a lack of housing in a particular community, does your department have the capacity to insist that that become a priority? If 30 per cent of the kids have got pus in their ears and all that sort of stuff because there is no housing, do you have the power to do that?

Ms Goodes—We had an example of that coming up in the plans at Yalata, which is over on the west coast, where there are about 46 houses for over 350 people, and that situation has been that way for some time. Up until now our department, as in Health, has not necessarily had the power to try and say, 'This is a particular issue.' In Yalata, for example, there is an extremely high incidence of gastroenteritis at the local Ceduna hospital which you would imagine would actually be linked to the environmental and housing conditions in that particular community. But, no, it has not been possible to necessarily intervene when you can see that that has actually been the case.

But the development of an Aboriginal housing agreement here, and assigning then an essential services agreement, and the Aboriginal health partnership, could well in the very near future provide a situation where we can say, 'Well, the situation in Yalata is an absolute priority. We should be working on this together.'

Mr QUICK—That is a good example of synergistic planning, is it?

Ms Goodes—Yes, it is.

Mr Dixon—And as I think I was saying before, the whole concept of the Aboriginal partnership brings together appropriate jurisdictions. It may sound funny but in fact these organisations are talking to each other and sharing ideas and problems and resources, and in a cohesive manner they are able to address the types of problems that we are talking about around the table. Certainly the housing for health project was conducted in the AP lands. There is a strong environmental push by the South Australian government in providing funding to enable the environmental personnel to be employed up there.

There is also a very strong association with the health surveyors from the South Australian Health Commission who work jointly with the environmental personnel on the AP lands, and they are heavily involved in the examination of the standard of houses up there, and insist, through the South Australian Health Commission Act, that that work be done appropriately, and that carpenters and plumbers who visit the AP lands, for example, do not do shoddy work any more. There is a strong process in a joint manner to make sure that the standard of housing and other constructions in these areas is up to date and appropriate.

Dr NELSON—Are Aboriginal people involved themselves in the building of their own dwellings?

Mr Dixon—From what I understand, yes, they are.

Ms Knowles—Yes, as part of the CDEP programs, I think.

Dr NELSON—Finally, I represent an electorate that has seven people who have identified themselves as being Aboriginal or Torres Strait Islander, so it is not a big group, but I have a lot of people who say to me that it is welfare that is killing Aboriginal people. What they mean by that is that the way in which we provide resources to Aboriginal people is in fact what is killing them. I must say I have some sympathy for this view—not in terms of programs that are being block funded or program funded and so on, but, rather, in terms of individual payments that are made to individual people in communities, a significant amount of which is spent on tobacco, alcohol, gambling, fast food, and so on.

Over the last 10 years, apart from perinatal mortality, has there been any improvement in any health indicator for Aboriginal people in the state of South Australia, and do you think there would be any support from Aboriginal communities for trying a different way of providing financial assistance to them?

CHAIR—If you feel more comfortable, take questions on notice, because I imagine we will have some discussion backwards and forwards as we really get to the bone on some of this.

Mr Dixon—Yes. I think with those sorts of issues we would certainly like to take those on notice. The other point, too, is that we are just a very small representation of Aboriginal health business in the state, and I guess we are talking about our experiences in the state health authority. I think I mentioned earlier on the question of whether in fact Aboriginal health organisations were also involved in this process, and I was advised that they have been, which is really important.

Dr NELSON—Could I just put another couple of questions on notice. How much does the South Australian government spend on health, and how much does it spend specifically on Aboriginal health?

Mr Dixon—Yes.

Dr NELSON—And when the national Aboriginal health strategy was reviewed, it was said that only remnants of it could be found. The argument had often been put that state governments had in fact not upheld their end of the commitment in terms of Aboriginal health strategies. Are you confident that the new agreement will rectify that situation from both the Commonwealth's point of view and the states' point of view? In other words, are you confident that the commitments that are made will be met? I realise that is one you can take on notice.

CHAIR—You might like to comment on the confidence issue.

Mr Dixon—Yes, I guess if we could take your last comment about how confident we feel about this new Aboriginal health agreement having an effect on Aboriginal health in South Australia, I mentioned earlier on that there was a whole series of reports, including the 1989 National Aboriginal health strategy report, and really there were not a lot of things that came out of that. I am seeing the Aboriginal health agreement document here in South Australia as a legal document which has been signed off by the heads of those four major stakeholder organisations. Certainly what is outlined in the plans here would suggest very strongly that the state government, in particular, in conjunction with the Commonwealth here in South Australia, is serious about Aboriginal health business, with support from the Aboriginal Health Council, which is the major advisory Aboriginal health body for South Australia—working very closely with that, and with support from ATSIC, who also have, on the periphery, health responsibilities.

Mr QUICK—So can the community Ms Goodes mentioned with 46 houses and hundreds of people have some assurance from someone that at the end of the year 2000, or 2002, their housing problems will be resolved?

Mr Dixon—Well, the interesting thing is—and I highlighted it earlier—that the Department Of Human Services here in South Australia, which is just newly established, incorporates the South Australian Health Commission, the housing authority, and also FACS. We see another example of this integrated process, like the partnership, which in a

more cohesive manner, we think, will address Aboriginal service issues a lot more effectively and appropriately. It certainly will not happen overnight, but we have certainly got the basis now where state and Commonwealth government departments and Aboriginal organisations are talking together and working together, I would like to think, a lot more effectively and efficiently than may have happened back in the National Aboriginal health strategy report days.

Ms Divakaran-Brown—It is seven years since the national commitment was signed by the council and the Australian government. This bilateral agreement was part of that national commitment. It has taken seven years to get to the signing of a bilateral agreement.

Mr QUICK—But the unemployment level of indigenous young people in South Australia would be pretty high, and yet the skills that you could learn by actually building your own homes in that area would provide employment and training and adequate housing and improve your health. Why isn't it happening?

Ms Goodes—Can I just say that Peter Miller, who is the chairperson of the South Australian Aboriginal Health Partnership and the executive chair of the Aboriginal Health Council, and who is actually my boss, says that the situation in Yalata is actually receiving attention as we speak, which I think is a result of the fact that these plans have come out—what Brian is talking about with the Aboriginal housing authority, and with the Department of Human Services. So there is attention happening to Yalata actually as a result of this.

Ms Knowles—I think another thing that we forgot to mention was the memorandum of understanding which has been signed between the Aboriginal health division of the South Australian Health Commission and the Aboriginal Health Council. The Aboriginal Health Council represents the community controlled sector and the communities, and is our peak advisory body. It was really important that the relationships between the government arm of Aboriginal health and the community control arm had a working relationship, so we have had a memorandum of understanding between us since 1996. All has not been smooth sailing, but we are committed to working towards collaboratively addressing Aboriginal health in this state. So there are layers of these partnerships being modelled at a range of levels.

Mr QUICK—So despite governments of all persuasions and all levels—local, state and federal—spending billions of dollars, we are finally getting to the stage—

Ms Knowles—Yes.

Mr QUICK—Do you honestly believe that this synergistic approach that addresses mental health and housing and all the other issues is starting to work in South Australia? Are you that confident?

Mr Dixon—I think what is happening with the organisations that we have been associated with is that there has been a reasonably transparent exercise whereby nowadays each of the individual jurisdictions is basically aware of what each other's roles and responsibilities are, and what resources each organisation has, and there is a working arrangement to say, 'Well, what are the priorities, under the umbrella of the partnership, that each of the agencies can work through to determine as a priority how we see a joint funding arrangement in a lot of these programs around the place?' That probably did not exist as harmoniously in the past.

Mr QUICK—So retention rates in schools for indigenous young people is going to hopefully improve, which means that they will be feeding into TAFE and university courses, so that, if you do not have a one-day course for GPs or a six-day course of people doing masters degrees, we will have a realistic feeding through the system of culturally aware and sensitive people who might make health one of their priorities as an educational process to solve lots of these problems.

Ms Knowles—I think that the health realm can only do so much and government can only do so much in improving Aboriginal disadvantage. Some of it is actually society. There are layers in this society which we need to change, which cannot be done by governments. That needs to be done by individuals through education. I think that in that context it is longitudinal, it will take time, but I think we have begun quite clearly in this state to demonstrate how a partnership approach can work. We have increased numbers of Aboriginal health workers in some of our regions. We have supported the Yalata example, for instance, through the identification of the plans—that that was an issue. The four partners have now lobbied around the place to make sure that issues are dealt with. So I think there are layers of it and it should not all be laid at the feet of government. Actually some of it is broader than the government, it is us as individuals.

CHAIR—Before I give the next question to Mrs Elson, I welcome Allan Morris, member for Newcastle on the north New South Wales coast, and Andrea West, member for Bowman, suburban Brisbane, a Queenslander. They have both come a long way; that is why they are a bit late. Let us have a short break.

Proceedings suspended from 10.58 a.m. to 11.25 a.m.

Mrs ELSON—Mr Dixon, you said in your opening statement that South Australia was divided into seven regions of Aboriginal health and that there was an Aboriginal on each board. Are the Aboriginals on each board for each region actually out of that region or are they from, say, an urban area, because they are educated enough to be there to speak on Aboriginal health? Are they coming from one area and being put on the board for that region to represent that region, or do they actually come out of that region and sit on that board to advise what that region needs?

Mr Dixon—The regions have been set up under the South Australian Health

Commission and in fact it is for the general population of the state whereby those regions have been established. It is not for Aboriginal health purposes alone. I just make that point.

Mrs ELSON—It is not for Aboriginals.

Mr Dixon—No. A regional board has been established to look after the health activities of that particular region. In the establishment of that board there was a place set aside for one Aboriginal representative to put across arguments for Aboriginal health needs and concerns.

Mrs ELSON—In that region?

Mr Dixon—In that region. The Aboriginal person has been elected by the community as such as the appropriate person for that board. However, when you look at a couple of the regions, the larger regions in particular, that person has a very difficult job in representing three or four various Aboriginal groups in that area. We have argued about that for quite some time in conjunction with the Aboriginal Health Council, and to date we have not been able to have the number of Aboriginal representatives expanded on the regional board. But it certainly is an important thing, and there is a need for more than one Aboriginal representative on that board.

Mrs ELSON—Yes, because there appear to be problems within Aboriginal culture—which, as we know, is very diverse—if you have an Aboriginal representing somebody in that region who is not from that culture. Having had experience with Aboriginals fairly extensively in the past, and presently, they do not seem to take advice from or notice somebody who has come out of a different culture or is not a full-blooded Aboriginal, if they come in and try to solve those problems in that area. Is that your experience over the years? That is what I am worried about. We have not been able to solve this problem over many years, and we are on this merry-go-round, not getting off and not solving the problem. It gets quite frustrating. Could it be that the communication between the different cultures is not there, and that is why we cannot solve this problem?

Mr Dixon—We talked about that a little bit earlier on during the interview. Those types of issues have been taken on board, and certainly taken on board by the Aboriginal component, of the responsibilities of health in each of the regions there. Once again, we talked about the cross-cultural training programs for the non-Aboriginal component.

Mrs ELSON—If you do not start on the board and with the regions, how are you going to finish or solve the problem? That is what I am probably trying to say. If you do not get it right first you cannot change it. When you do have your problems in your hospitals and find that certain communities have a fairly high health problem in that area, I would have thought that the person on the board who is representing that region would be the ideal person to go in and communicate with the areas to see how they can solve it.

