HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

PERTH

Thursday, 19 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

PERTH

Thursday, 19 February 1998

Present

Mr Forrest (Chair)

Mrs Elson	Mr Allan Morris
Mr Jenkins	Mr Quick
Mrs Johnston	Mrs West
Mrs De-Anne Kelly	

The committee met at 9.30 a.m.

Mr Forrest took the chair.

CHAIR—Before welcoming representatives from the Health Department of Western Australia I would like to make an opening statement in that I am pleased to open this fourth day of public hearings on the committee's inquiry into indigenous health. This was an inquiry referred 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 at 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 these communities. Barriers still appear to exist to access mainstream services for Aboriginal and Torres Strait Islander people.

This hearing today in Perth follows previous hearings held in Canberra, Hobart, and Adelaide, and provides an opportunity for the committee to explore issues with the West Australian government and other locally-based organisations who have made submissions to the inquiry. This will be followed by further hearings in other cities over the next few months and later on in the year the committee intends to visit remote and rural areas in Queensland and Central and Western Australia to gain first-hand experience of living conditions outside the major urban centres. This is important, we feel, where population levels are low, which creates all of the other normal problems confronted by remote communities.

Following the hearing this morning, the committee will visit the national Aboriginal and Torres Strait Islander health clearing house at Edith Cowan University in order to gain an appreciation of the development of a national indigenous database. We had the opportunity yesterday afternoon to visit the Perth Aboriginal Medical Centre. I think I speak for all members of the committee when I say that we are very impressed by the commitment in that organisation and the goodwill, and that is part of what we are trying to find, to come up with some recommendations to mobilise the incredible goodwill that does exist.

All Australians, particularly the committee, are very frustrated by the comparative lack of performance we have made in comparison with our near neighbours in New Zealand, and the Canadians, and the United States, with this issue of indigenous health for their communities. As I have indicated on a number of occasions before, I would like to stress again that this committee is seeking to conduct this inquiry in a spirit of collaboration and cooperation with all the players, particularly the Aboriginal and Torres Strait Islander people themselves. It is important to consult these communities directly and combine the collective experience of everyone involved in this wide area of health delivery.

In that context, there has been some concern expressed about point (f) of our terms of reference. We are not about finding scapegoats and finding people to blame. We have a bipartisan commitment in this all-party committee to crack through and get some determined direction on this whole area of indigenous health.

GRACEY, Professor Michael Samuel, Principal Medical Adviser to the Office of Aboriginal Health, Health Department of Western Australia, 189 Royal Street, Perth, Western Australia 6004

HOUSTON, Mr Edward Shane, General Manager, Office of Aboriginal Health, Health Department of Western Australia, 189 Royal Street, Perth, Western Australia 6004

LESLIE, Mr Ian Charles, Acting Manager of Policy Development Section, Office of Aboriginal Health, Health Department of Western Australia, 189 Royal Street, East Perth, Western Australia 6004

CHAIR—I welcome representatives from the West Australian Health Department, and ask if you have any comments on the capacity in which you appear.

Mr Leslie—Yes. I have a functional role for strategic planning and development of the policy frameworks within which the state Health Department operates.

Mr Houston—I have a general responsibility for the management of the office per se and the provision of strategic and executive advice to the Health Department and health sector in Western Australia.

Prof. Gracey—My main responsibilities are in health information and evaluation of health and health programs. I am also Professor of Aboriginal Health in Curtin University in Perth, which I believe is the only position of its type in Australia.

CHAIR—I might just introduce our committee. I am John Forrest and I am the chairman. I am the member for Mallee, which is a large regional seat in Victoria. I have been the chairman of the committee since September last year. Harry Quick is the member for Franklin, Tasmania. He is deputy chairman. Andrea West is the member for Bowman, Queensland. Ricky Johnston is a Western Australian member here, the member for Canning. Bjarne Nordin forms the secretariat. He is assisted by Jim Kennedy at the rear, whom you would know. Kay Elson is the member for Forde, Queensland, and De-Anne Kelly is the member for Dawson, Queensland. Allan Morris and Harry Jenkins will join us shortly.

Before I offer you an opportunity to make an opening statement to us, I express some disappointment that the committee has not had available to it a written submission from the department. It is very helpful for the committee to have perused what you have got to say so that we can form some sensible questions to have a really meaningful exchange. I understand that submission is forthcoming. I am hoping you can advise us when we will receive it, but I would like some explanation as to why it has taken so long, if you could please, Mr Houston.

Mr Houston—Mr Chairman, the responsibility for the delay in the submission rests at the end of the day with me as the General Manager of the office. The submission that we have prepared is a document which canvasses each of the terms of reference of the committee. It seeks to outline, from our point of view, what the principal issues are under each of those headings, and tries then to summarise them in a few dot points at the end of the first section under each term of reference. Then we also go on to talk about what is and what is not happening in Western Australia in respect of each of the terms of reference in the inquiry.

We have deliberately not included large amounts of statistical information in the document. Rather than that, we have referred to the minutes at the introduction of the report and included them as a series of appendices to the report. There are about half a dozen or so substantial reports which have been attached to it, including some comparative data around Aboriginal mortality rates from the late 1980s through to the mid-1990s. The delays largely were caused through the absence of senior officers within the Health Department of Western Australia. But, as I said, the principal responsibility for its delay rests with me. At the end of the day I would imagine that the submission would be with the inquiry no later than the close of business of this week.

CHAIR—I have omitted a standard procedure. I am not doing this because of the comments you have just made, but 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 would be regarded as a contempt of the parliament.

Just getting back to that question, we are having a parallel inquiry in respect of competitive tendering. We held a hearing here yesterday, and again there was no submission from the Health Department of Western Australia either. I know you cannot address that. It is not part of your division. It could well be the fact that our liaison point is the Department of Premier and Cabinet. They assigned the Department of Family and Children's Services to come and talk to us, and we had a very meaningful exchange, but I would like you, if it is possible, to convey back to the department that we are disappointed not to have a submission on that very important inquiry we are having. You could suggest it is not too late to make a submission, because the Department of Health obviously crosses over. It may well be just a process of gaining some coordination here, but I would be grateful if you would convey that message back to the department.

Mr Houston—Mr Chairman, I will certainly make sure that the message gets through.

CHAIR—Probably the best thing for you to do then is to offer us some comments about progress on indigenous health here in Western Australia, and then we will proceed to questions, and hopefully have a meaningful exchange.

Mr Houston—Thank you very much. I suppose the first thing I should say is that Aboriginal health is recognised as one of the core responsibilities of the Western Australian health system. The partnership between health interests in Western Australia and the department is strengthening, and Aboriginal people will play, and have played over the last five years, a significant role in determining the strategic directions in the health sector. It is certainly the case that arrangements that have been put in place subsequent to the signing of a bilateral agreement between the Commonwealth and the Western Australian governments on 6 November 1996 will certainly see that partnership strengthened even further.

The department has established a division that has the title of Office of Aboriginal Health. We are an office which has both a strategic development function, in that we are charged with the responsibility of helping to move the big blocks of the health system around to ensure that they best suit and serve the needs of Aboriginal people, and at the same time we are asked to take on a role of developing, managing, and negotiating special gap-closing services which are intended to specifically reduce the health differential between Aboriginal and non-Aboriginal Western Australians.

In order to do this, we have a number of functional units within the office, some of which are represented today, but I think it is worthwhile just to touch on some of those areas. We have a policy development branch, which is charged with the responsibility of the long-term strategic development around Aboriginal health, particularly in the five- to 15-year time bracket. We have an information and evaluation branch. I should point out that Ian Leslie, to my left, is the current manager of that area. That branch's principal job is to try and ensure that the department, the industry, and the office, have available to them the most up-to-date information about Aboriginal health which is reliable, which is accurate, and which can be used as tools by those decision-makers within the health service to ensure that our efforts are directed at those most critical points of intervention.

The office also has a planning and commissioning branch, whose principal role is to negotiate and monitor the various contracts the department has across Western Australia. Currently we have about 70-odd contracts for specific health programs with a variety of health service providers across Western Australia. The very great majority of those are with Aboriginal community-controlled health services. That same branch is also responsible for the development of what we have called mainstream health service specifications—the notion of trying to describe for the mainstream a number of key deliverables which we think they need to address in terms of their general activity. Miss Tracey Pratt heads that branch of the office.

We also have a provider support and development branch; a branch which is charged with the responsibility of trying to capture some of the goodwill that exists out there in the health system. What we have found in our travels is that in most cases most people within the health system actually want to make a contribution, but the first thing they say is, 'We don't know how. Tell us how we can do better, or tell us what we can

do.' So the provider support and development branch is about trying to develop the capacities of the various providers across Western Australia so that they can marshal a better contribution to Aboriginal health.

The office is also taking a fairly prominent role in a number of whole of government initiatives which are intended to broaden the impact of effort on Aboriginal health. Principal amongst these are our efforts to promote and secure greater levels of intersectoral collaboration between the various functional agencies and functional areas that impact on human development in Western Australia. I will talk a bit more about that later on.

I suppose one of the principal issues that we need to mention is that Western Australia has taken a particular interest in the development of what we have called a culturally secure environment for Aboriginal people. We have spent some time looking at the issue of cultural appropriateness of services in Western Australia, and have come to the view largely that the term 'cultural appropriateness' is jaded, old-fashioned and basically means little to people now. It has been used so often that it has lost its impact. In recognition of that, and I suppose in recognition of the need to do something different, we have embarked upon the notion of developing what we have called a cultural security program.