But if he is not from that region they are not going to listen to him.

Ms Knowles—That is one of the key reasons why the communities elect or nominate their representative, and that is another reason why the Aboriginal advisory committees which we are establishing are absolutely vital, to make sure that the Aboriginal representation works effectively on regional boards. Where there are regions where you have various clan groups, particularly the Eyre region and the far north-west of our state, you would ensure that your Aboriginal health advisory committee, which has a direct link to the regional board as an advisory type of subcommittee, would have representation from the various factions, if you like, within a region. You will never get consensus. Even those people we have elected as ATSIC representatives are not seen by other people in a particular area as representative. I think that is true for non-Aboriginal society as well as Aboriginal society.

Mrs ELSON—Yes, most definitely.

Ms Knowles—But that is why it is vital that the partners support those Aboriginal health advisory committees, and it is also equally important that we provide training development to the Aboriginal rep on the regional board, to ensure that, firstly, they get Aboriginal issues on the agenda and, secondly, they know how to progress them. It is not just about having a token Aboriginal person sitting on a regional board because it looks good; it is actually about making sure that Aboriginal health is a priority in the regions, and is not an Aboriginal people's priority but is the priority of everybody in the region. Aboriginal health is not our problem; it is our community's problem as a whole: everybody in it has a role to play in advancing Aboriginal health.

That is what the regional board, Aboriginal health advisory structure should be working towards: increasing the capacity of community controlled health services to deliver an appropriate level of service, but also ensuring that the mainstream health services within that region are providing adequate or appropriate resources to Aboriginal health, either in direct service provision or in supporting community controlled services to do their job. But that sets us up, because half of our state does not have community control and we need to be looking at and exploring the communities, as to whether they are appropriate mechanisms for them, and what type of service delivery they want. Community control is not just about providing a service; it actually provides an identity for people within a region. They are issues which we are exploring across the state.

Mrs ELSON—How many people are on the board for each region?

Ms Knowles—Ten.

Mr Dixon—The other thing about the regional boards, too, is that in dealing with health, or any other issue that affects Aboriginal people, there is the need for information. You can have people on boards who may get their papers a day or two beforehand, but

not have a full background on the issues that are being discussed. We argue that is important for people to be able to make informed decisions about a whole host of issues. That does not happen to the extent that it should; certainly on non-Aboriginal structured and controlled boards or committees it happens more regularly. We think it is really important for the Aboriginal community to know what things are going on around the place so that informed decision making processes can be activated.

Mrs DE-ANNE KELLY—Mr Dixon, thank you for a most interesting report. You said that each region requires an individual approach because of the cultural differences. Are the cultural differences also implicit in the way in which mainstream services administer Aboriginal health? What I am saying to you is: does the Aboriginal culture define a different way of administering, of taking responsibility, of choosing those who are responsible? It is far beyond just a matter of manners, and painting and dancing: is it inherent in the administrative arrangements in Aboriginal society? You have also made the point in your report that the traditional health beliefs, the spiritual causes for illness and so on, are quite an impediment to accessing mainstream health services. Should we be making it easier for Aboriginals to access mainstream health services, or should we be changing the cultural approach of mainstream health services so that Aboriginals will find them acceptable within their cultural context?

Mr Dixon—One of the major issues that arose from the Aboriginal health partnership exercise and which is contained in the plans there is the need to make mainstream health services a lot more accessible for Aboriginal people. It is an alien environment for anybody—nobody wants to go to hospital—but going there away from family, away from friends, away from your children, et cetera, is a pretty daunting prospect, especially for people coming down from the AP lands to the Royal Adelaide Hospital. We are arguing that people who go into a mainstream service ought to feel as comfortable as one can feel undergoing an illness in an alien environment.

Hence the need for mainstream service providers to be trained in a more appropriate way, to make non-Aboriginal staff aware of Aboriginal lifestyle and Aboriginal cultures, and to have respect for traditional values, et cetera. Yes, it does happen in some mainstream services whereby the cultural aspects are taken into consideration, but in the majority it is not, and that is a fault on both sides to a certain extent.

Through our cross-cultural training program that is being developed at the moment we will see an increase in cross-cultural training programs occurring in mainstream services—not, as they do at the moment, on an ad hoc basis, but having a formalised program attached to each of those services. We will in fact have written into service agreements the need to fund and run cross-cultural training programs. Amongst other Aboriginal health issues, that has come out of documents of this nature, and we are having those formally inserted into legal documents like health service agreements that highlight the funding arrangement that you have from a state health authority.

Ms Knowles—Also with respect to the spiritual healing components, I think that we need to be promoting two-way medicine where non-Aboriginal health professionals respect and recognise the role of spiritual healers and the spiritual realm in Aboriginal lives. I think that is the role that the Aboriginal health worker can play in providing information and advice to the non-Aboriginal health professional, but also relaying that same medical message back to communities. So they play a cultural brokerage role, and they are vital in the remote rural setting in doing that.

Mrs DE-ANNE KELLY—How many Aboriginal doctors are there in South Australia?

Ms Goodes—None.

Ms Knowles—We have got someone who is in sixth-year medical school, but we do not have any Aboriginal doctors.

Mrs DE-ANNE KELLY—That is an Aboriginal person in sixth year medical school?

Ms Knowles—Yes. We have got four actually currently. The South Australian Health Commission is offering a sponsorship—what is it called?

Mr ALLAN MORRIS—Which would disqualify them from Abstudy, as the Queensland government does.

Ms Knowles—Does it?

Mr ALLAN MORRIS—Yes. This will come up in one of the hearings, hopefully, but there is a disgrace at the moment where a student at university on a Queensland health scholarship has lost his Abstudy because of that. It is absolutely disgraceful.

Ms Knowles—I thought it was only if you hit the $6,000 threshold and we sort of jigged it so that he would not get that.

Mr ALLAN MORRIS—If it is offered by a state government to a student then the Austudy rules currently—and the ministers for health and Aboriginal affairs both refused to change it—it disqualifies them from Abstudy. So the thing they are trying to do with the state scholarships is actually effectively remove them from eligibility for Abstudy. We have to think of another way. I would encourage you to think of another way of doing it where you actually do what you are doing, but watch out because the Commonwealth rules are now so rigid that I have got a student now who has to pay—

Mrs DE-ANNE KELLY—Point of order, Mr Chairman. We are here to hear these people who have travelled a long way.

Mr ALLAN MORRIS—Well, I am engaging—

Mrs DE-ANNE KELLY—Thank you for making your point. It is an educational point, Mr Morris. Mr Chairman, I would ask you to run this, please, strictly to the rules. We would like to hear our witnesses. They are most interesting and well-informed.

Mr ALLAN MORRIS—It is nice to be here. Nice to see you, Mrs Kelly. It is the first thing I have seen you at for a very long time.

Mrs DE-ANNE KELLY—Moving on, Mr Dixon—

CHAIR—Perhaps Mrs Kelly is right. Could we just have her question addressed. Mr Morris is trying to make a useful point but you have got the last question.

Mrs DE-ANNE KELLY—I thought I had the call. Thank you, Mr Chairman. Mr Dixon, in the report you make the point that medical schools do not sufficiently prepare health practitioners because of the multiple problems and the limited understanding of the social relationships and their effect on health care. Is that being addressed in your opinion?

Mr Dixon—Yes. I guess that it was touched on a little bit earlier on by Vicki—that there are some minor education programs that we run to prepare sixth-year medical students prior to them going into the open market of employment. It is certainly not being addressed to the extent that it ought to be, but we see that, with a combination of cross-cultural training programs, as probably forming the basis of educating doctors and specialists, once they go into the open market. However, I make the point that there are also Aboriginal run health services who do employ non-Aboriginal medical staff, who also provide an important education mechanism for those doctors who are working with Aboriginal organisations and communities.

Mr JENKINS—Dr Nelson put a question on notice about health expenditures in the state of South Australia. Can I just ask if you are able to supply those with regard to the figures for the overall state health budget, and whether you can make comment about the way in which Aboriginal people access that part of the budget, therefore converting it back to perhaps a per capita figure—and then in relation to the specific Aboriginal health funding we can get a better idea of the coverage.

My second question follows on from Mrs Kelly's questions about the importance of spiritual aspects. I wonder, when we decide upon the measures that we are going to use to plot outcomes, whether, from the viewpoint of Aboriginal people and Aboriginal communities, we should be perhaps using some different measures that they should develop that go not only to the health of the individual, but to the important aspect of the health of the community, however that might be defined. I suppose that may be something that you can assist us in, in giving us a bit of a key to the way that might be developed,

and it is also a comment about the continuing need to straighten out the relationship between the individual and that person's land, and the effect that that has on their spiritual wellbeing and then on their physical wellbeing.

Ms Knowles—In terms of your question about expenditure, the national performance indicators in Aboriginal and Torres Strait Islander health, which all jurisdictions have been asked to report against yearly to AHMAC, actually has a performance indicator around expenditure, and what we have found in each jurisdiction is that the Aboriginal identification issue makes it really difficult to get down to per capita spending on Aboriginal health. There are initiatives and processes in place between Commonwealth and state to address how we actually tease out from the total health dollar spent how much is actually spent on Aboriginal health, because we can look at the specific Aboriginal health dollars which are targeted, but how you actually examine how much money is spent on a client when they access the community health services versus the hospital is really difficult at this point, so that is a process which is in train.

CHAIR—We have already come across that, and I suppose that is why Mr Jenkins is pursuing that question. It would give us an answer to what is often referred to as a mainstream sort of view—that we throw, on a per capita basis, a lot of money at Aboriginal health. In reality it is probably—I think it was Mr Morris who made the point in Hobart—plus 10 per cent. We do not have a good handle on it. It is amazing that after 20 years we still cannot have a good handle on the data and the identification. That is a frustration we have already come across. It could be helpful to perhaps take that on notice. Are you happy with that one on notice, Mr Jenkins?

Mr JENKINS—Yes.

CHAIR—Mr Morris has been waiting patiently.

Mr ALLAN MORRIS—Mr Chairman, firstly I will make just a couple of comments. The point I think Mrs Kelly has to understand is that at hearings if an issue comes up that we have interest in, we do in fact cross-question. That is obviously what we do; otherwise we run the same question five times. The point I want to make—and it is appropriate to make it now, and I am trying to encourage your government to look very carefully at it—is that there was a situation in Queensland last year where a Queensland health scholarship was awarded to an Aboriginal student to study medicine. The young man, who has made a submission to the inquiry, hopefully will appear as a witness. He is an impressive young man, ex-Palm Island, left school at 15, a wonderful role model, went to Abstudy and said, 'I've been offered a scholarship. What's the score?' They said, 'Fine, take it.'

So he worked out his lifestyle, set himself up in Newcastle so he would not have to work, so he could afford his books, all the things he needed, and three months later he was told they had made a mistake. His Abstudy was wiped out. The actual income from

the scholarship was less than Abstudy, so he ended up with a lesser payment. He has now got substantial debts. I hope he passed last year. The last time I saw him last year he was frantic during his exams, because he had to move his accommodation; he could not afford to pay off the car that he was buying. The department admits that he was wrongly informed, but bad luck. I am trying to encourage you. The Queensland government's proposal was great, because for as long as this scholarship lasted, he would be indentured. They could send him to any remote area they wanted to as a doctor, which is ideal, and he was happy to do that.

The intent was excellent, but the liaison between the Queensland state government and Abstudy was obviously inappropriate or inadequate. I am trying to encourage you to encourage your department to help with those schemes, but watch out, because Abstudy is now rigid and inflexible. There has been lots of correspondence backwards and forwards to ministers and God knows who else, and that young bloke still spent most of last year on $3,000 a year less than he would get on Abstudy. The point is worth making. By the time he appears before us as a witness, it will be another month away, and I am trying to change it before the university year starts. It is about to start now. So talk to your department, and if you can find a scheme, by all means do it.

The second point I wanted to raise, Mr Chairman is this: I am not sure if you are aware, but one of the major benefits of these inquiries is that the submissions that are made are available to the whole countryside. Your submission was really very late, which means that no-one else has got it. It will not be available to the people who are following the inquiry in other parts of the state. We have not seen it until this morning. Can you explain why that is? And I have one more question after that, just briefly. Why has it taken so long? Was there a particular problem?

Ms Divakaran-Brown—The procedure is that it was a whole of government response, which was signed off by cabinet, so whilst the individual agencies put in their submissions, premier and cabinet then collated the response. It was then brought before cabinet.

Mr ALLAN MORRIS—I would just like to put for the record the point that your government is clearly supportive of this area—I have only been here a short time—and your submission is excellent, and you are one of the first to sign the agreement, so it is not as though I am being critical, but I think perhaps it is important to realise that one of the real benefits is that documentation of your position being available to both your community and to other communities around Australia. But it had come so late. That means it is not circulated.

Mr Chairman, my final question, just briefly, is this. One of the things that came through as very important, from ATSIC in particular, was the problem of communication, and saying, 'There's the health budget,' which is about delivering of services. One of the real problems that they have in their finding is that any squeezing of government

expenditure tends to cut the intangible areas which cannot be seen as being directly health, but which are so vital to communicate health profiles and health policies. So access to the mainstream system, explanation of things or preventative medicine are areas where funds are being squeezed, and that of course undermines the actual health part. Is there a response to that? Your submissions does not seem to indicate that is the case in South Australia, but is there a deliberate program to make sure that there is a health communication strategy in place for Aboriginal health—that you are actively pursuing communications, both within the communities and within the system itself? Are there funds dedicated to that which have been maintained?

Ms Goodes—The implementation of the regional plans has been agreed to be jointly funded by the Commonwealth and the state until June 2000, which is an example of a commitment to an ongoing process of communication, not just between governments at a state level, but also from local and regional Aboriginal communities.

Mr Dixon—And the other point, too, is that ATSIC is a member of the partnership. Not only is the state manager of ATSIC part and parcel of the discussions that take place with the partnership, but the elected arm of ATSIC representatives is also part of the dialogue that happens within the partnership environment.

Mr ALLAN MORRIS—But ATSIC was saying that what they are finding with the squeeze was that whilst they are hanging on to a lot of the health services, they are being squeezed on the communication of services of health. That was an ATSIC comment. I am sure, Mr Chairman, it was ATSIC who said that. It was ATSIC last in Canberra.

CHAIR—We have spoken to ATSIC in Canberra.

Mr ALLAN MORRIS—I am sure it was they who were making that point to us.

CHAIR—We could come back to that point.

Mr ALLAN MORRIS—There is no delineation here of actual funding for communication as contrasted to services, is there?

Ms Goodes—Well, I guess it depends what you mean by communication.

Mrs WEST—How many health workers are there in your department?

Ms Goodes—Aboriginal health workers?

Mrs WEST—No, the whole number first, all health workers—how many altogether? My second question is, what is the proportion of Aboriginal to non-Aboriginal?

Ms Goodes—You mean nurses, doctors, allied health professionals across South

Australia?

Mrs WEST—Yes. You have no idea?

Ms Goodes—I have no idea.

Mr Dixon—We will have to take that on notice.

Mrs WEST—The other question is: is there a cross-portfolio liaison—between the education department and employment department, for instance—to maximise your human resources in that respect in the Aboriginal and non-Aboriginal workers in those portfolios? Do the health workers liaise with the education department workers, and in what proportion in other portfolios? Is there communication between—

Ms Knowles—At the service provision level there is definitely a lot of interface. Aboriginal education workers work very closely with Aboriginal health workers, who work very closely with DSS workers and FACS workers. So on the ground it works really well. As you move through the system it becomes a very one-on-one relationship, so there is not a structured interaction between those particular agencies, but I think that with the development of the human services portfolio—once that begins to work smoothly—we could actually see that these are not working and that it will create opportunities to begin to work—because obviously education impacts on family and health issues. I think there is a great impetus at the moment to make that happen, because service providers are saying, 'Why aren't you making it happen at the policy level?'

Ms Goodes—Could I just go back. Whilst we do not know of the hundreds and hundreds of non-Aboriginal health workers across all sorts of ranges in South Australia, we do know that there are 109 full-time equivalent Aboriginal health workers working in the state, and we know that because recently we were asked to pull out some figures of the number of those resources that work in the area of diabetes—that are designated specifically to work in diabetes—given that diabetes was one of the four priority areas across the state. From our statistics we found that there were 110 full-time equivalent Aboriginal health workers. There were six of those 109 that were designated to work in the area of diabetes, and only one that works at Nunkuwarrin Yunti, where you are going this afternoon, who was a trained Aboriginal diabetes educator.

So for something being nominated as a priority, not just in this state, but across Australia, the statistics of the number of Aboriginal health workers that were actually working specifically in that area were very small. That is really a statement about the fact that Aboriginal health workers have to do everything. They are generalist. They have to be a generalist across many areas, and there are just not the resources and training opportunities for them to be able to specialise.

Ms Knowles—We do know that we have met the one per cent employment

challenge for the health sector. What we also know is that most of those are in base grade positions and are not across all occupational levels or categories. The challenge for us now is to review that challenge and look at a one per cent challenge within occupational categories. That is something that the Aboriginal health division is working towards.

Mrs WEST—Is it your aim to increase the proportion?

Ms Divakaran-Brown—Absolutely. In terms of dialogue between agencies, there has been a forum of the heads of Aboriginal policy units within government that has been convened by the state Aboriginal affairs agency. That went on for about three years and then sort of died off a bit. There is an intention to reconvene that group.

CHAIR—I think we had better call it quits there. Can I thank you very much, Mr Dixon, and Misses Knowles, Goodes, and Divakaran-Brown. You have been very generous with your time, and no doubt we will be talking with you again. There are a number of questions on notice which Mr Nordin and Mr Kennedy will follow up with you. Thank you very much, and we look forward to some progress as a result of this. We do not know where we are going—it is only the third day of the inquiry—but we are starting to get a better grip on the issues. Thank you.

[11.41 a.m.]

FORSYTH, Professor Kevin, Head of Paediatrics and Chair, Information Technology Developers Group, Flinders University of South Australia, Sturt Road, Bedford Park, South Australia 5042

CHAIR—Professor Forsyth, before we proceed I need to point out that this is a formal committee of the parliament. We do not swear our witnesses, but I have to say to you that the proceedings are legal proceedings of the parliament and warrant the same respect as the House of Representatives itself. Any deliberate misleading of the committee might be regarded as a contempt of the parliament.

We have your submission and we are very keen to talk to you. This is the third day of our hearing and the issue of training of health workers has come up at every session, and again just a little while ago here. We are keen to take advantage of your insights and lean on some of your experience so that this inquiry can make real progress. In my opening statement today I indicated some frustration that after 20 years we have not got a better result. Obviously the training of health professionals of indigenous origin is a key to solving the issue. You might like to make an opening statement, and I assume my colleagues will have a few questions to tease out some of your expertise.

Prof. Forsyth—Thank you. A few years ago I was working in Perth at the children's hospital and I remember vividly having a four-month-old infant flown in from up in the Kimberley region with acute respiratory failure. This Aboriginal infant had advanced disease by the time he presented at Derby hospital. He was flown as quickly as possible to Perth and put in our intensive care unit, and I had responsibility for looking after this baby. His mother was brought with him. His mother was a young Aboriginal lady. She was put in the room next to the intensive care unit. We ventilated this baby, who had a treatable respiratory condition, for about 10 days.

During that time, his mother in the room next door did absolutely nothing. She did not eat. She did not talk. She must have drunk a little bit, but not much. She would lie across her bed, day in and day out. We actually became more worried about the mother than we were about the baby. We ended up getting that baby off ventilation and back up to Derby as quickly as we could, for the sake of the mother. The questions that I had, and that we had as health professionals in the hospital were, 'What's going on? Why is it that this young Aboriginal mother is completely incommunicative to us?' She obviously felt really out of sorts and was a complete misfit in the hospital environment.

I guess our answer was that we did not actually know, and we did not in those days—which was not all that long ago—have the Aboriginal liaison people to assist in finding out to enable us to know how to deal with her. It became clear to me at that point that, for me as a medical practitioner, I had never had any training in how to deal with Aboriginal people, or indigenous peoples, when they contacted the health service.

The other thing I would say is that at the moment in Australia the medical training for doctors has no program to educate doctors to deal with Aboriginal people. Across the medical schools in Australia there is no common curriculum on anything. Every medical school just decides what it is going to teach, and it teaches it. There is AMC, an accreditation body, that goes around every five or 10 years and makes sure that the basic medical program is okay, but there is no discussion across the medical schools about how they are teaching and what they are teaching.

In nursing it is slightly different. There is a nursing council who have decided nationally to have some competencies that need to be met. As I understand it, there are none around Aboriginal health. I may be wrong, but that is my understanding. There is no way of assessing or checking whether those competencies are taught well, and there is no common curriculum within nursing education.

My point of view is that education is the only way to empower people. Education is absolutely fundamental. The ABS statistics about Aboriginal health, in a 1997 booklet, show that only 0.5 per cent of indigenous people are training as health professionals. That was in 1991. It is the same in 1995—0.5 per cent. That is way less than the percentage of the population of 1.6 per cent. In terms of medicine and nursing, there were 263 enrolments in 1992, and 264 in 1996. So if you are thinking about indigenous peoples training in the health professions, we are doing a poor job.

If you think about the rest of mainstream Australia training in the health professions, we are also doing a poor job, because we are not equipping them to deal with the problems of Aboriginal health and the difficulties they have with accessing health services, and just being culturally sensitive, and making an environment in which Aboriginal people feel comfortable dealing with the health system. I feel quite strongly about that. I think there is actually a relatively simple way to address it. Within paediatrics, which is the only discipline I can talk about, we have recently met, since I wrote this submission, in November in Sydney. By ‘we’ I mean all the medical school paediatric departments in Australia—and New Zealand, because they actually wanted to join us.

We agreed to set a national curriculum to teach paediatrics throughout both countries. In that curriculum there were detailed issues about indigenous health that obviously had to be incorporated. We agreed to set common assessment tools across the board so we can share and check whether we are all actually doing a good job. We are going to underpin that with information technology as a way to do it, but I do not want to dwell on that just at the minute.

It seems to me that there is no reason why the medical schools, at a minimum, across the country, recognising the state of the problem we have, could not agree to actually incorporate in their curriculum an agreed framework for teaching medical students in a thorough and systematic way about indigenous health and cultural issues. I think it

could also be done in nursing. Nursing would probably be more amenable to it, actually, than medical schools. I can tell this committee that if the medical schools as a whole cannot agree to it, the paediatric departments can, and every medical student goes through paediatrics in their training. So I believe it is quite doable.

In terms of how you go about doing it, because it is a very complex issue, I have a few suggestions, but I am sure there are many better ways to do it. Indigenous health and cultural issues are complex, and need to be taught in a very standardised format. Basically a template could be used. The template could then be adapted for physio students, dental students, medical students, nurses, or whatever. The basic template—in other words, what is the curriculum, how we assess and how we teach these issues—would need to be built by I think an expert body consisting of educationalists, health professionals and indigenous peoples. There could be, for example, a board for training in health for indigenous peoples or some such similar body that could provide advice to the training institutions across the country about the way they could incorporate into their curriculum an indigenous health component.

I guess they are the main elements of what I wanted to say. The implementation of it I think could be through information technology. Bill Gates said just recently:

We at Microsoft strongly believe that the single most important use of information technology is to improve education.

I can tell you that the universities at the moment are very concerned about how they educate students using information technology and are investing large amounts of money in it. We are doing it extensively in my department, and around the country in paediatrics. The thing about information technology is that you can have a standardised format, and you can deliver it anywhere and any time. In it would be, for example, videos of Aboriginal people talking about their experiences when they contact the health system, talking about the ways they need to be handled and dealt with, talking about their spiritual values, their physical values and their group values.

All that sort of material could, without too much difficulty, be incorporated into an electronic format. That is the way such a curriculum could be implemented. If we expect medical schools and nursing schools and physio schools to all somehow tool up all this at an individual level, I do not think it could be done well. I think there needs to be a national template which could then be implemented nationwide.

CHAIR—Thanks very much, Professor Forsyth. You would be aware the committee last year completed a report we tabled in parliament on telemedicine. ‘Health on line’, we called it.

Prof. Forsyth—Yes.

CHAIR—The inquiry revealed some tremendous things being done with renal medicine here in South Australia. We share your enthusiasm at the potential for that. But I worry a little at the cultural difficulties of indigenous people being able to embrace that. I mean, that is not as easy as it sounds, is it?

Prof. Forsyth—The issue about telehealth is that essentially it is synchronous. In other words, it is like a telephone call with vision. It is on-line, it is mutually interactive, and it is quite intimidating. What I am talking about is essentially CD-ROM or DVD-based material.

CHAIR—Yes.

Mr ALLAN MORRIS—Working from CDs on Aboriginal culture and mores.

Prof. Forsyth—That is right. The value of that is that it is not so intimidating. It can be constructed over 18 months or two years with the appropriate inputs and checks and balances. It can be just burnt as a CD, which only costs a couple of dollars, and then it can be delivered anywhere, any time. It is actually a little bit different from the concept of telehealth, because, I agree, engaging indigenous people with that technology could be very difficult. I am also talking about using it largely in the populations who are training in physio and medicine and nursing who are very familiar with using the technology.

Mr ALLAN MORRIS—Professor, your concerns are very much reinforced by a submission from ATSIC which pointed out that in 1989 a survey of Queensland university medical faculty found that 80 to 90 per cent of students felt Aboriginal health was their own fault, and that it was their own responsibility—that they were responsible for their own ill-health. That was seven or eight years ago, and the feeling is nothing has changed much since then. So what you have raised is the question of a technical teaching aid, and the need for a national curriculum process, but how do we overcome the cultural problems of attitudes and prejudice and bigotry and ignorance and so on? I mean, that is all part of it, isn't it, when medical students in a major university have that view to start off with.

Prof. Forsyth—That is the very reason why we need to do this.

Mr ALLAN MORRIS—So they will still think it is their own fault, but they will know how to treat it.

Prof. Forsyth—The only way to overcome those issues you raise, which are very real, are through education. Actually, I think most students are quite malleable, and I think we probably underestimate the ability of students in learning environments to adapt and lose old habits and lose old ideas. I mean, that is what they are there for. Certainly in my experience of teaching medicine, there is a real willingness to embrace new ideas and new perspectives, so I would be fairly optimistic.

Mr ALLAN MORRIS—We have one of your students talking to us shortly. I am going to ask him that question. I put on the record that I am pleased with Professor Forsyth's response, and I hope his colleagues will be listening to him.

Mrs ELSON—Professor, I just wanted to ask you to relate to us about the young Aboriginal baby who came in. That is going back a few years ago, isn't it?

Prof. Forsyth—Yes.

Mrs ELSON—Has that happened since, and how was the mother handled this time?

Prof. Forsyth—I have not had quite such a brazen episode since, I must admit. I think the difference now, as you heard from the South Australian Health Commission, is that within our hospitals we do have Aboriginal liaison people. The difficulty is that when people come in, they access health service often out of hours, through the emergency department. They get new recruits, new RMOs, residents. I think in general there is a better awareness now, but it is still not good enough. I actually believe that until we have got a national curriculum running through the health professions and their training programs, we are not going to make a big impact on people's attitudes. It clearly needs to be multi-pronged. We need more indigenous health people trained so they can take ownership. That is clear—I am just assuming that, actually. I am talking more in a focused way about the rest of us who are the major part of the health system.

CHAIR—Have you got any Aboriginal students in your university currently studying medicine?

Prof. Forsyth—I am actually not sure. Not that I am aware of.

Dr NELSON—As it is my turn, I would just say that when I was president of the Australian Medical Association in 1994, I convened a meeting of the deans of all of the Australian medical schools specifically to ask them about doing just this, that a component of the undergraduate course be committed specifically to the teaching of Aboriginal culture. I understand that to varying degrees it has been done. There is nothing coordinated. A number of medical schools have nothing. Newcastle in particular, of course, has a significant component. I would suggest perhaps, Mr Chairman, that we might actually invite the chairman of the committee of deans of Australian medical schools to come and speak to us and put to him—it is probably not her, but him—what Professor Forsyth has said, and find out specifically what is happening, what perhaps their reaction is to this. I would strongly support it.

CHAIR—Where is he located?

Prof. Forsyth—Can I respond to that? The chair of that committee is Derek

Frewin, who is the dean of Adelaide University. In fact, I wrote to him, at his suggestion, telling him what we were doing in paediatrics with a national program. This is not to do specifically with indigenous health. He said, 'Well, that's novel,' so I really wrote to his committee and said, 'Does the committee of deans have a view on what we're doing?' I am still listening. But Derek Frewin is the person, and I think that is a good mechanism to pursue this.

CHAIR—No doubt we will be back through Adelaide. We might put that on the schedule. We would like to talk to him. We are desperate to get everybody involved in this, so we can get some determination regarding a direction.

Dr NELSON—Perhaps another useful thing for us to do, Mr Chairman, might be to see if it would be possible for us to speak to a couple of Aboriginal undergraduates about their experiences and so on. One of the things I think we need to be mindful of is that some indigenous people who do go to medical schools have aspirations to do something other than work in Aboriginal health, and are not always enthusiastic about being identified as Aboriginal background for that reason.

Prof. Forsyth—One of the national submissions I read talked about the need to support Aboriginal people in their training within the health professions, because not many make it, and they drop out. I guess one of the things I was wondering about was this: if there was some sort of grouping or board or something that looked at and examined this issue of a sort of national curriculum, they could also be used to support indigenous people who are training within the health professions, so they would have a role of overseeing curriculum across health professions, but also supporting indigenous peoples as they come into the health professions for training.

CHAIR—Not that I have formed any conclusions yet, but it seems to me that the urgency is not to necessarily have Aboriginal doctors and specialists, but to have the connection in the broad spectrum health support network. If they come to see an eye specialist, the fact that he is not an Aboriginal doctor is not the issue. It is helping them cope with the environment they are in, where the support network is that it is more important to have the cultural link. Is that a reasonable perception to have after three days of inquiry?

Prof. Forsyth—No doubt. The issue of connectedness—Aboriginal health people being able to connect with the health service, because clearly they do not at the moment—I think needs to be tackled in all sorts of ways. The point I am making is that if the health professionals are given appropriate training, at least they will be more sympathetic, and they will advocate within their health environments to make the environments more Aboriginal friendly. The reality is that, unless the doctors are actually advocating for it, it is not really going to happen that well, because they can block things, and they are the ones who are dealing with the patients. If we can get the Aboriginal people to feel more comfortable accessing health services, they will access them earlier. That is a major

problem, as you know. If they access them earlier, they might take on preventative health issues, and that is going to have an effect on their health outcomes.

Mrs ELIZABETH GRACE—Professor, it is probably a fairly obvious question, but I want to get it on record. Your suggestion of the training program within the medical schools—do you envisage it going a step further and specialising in areas? When young students come into paediatrics, cardiac, endocrinology or whatever it is that they decide they want to do, do you envisage it going that step further and encouraging them there also, or impacting a bit further on the differences, particularly with the diabetes problem that we have with the Aboriginal people, and the respiratory problems we have with them? Do you see that as part of your vision splendid?

Prof. Forsyth—Yes. Thanks for the question. Undoubtedly that is true. In fact, I see this as needing to be done at an undergraduate level in health professions for training, but obviously it needs to be taken up into the colleges—postgraduate training. In most health areas now, people who are in practice need to continue to be accredited in different ways. They need to undergo a continual training program. Clearly, something that was tailored well at the undergraduate level could then in due course be factored into the colleges, say the ophthalmology college, the O&G college, whatever—general practice, the CME points—as ongoing training so it would actually impact on training across the board as lifelong training. That would clearly be the direction it would go.

I suppose I would see that as again having this core template, and out of that template you could then bud off bits that were appropriate, at postgraduate level for an obstetrician, for example. What they need might be different from what is needed for a dermatologist, or what is needed for a general practitioner, or for a physiotherapist, or whatever. But yes, I see it as substrata early on, because people need to be captured early in their health training, but continue to unfold through their practice.

Mr QUICK—You were here when we heard the state people talk about this synergy between departments, and we were looking at their master plan, which I think is wonderful. They mentioned that there are a whole lot of contributing factors, and we were talking about preventative medicine and accessing things earlier. In something as simple as inadequate roads—because that contributes to eye problems and asthma—waste management, the problem of dogs, water quality and the like, how do you people fit into that so-called synergy, trying to get the various departments to talk to each other?

What input do you have to say, ‘If we expended X number of dollars and sealed all the roads in South Australia going to Aboriginal communities, there would be a perceivable difference in A, B, C and D, and the cost of that is wonderful compared to the problem when they all turn up in Adelaide, or wherever it might be’? You’re talking about having trouble getting colleges to come up with a national thing. What avenues do you have to say, ‘We are influential people. Listen to us.’ Were you involved in any of that?

Prof. Forsyth—No, and not so influential when it comes to roads. I would say I have no influence.

Mr QUICK—But there are simple things that you could say. 'Why aren't you listening to us?'

CHAIR—I am always being accused of bias when I say, 'Send the engineers in, not the doctors.'

Mr QUICK—You ought to say, 'We don't need to spend a whole heap of money in this preventative thing. It's something as simple as the vet liaising with the local community saying, "These dogs need to be immunised." We need to seal the roads, deal with waste management, drag the army in.' How is your voice heard in various government departments?

Prof. Forsyth—Through mechanisms like this, I suppose. Not really, is the short answer, because you have to ask what in our society is the role of academic medical departments in a broad public health problem, which is very complex and intersectoral in all sorts of ways. I do not know. I guess my view about all this is to say I have one perspective on one element of the issue, and that is why in my submission I said I am only addressing point C about education. The others are very important, I think beyond the scope of my expertise, quite honestly.

Mr QUICK—But could you see it as part of this DVD/CD-ROM thing—that that could be introduced?

Prof. Forsyth—Absolutely.

Mr QUICK—And something like what we heard at Kintore in the Northern Territory—that the women are not breastfeeding their babies because it is easier to go up to the store and get your tin of condensed milk and whatever it is, and make up a formula and stick a bottle in the kid's mouth.

Prof. Forsyth—Yes. I guess what I have not done here is outlined the components of what I think a curriculum might be, because I think that is another whole step and needs a lot of consultation process. Clearly there would be in that information on the context of the ill health of indigenous peoples. Why is it that there is so much petrol sniffing, and why is it that breastfeeding rates are low and there is malnutrition? What is it about their dispiritedness, their disconnectedness that is important? That is the sort of material that would be incorporated into a curriculum. What I would hope is that as the next lot of health professionals are trained, there will be individuals in that group who pick this up and actually run with it, and they will have done it from having the sort of basic bit of information given to them on which they can pick it up with a passion and drive it, and so there will be some individuals who might get up and advocate for better

roading. It will not be done by every doctor or every nurse, but that would be my hope. I think it would happen.

Mrs WEST—Given that change takes a very long time to impact positively in communities, can you see that it will take a long time to overcome those difficulties that we are presently experiencing through such a program as you are envisaging? That is my first question. The second one is: is your model designed for Aboriginal professionals or all health professionals?

Prof. Forsyth—Let me take the latter one first. It is designed essentially for all health professionals—health professional training. Within it I think would be those who are Aboriginal people who were training in the health professions. There could be some focused extra work if they wanted it, but I am talking about right across the board. In terms of timing, it might sound like this process would be slow to change the mind-set of people, but it was not very long ago when Brendan and I were working together at Flinders as fairly junior doctors, and now he is in a position of considerable authority, and I am much less so, but—

Dr NELSON—Working on it.

Prof. Forsyth—But I think what that illustrates is that in fact in quite a short period of time actually in the scale of things, if you institute training across the health professions at the undergraduate level, it does not take long for those people to just grow a bit older and have an impact. It happens quite quickly, and clearly this is only one aspect of improving the health of indigenous people—one aspect only. If it was done well, combined with other things that you will be dealing with, I think it, in fact, could bite in five or 10 years.

Mrs WEST—Following on from that, given that we have a dilemma in Australia where there are not enough medical professionals going to rural and remote areas—it is very difficult to attract doctors to those areas—what incentives would you envisage need to be offered to encourage people to go back to the communities to reinvest their knowledge into that community and overcome those problems? We have got that problem at the moment and there needs to be some incentive or some carrot to entice people to go back to overcome those problems. Have you any suggestions or solutions to that?

Prof. Forsyth—I think that is a very important question and a very difficult one to answer. No doubt there have been changes recently. The Commonwealth is allocating a considerable amount of money for training in rural health and I think that is having an impact. We, for example, have students training in the Riverland. They stay there for all of their clinical training. They are going up to Darwin and doing all of their clinical training in Darwin as from this year, and it is happening in other places as well.

What we are hoping is that some of those students who do their training say in

Darwin will find that the clinical issues there attract them and they remain. In terms of incentives, I think the whole area of dealing with indigenous health needs to be at a higher level. If it is seen as an important preoccupation within medicine, if it has a high profile, if there is a bit of collectiveness about it, if there is high-level academic support for it, people will tend to remain in it. I do not know—I have not worked in a rural area—but I imagine it is a lonely, sort of godforsaken task. I think if a bit more academic credence and support was given it might retain people there, but I am not sure.

Dr NELSON—Kevin, would you see a place for the teaching of Aboriginal culture and related issues as being a part of a broader cross-cultural training activity, keeping in mind we have many cultures now that make up Australian society?

Prof. Forsyth—Absolutely.

Dr NELSON—Secondly, would you and your colleagues be prepared to fail a student for not coming up to scratch in this component of an undergraduate course; and thirdly, do you think there is a place for requiring postgraduate trainees to spend a period of their time exposed to teaching in and providing services in Aboriginal communities?

Prof. Forsyth—I think we would be prepared to fail people. I can tell you at the paediatrics level in our discussions we have identified this as a high priority area in which we do poorly. We are going to put it in our curriculum, which means we will fail people against it if they do not come up to scratch in it. I cannot speak for the rest of the disciplines in medicine, but within paediatrics we are prepared to do that.

In terms of whether people should be required to spend time, I am involved in a couple of colleges—not in this area but in another area of medicine—and we have talked about the requirement to have people rotate around to get good training. The colleges will not wear it. I think the colleges would be very reluctant at this point in time to require people to actually get practical exposure or be in a situation where cross-cultural training is important, and that is way out of my control. This is about indigenous health, but I would extend the cross-cultural issue to include dealing with different cultures and different ways of thinking about things.

Dr NELSON—If preferential progress through a training program was given to those who were prepared to go and work in certain areas, do you feel that that would be likely to be a successful strategy?

Prof. Forsyth—I think industrially that would be knocked back. We have looked at incentives within postgraduate training in different areas and the point is made that industrially if, say, a lady training in paediatrics is married and has children at school and we require her to spend time in Alice Springs or somewhere for training, it would not work. Industrially you could probably argue that unless the curriculum and the whole thing was very strongly shaped, it would be difficult. I agree with the sentiment. I am not sure

how it could be effected.

Dr NELSON—Yet the same people have no trouble going to the United States for 12 months to do advanced training or do a PhD.

Prof. Forsyth—I agree. Even within medicine, doing the undergraduate course, it would be excellent if we could require them to have spent time at an Aboriginal health service or whatever and to have shown that they have learnt and benefited from it. Again, I think within paediatrics we could agree on that, but it is a bit beyond my capacity to actually answer that completely.

CHAIR—It is a question that some of us who represent rural electorates are quite interested in, in the broader sense actually. I need 16 doctors for the part of Australia that I represent right now, and that is being supplemented by foreign doctors. The Aussies will not come out.

Prof. Forsyth—Telehealth and those sort of things might help support—

CHAIR—That is why we are so keen on that report. There is a lot of that resource use in there. Mr Jenkins?

Mr JENKINS—Mr Chairman, very quickly, I thank you for inviting Dr Nelson to ask my question! I should put it in context very quickly. For me, like Brendan's electorate, there is a very small Aboriginal community but a very high immigrant community. I am more likely to be, in an electorate sense, confronted with the problems of say a Somali, Eritrean or Iraqi refugee family and, to an absolutely enormous extent, say southern Mediterranean families. It just struck me today, Professor, that in training of medicos and other health professionals these cultural issues are very important, and the ability of the person as a professional to look upon the person's cultural environment as being important to the way they treat them, I would have thought, was integral to the way that we tackle these problems.

But, having said that, I suppose the further question I would ask, so that I get a better appreciation of whether there are things intrinsically different about treating Aboriginal people and people of other cultures, is whether in your experience there are things that you could share with us that are different.

Prof. Forsyth—The health statistics are outstandingly bad, obviously. That is one key area. I think also the cultural difference from Aboriginal health people to Western medicine is extreme. I suspect that across the other cultures we have in Australia the Western medicine is not so extreme. It is different, yes. An example is the issue of female genital mutilation which some of us have been working on recently. That is a cultural difference and we said, 'Well, there are some absolutes that we are not prepared to bargain with, even though there is a cultural difference there.'

I think the issue with Aboriginal people is just so marked and so extreme and so outstanding as an Australian problem that it needs particular emphasis. But I agree entirely, it needs to be put in the context of medicine and other health professions being able to cross-culturally understand and work with people, and we need to find a mechanism to do that.

Mrs DE-ANNE KELLY—Professor, in relation to your suggestion of the CDs, in answer to part (c) about education—and I come from a large rural electorate—I put it to you that having CDs is not going to help. I have heard your suggestion about telemedicine. I have put that to the doctors in my isolated areas and they have said, 'Forget it. It's not what we want. What we want is help.' In Queensland—and I can only quote Queensland—the number of doctors in rural areas is 235 per cent lower than it is in urban areas, and in remote indigenous communities it is 257 per cent less. The fact is, your graduates graduate, buy a Porsche and live in Adelaide. That is the reality of it. They do, I am sorry. Brendan was absolutely right in his question.

What are you going to do, first of all, to get them to go into rural and regional areas, and secondly, to see that it is satisfying not just to make Aboriginals feel comfortable in mainstream services but to actually serve the indigenous communities?

Prof. Forsyth—Just in relation to the issue about CD-ROMS being irrelevant in the back of the bush, I have been enlightened recently to learn that in places like Malawi, one of the poorest countries in the world, the medical school is desperate for CD-ROMS on anything they can get, because they do not have the professional people teaching. I said, 'Hang on, what's a place like Malawi wanting high-tech stuff for? Surely you just need basic medicines.' I was misled in that.

Mrs DE-ANNE KELLY—Yes, but we do not have any Australian Aborigines in Malawi, and we are talking about indigenous people here.

Prof. Forsyth—But what I am putting in context is that you can have a perception that rural areas and remoteness are kind of anti-technology, and the point I am making is that that may not necessarily be true, and the power of technology is that it actually works equally effectively wherever you are. In terms of encouraging health professionals to get out of their nice inner-city practices and work in the rural areas, it comes back to education at the undergraduate level, and secondly a mechanism, if they go out, to reward them; a mechanism to engage them in a framework that is supportive, makes them feel that that is real medicine, actually more real than working in the centre of Adelaide. So that empowering of their ability to practise in a remote environment needs to be in a professional way. Whether there can be some professional grouping of those sort of people I do not know.

I have had discussions with some of our doctors in Darwin about this and said, 'Why is it that we can't get doctors to go and work at Maningrida and those sort of

places? What can we do to actually encourage them not to just go there but to stay there?' I think what they have done in Darwin with the Menzies School, for example, where they have got a centre of excellence that is academic and there is research involved, is attracting lots of doctors up to Darwin, and the spill-over is that some of them are going to Maningrida to work. So there must be something about empowering them through ongoing training and feeling engaged with the rest of the community that is important.

Telehealth and those sort of things can do it. Maybe a college of rural and remote medicine, where there is a big focus on the indigenous health issues would be one way. I do not know, but I think those are important things that need to be worked through. But above all, at the medical student level, we need to give them a vision that this is actually real medicine.

Mrs DE-ANNE KELLY—It certainly is. Just with your point about telemedicine, I am certainly not against technology—I think it is terrific—but you have got to have the time to be able to access it. I have a doctor in one of my towns who has been advertising for 16 years for some assistance. He works seven days a week. He didn't even go on Christmas holidays with his kids. He is not interested in telemedicine; he just wants to have a sleep. The man is just exhausted. He is soon going to pack up and go back to Brisbane. He said, 'It's the only way I'll ever get a holiday. I'm just going to give up.'

You talk about education and empowering people to work in regional areas. I just think the problem is more fundamental than that, and we have not got that much time, because a lot of the doctors in rural areas now are absolutely worn out, and they are older people.

Prof. Forsyth—No doubt. So there needs to be some attractiveness made in that position for other doctors to come. It needs to be made attractive.

Mrs DE-ANNE KELLY—This position is at the Whitsundays. You cannot get more attractive than that, doctor, with respect.

Prof. Forsyth—Well, doesn't the fact that you can't get doctors there imply that it is in some way unattractive to doctors? And if that is the case, then—

CHAIR—They feel vulnerable and exposed and they are away from a support base.

Prof. Forsyth—No doubt.

CHAIR—It is not so much the perspective they look at.

Mr ALLAN MORRIS—How many medical students call remote Australia home? Zero.

CHAIR—It is a broad issue; just relate it to what we are about here though.

Mr ALLAN MORRIS—I seem to recollect at the hearing in Canberra, Flinders University was actually mentioned. I cannot recall the context, but I am sure someone made some reference to Flinders University at a public hearing.

Prof. Forsyth—The clinical school in Darwin?

Mr ALLAN MORRIS—No, at the hearing in Canberra the other day. I cannot recall what it was.

CHAIR—We will follow that up. Can I ask about Darwin? You have made reference to the medical school that operates up there. Is it worth us pursuing the things you are doing there?

Prof. Forsyth—There is a submission in the documents from Allan Walker, although he does not really speak on behalf of the clinical school.

CHAIR—So far we have not received any submissions from Darwin.

Prof. Forsyth—From the hospital or the clinical school there? I do not think you have. Alice Springs is now also a university department from Flinders, so Flinders has now a university department at Darwin for medicine, and also Alice Springs. We were also the first medical school to get this new four-year graduate medical program, so we have completely re-engineered our curriculum. It is all taught differently. That is now being duplicated at Queensland and Sydney; in fact, it is actually happening right through Australia. All the medical schools are re-engineering their curriculums, saying, 'We need to teach differently.'

There is a good window of opportunity, I think, to get in now if you are thinking about teaching differently and thinking about what your curriculum is. Now is a good time to say, 'What are the important health issues in Australia that we need to address?' and this I think can be No. 1.

CHAIR—Good, but I would like to reiterate Mrs Kelly's point. I represent 26 per cent of Victoria. It is a remote area. It is not remote in the sense of northern South Australia—and hear that, will you, please, from rural constituencies! But if there is a window, then I will try and open it by—

Mr ALLAN MORRIS—A question to you, Mr Chairman. How many of your constituents are actually students in medical faculties at the moment?

CHAIR—From what I am aware, three, and one of them is on a new program in Victoria.

Mr ALLAN MORRIS—Yes. The point I am trying to make with respect to regional universities relates to the problem we find unless the students come from areas that they relate to and feel their roots are in. To try and get a Sydney person to migrate to a remote area does not tend to work, so we have to find ways to get those students into university.

CHAIR—The point has already been made by Professor Forsyth that even if they come from a rural community, it does not mean to say they are going to go back, because the big carrots are in the big city.

Prof. Forsyth—And the point about the Darwin school is that it was designed so that Northern Territory people would do their clinical training in the Northern Territory and that would encourage them to stay there and to work in a remote environment.

Mrs WEST—Only for a period of time, because once their children get to high school they inevitably want to come back.

Prof. Forsyth—Yes.

Mrs WEST—So there should be a shift or a rotation, if you like.

CHAIR—A complex question, but we are all interested in it. Thank you very much, Professor Forsyth, for your time and your willingness to come along. We very much appreciate it. We may want to talk to you some more, but I am particularly keen to have another look at Darwin. If we have got a submission from up there, we will follow that up. Thanks very much for your time.

[12.28 p.m.]

STOKES, Mr Ian Charles, Unit 7, Block A, Flinders Medical Centre Flats, Flinders Drive, Bedford Park, South Australia

CHAIR—Thanks, Mr Stokes, for coming along to talk to us. Do you have any comment to make on the capacity in which you appear?

Mr Stokes—I appear as a medical student and an interested member of the public.

CHAIR—We are very pleased you have been willing to give of your time to come along. It indicates an interest. My colleagues will have questions for you later. There are a few formalities. I need to point out that this committee does not swear its witnesses, but the proceedings today are formal proceedings of the parliament and warrant the same respect as the House of Representatives. Any deliberate misleading of the committee would be regarded as a contempt of the parliament.

We have a copy of your letter and submission. You might like to make an opening statement about why you felt motivated to make the submission, and then my colleagues will have a few questions.

Mr Stokes—Yes. I will not go through my whole submission. That would take too long and, as you said, you have got it.

CHAIR—Well, it is already on the public record.

Mr Stokes—Yes. My main motivation was that last year I was a first-year medical student at Flinders University and, as part of the curriculum, they do a series of lectures on Aboriginal health, so we had some exposure to the conditions and the situation of remote and rural communities and Aboriginal health. I saw the advertisement in the *Age* newspaper and, given that it was relevant to our education at the time, I wrote and made a submission. That was purely out of interest. We had had some exposure to it and that had got my interest in the issue going. We had had lectures from Aboriginal persons themselves and also from white doctors who work in rural communities. It was quite an opening to get into.

CHAIR—From a student's perspective, do you have any suggestions? No doubt you have been talking with the professor, but from a student's perspective could it be done better? What about some of your student colleagues? What is their reaction to it? Did it frighten them off, the idea of going up to be part of the community?

Mr Stokes—It is very complex. As has been said, Flinders, in conjunction with the Northern Territory, runs the medical school at Darwin. As of this year, 10 students go to Darwin for third and fourth year, five of whom are Darwin people. The prospect is that at

least five of those 10 would stay there for at least a few years. Then 10 go to the Riverland as well. So there is some receptiveness to it. But given that we are the graduate entry course, there are people from all over the country, and it is very difficult to appeal to the overseas students that we have got, and also some of the interstate people who are not all that interested in it. It was good that it was a compulsory subject, in that it exposes us to Aboriginal health.

Not all the reactions were positive. Most were. It was a good exposure and people were a little bit surprised about exactly what things are like. But it was just the second year, for us, of having it taught. It still being changed. It is changing and evolving. It is pretty positive, the perception people have of the whole issue, but that will not encourage people to rush off into the bush. No matter how much money you throw at them, they will not do that if their desire is elsewhere. So it is going to be a very complex issue for the medical schools. I am not sure how Newcastle runs theirs, but I believe they have placements out into the Aboriginal communities also.

CHAIR—Mr Morris represents the region there. He is quite knowledgeable on that.

Mrs DE-ANNE KELLY—I have read your submission, and you make the point in the second paragraph that people should have whatever health needs they want, and then quite sensibly you make the point that resources are limited, which they are. You do go on, though, to say that if a greater number of the indigenous people were employed, they would be paying greater tax and 'even the economic rationalists could not argue against increasing the spending on indigenous health'. Who do you see are the economic rationalists, and surely you are not suggesting that we tie only people that pay tax to access to health care?

Mr Stokes—No, definitely not. The point of that statement is that there is a perception in the wider community that all this money gets thrown to the Aboriginals and that they do nothing for it, that they sit around and collect their dole cheques, and that they do not do anything constructive for the community, yet they demand all this health care, and they seem to think that everyone else owes them a living. That is a popular perception, probably in the press more than anything else. The point of that was that if you had a member of the community come up to you and say, 'They're just bludgers,' if you could point to statistics saying, 'Well, actually, a great percentage of Aboriginal community members do work,' then there would be fewer grounds for the knee-jerk reaction of 'They don't work, why should they get money?', which does happen. It is a perception out there.

Mrs DE-ANNE KELLY—Are you aware that in the isolated communities in North Queensland most people do work under CDEP?

Mr Stokes—Yes.

Mrs DE-ANNE KELLY—So that is already the case. Your professor was here earlier. You have said that doctors will not go to remote areas, and you would be aware of the statistics. There are 235 per cent fewer doctors in the rural areas than there are in urban areas.

Mr Stokes—Yes.

Mrs DE-ANNE KELLY—And 257 per cent less in indigenous communities. You just said throwing a lot of money at them will not solve the problem.

Mr Stokes—Yes.

Mrs DE-ANNE KELLY—So what will?

Mr Stokes—It is very difficult. I think it has a lot to do with the fact that you are dealing with a very highly motivated group of people, especially now. The mark in Victoria to get into med school puts you in about the top half per cent of the state, which means going from a very high-achieving environment to a small town which may not necessarily have any facilities at all. There may not even be movie theatres where children can go and have a night of entertainment. I imagine that from an academic point of view—the United States seems to run a lot of things around the place—for a doctor to get the degree of prestige and the research background to front up to committees in other parts of the world requires being in a major centre of education: Melbourne or Sydney or Adelaide. There are very dedicated rural GPs, and there are a number of people in my course who will end up in the bush and will stay there because that is what they want to do.

Mrs DE-ANNE KELLY—What motivates them to go to the bush then? What singles them out amongst your colleagues?

Mr Stokes—A number of them were born there, which helps—they were born in the country towns. We have got particular members who were born in very small communities of a few thousand people. They have then come into this course and want to go back. That is not necessarily meaning that they will stay there for the rest of their lives. And then you have got the normal Adelaide people, a lot of Adelaide students and Melbourne students who are brought up in the suburbs; that is what they know. It is difficult for people to change their culture.

Mrs DE-ANNE KELLY—Only nine per cent of students, in fact, Australia-wide come from a rural or regional area.

Mr Stokes—Yes.

Mrs DE-ANNE KELLY—So what you are saying is that the criteria under which

students are admitted into medical school are faulty at present?

Mr Stokes—They are possibly not the best, no. The criteria now for Flinders and the other graduate entry courses may well be addressing that, given that we have to submit to a general knowledge test of biological sciences and other things, and also an interview. So we are not taken purely on academics, which may well help redress that problem. But, yes, it goes deep to the whole issue. A rural child who has to catch a bus to school and has three hours in transport, whose parents are farmers and cannot afford to buy a computer and cannot afford to get all the fancy stuff that other students can, will not get into university. They just will not make it to Melbourne uni or Sydney uni. It goes very deep to the whole support system.

Mrs DE-ANNE KELLY—You are very refreshing to talk to, Mr Stokes. Where are you intending, when you graduate, to work?

Mr Stokes—My background is a bit mixed. I was born in Melbourne and I spent my first few years in suburban Melbourne. I then moved to Sydney with my family and we spent most of my formative years in the rural urban fringe area up around the Hawkesbury River, so I would like to work in a situation like that. I have aspirations for paediatrics, so unfortunately that will probably tie me to being close to Melbourne, and my family is in Melbourne and my girlfriend is in Melbourne. But I do not want to be tied in to the city. I want to have scope. I believe Bendigo Base Hospital is a good paediatric centre. I hope to work in both: I hope there can be a happy mix between pursuing the suburban area, which obviously has a lot of prestige attached, but also contributing to the rural community.

When we were in Sydney, my mother worked with a vast number of people on the rural urban fringe. She had a rather wealthy television anchor person coming to see her, and the farmers. That was very enriching. I would like to work in a situation like that. I cannot see myself going into an extremely remote community for an extended period of time. Again it comes back to the whole family issue and what you want to achieve.

CHAIR—There is a perception here about remoteness, but I have to say to you that provincial areas like Horsham and Mildura—and I am pleased to hear you mention Bendigo—cannot get specialists.

Mrs DE-ANNE KELLY—Do you think Airlie Beach is remote? We cannot get a doctor there.

Mr Stokes—With locations like that, there is the perception that they are, but, yes, indeed they are not. That must obviously go deeper to the whole issue of achievement, of where people want to go. It may well be a misperception in the whole of the medical student community that anything outside the city is not worthwhile, and to change that is just purely going to be a cultural change, through years probably.

Mrs DE-ANNE KELLY—Thank you, Mr Stokes.

Mr JENKINS—The comments about how we select medical students I think is something that probably needs discussing for a greater time than we have today, because the top half percentile of VCE students in Victoria might not be the most appropriate people to join medical students. You are in second year now?

Mr Stokes—I am now in second year, yes.

Mr JENKINS—Was the Aboriginal health unit an examinable unit?

Mr Stokes—It was, yes.

Mr JENKINS—As a separate thing?

Mr Stokes—Yes, it was a component like any other. I will just give you an example. We did cardiovascular and we had an exam on it; we did respiratory and we had an exam on it; we did Aboriginal health and we had an exam on it. So it was split up, yes.

Mr JENKINS—Will there be formal units in Aboriginal health later in the course?

Mr Stokes—I do not believe there is as much. Most exposure is in first year, so some more could be done, but this year we do have what is called a rural health week, where all 60 of us—there are actually 80 of us and 20 are overseas students, but they are also included—go bush for a week, which is not very much but it is a start to exposing us. It is not necessarily to Aboriginal communities, but it is to more remote communities, if you can call the Riverland necessarily remote. It is to outlying regions, and that is for the full week. In third year they start the Riverland program, and there are electives and selectives where we are encouraged to go to Katherine, Alice Springs, Darwin, locations like that.

Mr JENKINS—How many places in a year at Flinders?

Mr Stokes—It is going up. The new intake of first years must be 65 Australians and approximately 20 overseas persons. It is a very small medical school.

Mr JENKINS—Is it 10 positions in total go to Darwin?

Mr Stokes—Yes.

Mr JENKINS—So about one-eighth have the opportunity. How many go to Riverland?

Mr Stokes—Ten.

Mr JENKINS—And the others are placed in hospitals around Adelaide?

Mr Stokes—We stay mainly at Flinders, yes, but also Noarlunga and one of the psychiatric hospitals. I cannot remember its name. We get to go out and about as well, but the main thrust is that those 20 people are out for the year.

Mr JENKINS—The Aboriginal health unit you had in first year: how many weeks did that go for, how many hours exposure?

Mr Stokes—Probably about a lecture a week for half the year. We run an extended semester, so 30 hours, possibly more, with a few workshops. I cannot be quoted on those exact figures, but it could be 30, 35 hours of exposure.

Mr JENKINS—Just as a thumbnail sketch, what were the most striking things that you learned or were exposed to from that unit?

Mr Stokes—I did not actually learn all that much new about it, but it did confirm a few things: the difficulties of working in Aboriginal communities and remote communities as a whole. Everyone singles out Aboriginal communities, but as a fellow student said to me yesterday, 'It is not necessarily any different particularly, except the cultural things, for a remote white community.' As has been repeatedly said, remote communities are having problems getting doctors, and that is just the normal white towns that can be the same. We learnt a lot about the remoteness, how to deal with it, and culture. We have had exposure to the cultural differences. We had some members of the Aboriginal community come down who had had medical procedures, to talk us through their whole experience of being in a large hospital—being at Flinders, I think it probably was—and having a major operation. That was good, because we got the patient's perspective, but particularly the Aboriginal patient's perspective on the whole way their culture can impact on the way they deal with their diseases. So it was very good. It was also an introduction to encourage us to go out into the remote communities—information about the course.

Mr JENKINS—Once again, thanks for coming before us and sharing your experience.

Mrs WEST—Why did you choose medicine?

Mr Stokes—I do not really know, to be honest. It will have something to do with my family background; it will have something to do with my upbringing, my schooling; it will have something to do with just the way I am. I wanted to be a doctor when I was little, and then I changed to wanting to be a vet, and then I made a brief foray into thinking about law, but ultimately it came back to medicine. It seemed that you could do a lot more in medicine. My first degree was science, so I had a basic science degree before I started medicine.. The whole research side of things did not really appeal to me. I

wanted to be out working with people.

Mrs WEST—What do you think is the reason most of your colleagues chose to do medicine? Do you have any idea?

Mr Stokes—I think in my course, much the same. A lot of them have had previous careers. The average age of our intake for my year I think is 26. They have had careers previously and found them unsatisfying and wanted to do more. Rather than it be a misperception or whatever, there is a certain stream of people who go to med school because they got the marks or because it is the way to earn lots of money, but I honestly think that with a lot of the people from my year it is very much to dedicate themselves to helping other people.

Mrs WEST—In your interview, which is a component of selections—is that correct?

Mr Stokes—Yes.

Mrs WEST—Were you ever asked that question—why you chose medicine?

Mr Stokes—Yes, we were.

Mrs WEST—Did you know that question was coming?

Mr Stokes—We did not know, but it was a high suspicion by everyone that they would ask you that.

Mrs WEST—What would your reaction be if there was an element of compulsion to visit or spend some time, after your training, to practise in a rural and remote area? What would your reaction be?

Mr Stokes—It would depend very much on the timing. Suppose someone said to me, 'You've got to spend your intern year in a remote setting.' There may be no disadvantages to that. If you are in a large hospital you can have exposure to everything, so you can see very intricate operations, whereas if you go bush for a year there is no guarantee that you will see anything of particular interest. Suppose that was then held against you when you came to entering large medical facilities. You might front up to the Royal Melbourne Hospital and say, 'I spent my intern year in such and such.' They might turn round and say, 'Well, you haven't covered all our criteria.' So there is that component. It would also depend on where I am with my relationship with my girlfriend, as to what she is doing and whatever. A compulsory thing, which has been aired in our medical school, will not work, because if you force people to do things you will have a reluctant community of people. It is a very short way to look at it. If you think you get all these people through their lives between 20 and 30 years of life, and then you are

expecting them to change their attitude, I think that is asking a bit much. It goes deeper, to the whole—when I entered first year—

Mrs WEST—What if it was in lieu of your HECS payment?

Mr Stokes—I think that would encourage a number of people, yes. But again there seem to be a number of people in my year who are quite willing. They want to. They are surprised by how much money they will have given to them for doing something they want to do, which involves going to remote communities.

Mrs WEST—There is currently no incentive for people to go to remote areas, is there, as a young person?

Mrs DE-ANNE KELLY—Yes, there is. We have changed the Medicare provider numbers. You do not get them unless you go bush.

Mrs WEST—What other incentives may add weight to that? In a time frame, what would you personally—

Mr Stokes—What would I want if I was told?

Mrs WEST—Yes.

Mr Stokes—You need the support, as has been previously stated. You would need tuition. It is all further training when you are postgraduate, so you need to be able to learn what you have got to learn. If you get pushed off to a rural community to work in a base hospital which has a GP who spends his whole time seeing patients because there is only one GP, then you will not have a worthwhile experience. So there has to be the whole support, which I think is a good thing with Darwin and the Riverland. They teleconference—I think it is once a week down here—and they can talk to specialists, and they can do tutorials, and they have specialists go to Darwin also, so there is that support.

Mrs WEST—Is there any way that you could be accredited professionally for your time in remote areas? Is there any mechanism or training?

Mr Stokes—That would be up to the colleges. They are trying to push that through.

Mrs WEST—It would be through the colleges that they would acknowledge that?

Mr Stokes—Yes. They are trying to push that with the GP college who at the moment, in my limited understanding, are not exactly impressed with the idea of including a year away in the bush as a year of GP training.

Mrs WEST—What if it was to an Aboriginal mission or health centre, because they are extreme examples?

Mr Stokes—Yes, you would probably have a lot more exposure. I guess it would need to be an accreditation thing. You keep a logbook of your experiences—perhaps not strictly on a 'Today I did this and this,' but as a rough overview of what you have achieved in your year, or what you have been exposed to, and then that could be levelled up against the colleges. If you do not quite meet their criteria, they could arrange for you to be placed somewhere different to get that extra experience.

Mrs WEST—When you choose your location, when you have finished your training, what is the choice that you make as to where you want to go? What determines where you want to go, personally? For instance, if you were in the bush, could you then request or have an option to go somewhere of first preference where you have a foot in the door straightaway, over and above other graduates?

Mr Stokes—No, actually I would say that that would not be a good idea. That would just breed resentment of those people. The suburban doctors are dedicated people—we have got to acknowledge that—and if you were to say that a rural GP or a rural medical student gets preference over them, that just would not work. That would be disastrous. That would just breed resentment.

Mr QUICK—It works in the education system. I was a bonded teacher, and you had to have so many years out in the rural—

Mr Stokes—Yes, I know.

Mrs WEST—Thanks, Ian. You did not come to any conclusion over first preference?

Mr Stokes—Personally, what will decide where I want to go is the experience of the people above me. If I want to do paediatrics, I am going to go where I can find the best paediatrician to train me. That will be what it comes down to.

Mrs WEST—Thank you.

Mr QUICK—Just following on from Mrs West, we have got probably 85 per cent of the Australian population in five big cities, and most of those people never—apart from when they retire—wander round Australia, or when they are young sort of disappear up the Gold Coast, so their idea of what is happening in rural and remote areas is virtually nonexistent, apart from what is on *60 Minutes* and *A Current Affair*. Suppose it was prescribed that irrespective of which medical school you went to, the first year out we send you out in the bush—everybody, so that everybody gets a taste of it. Suppose we put in place structures, because there are big towns. That would be unlike the current system,

where some go out and some stay close, handy; and if you do go out and want to come back in, you know you are lower on the ladder.

Mr Stokes—Yes, I think it does need to be a bit more globalised. I do not know if I can provide much information on that. My suspicion is that perhaps Newcastle University may be able to assist. I went up and researched them, and they do a lot of work with the rural centres—like Wagga, Orange, those hospitals. Rumour has it they produce very good doctors, so they must have the structure there to be able to send their medical students and graduates to base hospitals and still get them to be extremely good at what they do. I guess there must be a system to do it, yes.

CHAIR—It is really good, Mr Stokes, for you to come along. The committee rarely gets an opportunity to talk to an undergraduate medical student. We go a bit broader than our terms of reference with Aboriginal indigenous health, and it is an important issue. Dr Nelson will have some specifics probably, but I would just like to reframe the question Mrs West asked you: what sort of carrots would dangle out there and entice you to reconsider and maybe think, 'Gee, practising in rural areas'—or provincial Australia, too; don't forget about that. We are talking about cities with populations of 100,000. The population of Bendigo is 160,000 and they cannot get specialists.

Mr Stokes—Yes, it is not small.

CHAIR—What sort of carrots dangling there would make you say, 'Gee, I'll be better off if I go out to one of these centres'?

Mr Stokes—Shepparton recently had their paediatrician retire, I understand. They could not find one, and I could not figure out why. It probably does have a lot to do with exposure to what you have got. This is an extreme way of answering the question, and of course it is unrealistic, but given my personal circumstances, the enticement for me to go to Bendigo, for example, or Shepparton or something like that, would be to move the academic institution where my girlfriend is doing her PhD to Bendigo. I know that sounds silly and it is extreme, but you have got that situation where doctors will marry other career professionals. They will marry career scientists or career physiotherapists or lawyers, and you cannot expect them to then go and pick up and go bush. The money will have very little to do with it. My understanding is that a doctor's salary is adequate, but you cannot expect your wife who has a very successful law career, for example, to go and be unemployed in a centre even of 100,000 people. I guess you need to catch people young before they get relationships going, send them bush, and hope they marry a farmer's daughter. That is almost the situation, yes.

Dr NELSON—It is very good of you, Ian, to do this. It says a lot about you that you would actually write a submission and come along and talk about this sort of thing. Whatever you do, I reckon you are going to do really well. You made the comment that the remote and rural communities, non-indigenous communities are pretty much the same.

I just point out to you that in Aboriginal communities you see malnutrition, rheumatic heart disease, leprosy, syphilis, donovanosis and a whole lot of diseases that the rest of us thought do not exist.

Mr Stokes—Yes.

Dr NELSON—You mentioned you have to be in the top half of one per cent for NHSC or get the TER or whatever to get into medicine.

Mr Stokes—Approximately, yes.

Dr NELSON—What if the system was such that 20 per cent of the places would go to those who were in the top 10 per cent who came from a rural background and/or were prepared to indenture to a rural postcode?

Secondly, why isn't it possible for us to develop a postgraduate training system, say in paediatrics, where before you apply to go into paediatrics you know that you will be required, in one of your last two advanced training years, to spend six months in a regional or a rural area teaching, supervising, providing clinical skills and all that sort of stuff?

Mr Stokes—I think that would be very possible. That would be a good idea. My understanding is the battle would be with the colleges, trying to get them to do it, to accredit for example paediatrics or ophthalmology or whatever it is, to do that—and have the expertise. But I see no reason why that cannot be done.

Dr NELSON—When the colleges interview and the subspeciality groups make decisions about advanced training positions, it is a bit like immigration, for example: you have to acquire a certain number of points to get in.

Mr Stokes—Yes.

Dr NELSON—Would it not be possible in making those decisions for someone who has done their first part, for example, to not only take into account their academic performance and the reports of their supervisors in the hospitals, but also get positive points for having spent a year working in a particular area—one of a number of postcodes that are considered to be areas of need? Would that be something unacceptable to prospective trainees?

Mr Stokes—I wouldn't think so because, as you mentioned, if it is a point system or if there are certain criteria that you have got to reach and there is a wide scope of criteria, then how you reach that is up to you. If someone chooses to stay in a rural community and then they achieve a certain criterion which lets them in, and you also have someone in an urban setting who also reaches the certain criteria and gets in, I would see

no reason why that could not be done—that you did give a special category to the rural people, not over and above the normal categories, but just as part of it. You know, if you had a choice of spending some time here or there and you could just up the points for going to rural areas, I think that would probably be accepted. That is my personal opinion. If I was confronted with that situation, I would think very seriously about going to a rural setting if it meant I got college accreditation quicker, yes.

On the issue of not taking just the pure high percentage, I think that is a very good idea and that is what they are aiming for at Flinders. We are taken on academic skills, but not purely on academic skills. Just because you are the genius of the intake it does not mean that you will get in, versus someone who is averagely smart but fits the criteria of being a good doctor. Melbourne university I believe is running an experiment where they are going to take one-third of the graduates by interview, and two-thirds by TER. It will be interesting to see how they compare.

Mrs ELSON—I just want to ask a question that probably does not relate to you: amongst your colleagues is there a concern about going into a remote rural area because of the responsibility that would be put onto their shoulders, being the only doctor in town? Would it help if they had a pair—in other words, someone to share that problem with them and make a decision without the worries of litigation and so forth falling on their shoulders?

Mr Stokes—Yes, that is true. I do not know. I have not actually spoken very much about that, but just from what little I know of my class I would say that there is a certain perception of that. I imagine it would be the same with any situation. In our case we do four years—the normal course is six—and when you finish that you are suddenly an intern, and suddenly you have all this responsibility, and indeed patients' lives are in your hands. You are suddenly thrown in the deep end. I cannot see that being viewed any differently from working in a rural community.

Mrs ELSON—It would be to an extreme, though—

Mr Stokes—It would be an extreme end.

Mrs ELSON—as you said, being put into a suburb, if you are in a normal GP's office where you have got other doctors to back you up—

Mr Stokes—That is right; you have got other supports.

Mrs ELSON—To a remote area where there is only you, and you would be handling a lot more serious cases, because you are the only doctor there and if someone gets badly hurt out on a tractor or something you have to accept that responsibility.

Mr Stokes—Definitely. You are the only one. I think that is a concern, yes. It may

well come down to good patient-doctor relations. If there is an understanding in the community that you are serving that you are the only doctor there, that you are going to do your best, and that whatever you do will be to the best of your ability, then there may be less fear of being taken to court, or being perceived as an inadequate doctor. I think there is a fear component, yes.

Mrs ELSON—It is a very big responsibility, isn't it?

Mr Stokes—It is, and yet there are other people that will thrive on that. There are definitely members of my class who, given that opportunity, will just jump straight for it. They want to be the only ones out in the middle of nowhere.

Mrs DE-ANNE KELLY—I would like their names.

CHAIR—Tell them about Mildura. Mr Morris.

Mr ALLAN MORRIS—Let us accept, Ian, that the point being made about the lack of students from those areas is probably the major factor, and then look at two major impediments. Firstly, there is the school one. The fact is it is much harder to get good TERs if you go to a small country school. The kids of wealthier families and the brighter kids tend to go to boarding schools in the capital cities, which means by the time they finish school, even though they have come from Gulargambone, they have actually grown up in Sydney during their adolescence. All their mates and friends are in Sydney, so they are no longer a Gulargambone kid. That is the first level.

Secondly, there is a move towards second degrees, so the fact that we are now moving towards a system, within a few years I expect, where all medical students will be second degrees only, is a further disadvantage against people from remote areas, because to get to university in the first place is much more expensive because you have got to board.

Mr Stokes—That's right, yes.

Mr ALLAN MORRIS—If you live in Sydney it might be a bit awkward with the buses and trains, but it is easy to get to uni and you can live at home, so your cost of living is much lower. Austudy does not compensate anywhere near enough for that. So to get into a course in the first place you have to get a TER that is drawn up by the school system, and that is a massive disadvantage, and then you have to go through two degrees.

Mr Stokes—Yes.

Mr ALLAN MORRIS—So of course on the one hand we are recognising that we need to somehow better reflect that the medical profession has failed, if you like, and has become so centralised simply because convenience has been an advantage, so it is biased

against people from remote areas, but we are actually about to bias it even more by making a second degree—

Mr Stokes—Yes, that is a problem, and I feel that that is particularly a problem for Aboriginal people.

Mr ALLAN MORRIS—Absolutely.

Mr Stokes—Flinders does have a certain number of places per year which are allocated to Aboriginal intake, but they are yet to fill one. I am not exactly sure on this, but I hear that we have two people in this year's first intake who have ties to Aboriginal communities, and they are the first ones out of the three—and I do not know what it was like in the six-year course, but I imagine it was pretty sparse. So, yes, to expect an Aboriginal person to achieve a degree and then expect them to achieve a second degree is difficult. I think there will always be a place for the undergraduate course, the undergraduate structure, but given that it is such a difficulty to get in on your TER, perhaps in the long run if you encourage Aboriginal persons to pursue a first degree, which is, for all intents and purposes, easier—such as teaching—and then pursue medicine—

Mr ALLAN MORRIS—But you pull them away from their communities for two degrees, so by the time they finish the second degree they are no longer from the bush. Mr Chairman, I am not expecting Ian to be an expert on this stuff, but I guess his input has been useful and I think interesting, and it may feed back to his faculty, but this is the kind of quandary we have, as a committee and as a country.

Mr Stokes—I agree, yes. Perhaps that will be solved by a university in Alice Springs, for example, which would then draw people from surrounding areas, or draw people into it, and it is more remote. I guess Newcastle is not really remote, but it is more a rural setting than Sydney.

Mr ALLAN MORRIS—It draws from those areas, but it is still hard on those pupils.

Mr Stokes—I agree. I think it is just the nature of the system, that you draw people away for six years to the city and they discover suddenly that urban life is fantastic, and that there are all these opportunities, and they are not going to go back.

Mr ALLAN MORRIS—And their girlfriends aren't from there.

Mr Stokes—That's right—and they are not going to go back.

Dr NELSON—It should be quite possible, though, instead of requiring indigenous students to do a first degree, that the medical school, in consultation with biological

sciences and other parts of the university, establish say a two-year module which prepares them for the four years. So they have just basically got the six years.

Mr ALLAN MORRIS—Yes. Mr Chairman, one of the things I hope we will do at Newcastle University is have a hearing and talk to Professor Hiller from the centre of clinical epidemiology, who does distance learning programs across the world. Distance learning has the potential to help overcome part of this problem by being able to put learning capacities into remote areas. This is not necessarily primarily for graduate medical students, but for some aspects of it. I think that is one of the areas we have to traverse to try and see if we can find some answers to problems such as this.

CHAIR—We have heard so much about Newcastle that if we don't go there we will never hear the end of it.

Mr Stokes—There should be the possibility to do exactly that—two years of basic sciences, for example. It has been proposed—rumour on the mill, inaccurate—that Melbourne at one stage—and I mention Melbourne because that was my first degree—were contemplating making all medical students do first-year science and then taking their medical students based on their performance in first-year science, much as vet science do. So you could get the Aboriginal or even other remote communities, but especially Aboriginal people, up to speed in two years.

Mr ALLAN MORRIS—Yes, except that the problem then is to do well in science you have to be non-verbal. Medicine is verbal. Medicine is about communication, about being verbal, and we test our pupils on maths and physics and chemistry, which is non-verbal, and we wonder why we get problems with some of our doctors and their relationships with people. I mean, it is important to have science in medicine, but it is more important to have doctors who are good communicators.

Mr Stokes—Yes, which then relies on your later years, but we have clinical exposure now.

Mr ALLAN MORRIS—But you are not tested, in entry, other than by Newcastle and the interview programs, on your communication and—

CHAIR—Can I wrap it up there. We have actually gone wider than our TOR. But we wanted to take the opportunity to have a chat with you, Ian, and it is very much appreciated.

Mr ALLAN MORRIS—It has been interesting.

Mrs DE-ANNE KELLY—It has, yes.

CHAIR—It is good of you to be generous with your time. You are probably

moving into a new curriculum right now. Thank you again, Mr Stokes.

Resolved (on motion by **Mr Quick**):

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 1.08 p.m.