The cultural security program is more about ensuring that the legitimate rights, views, values and expectations of Aboriginal people are respected and responded to in the health system, and that includes not just the provision of cross-cultural education programs, but the adaptation of work practices, including clinical work practices, to ensure that the legitimate rights, views, values, and expectations of Aboriginal people are respected. There will be some areas where clinical practice demands a course which might compromise some cultural standards, but that is the nature of clinical practice.

The other things that I think need to be said are that Western Australia, unlike many jurisdictions in the Commonwealth, has an exceptional database on Aboriginal health. We are one of three jurisdictions across the country that has publishable, quality data on Aboriginal health—ourselves, the Northern Territory and South Australia. Our data is used as the national data, so any national reports issued by the Commonwealth about Aboriginal health are in fact a compilation of data collected from those three jurisdictions. We have taken a deliberate effort in the West to try and expand that information system so that it not only embraces the normal and the routine collections that are gathered by health agencies, such as mortality and in-patient statistics, but also tries to capture some of the information that is currently held by Aboriginal community-controlled health services.

Importantly, though, it is not just a question of collecting information for information's sake. The office and the department have taken the view that information should be used as a tool by decision-makers and health managers to do a better job. We have been seeking to increasingly apply that information in ways that help sharpen the

focus of people engaged in improving the socioeconomic conditions of Aboriginal people, and in terms of also focusing the development of policy around health and other health-related activities.

I will ask Professor Gracey to give us a potted summary of the present status of Aboriginal health in Western Australia shortly, but in summary the one point I would like to make is that the information that we have gathered has increasingly been made public. We have taken the view that once we have collected the information and analysed it, we should return it to those people who have contributed to its collection. This applies not only to the broad collections that we presently maintain in respect of hospital and patient activity or mortality statistics, but also to that information base which we collect in a variety of our services across Western Australia.

For instance, we have just conducted an assessment of the health status of an Aboriginal community in the far north of the state, and prior to that information going anywhere else it is actually returned to the community and explained to them. They are then given an opportunity to think through that information in terms of what it means for them, and then we return to that community to discuss it and to find out what in fact we should do about it. The one point that I would make about the information is that, as I said, it is very public, and we believe that there is a need for a great level of transparency around information, because it is with good information that people are able to make good decisions.

One thing we do know about Western Australia—a point that is made up-front in our submission to the inquiry—is that the mortality rates of Aboriginal males in Western Australia between 1985 and 1989 and 1990 and 1994 saw a non-significant decrease of three per cent. However, the mortality rates for non-Aboriginal males decreased significantly by 11 per cent over the same period. The mortality rates for Aboriginal women increased over the same period by 11 per cent while the rates for non-Aboriginal women decreased significantly by five per cent. What these two sets of information tell us is that the health gap between Aboriginal and non-Aboriginal Western Australians is in fact widening rather than getting smaller. We are making some small inroads, but the health of non-Aboriginal Western Australians is in fact getting better at a rate faster than that of the health of Aboriginal Western Australians.

There are a number of other issues that I would like to touch on, but I suppose they would best come out of questions and, Chairman, with your indulgence, I will ask Professor Gracey just to give us a very short potted summary of the present state of Aboriginal health in Western Australia.

Prof. Gracey—Mr Chairman, I have asked that some documents be delivered to this office this morning so that you can see them and take them away. There is a whole stack of statistical reports about various aspects of health in Aboriginal people in Western Australia, which I feel sure the committee will find useful.

CHAIR—At the appropriate time, if you could name and table those, that would be very useful.

Prof. Gracey—I will, Sir, yes.

CHAIR—Will they be arriving before you have completed your submissions?

Prof. Gracey—I hope they will be arriving within minutes. I think there are a few points I would like to make. One is that from the late 1960s and the early 1970s, the infant mortality rate—that is, the number of babies who died in their first year of life—in the Aboriginal population in Western Australia fell from about 80 to 100 per thousand live births per year to about 15 per thousand live births per year at about the present time. This is a very significant improvement, but the infant mortality rate in Aboriginal babies is still about 2½ to three times what it is in non-Aboriginal infants; that is, babies up to 12 months of age.

In the last 20 years we have seen very significant declines in the rate of hospitalisation of Aboriginal infants and young children, particularly in the first two years up to five years of age, in Western Australia and for infections like gastroenteritis, respiratory tract infections and other infections. We have had a very significant decline in vaccine-preventable diseases, which has been related to very encouraging coverage rates of vaccination against these infections right throughout the state; in fact, compliance with immunisation is probably much better in remote areas than it is in the south-west and in the metropolitan area. We also have had small but measurable improvements in nutrition, particularly in infants and young children.

Having given you some of the more positive findings which are rarely given publicly, unfortunately, one has to admit that there is still a long way to go. For example, the age-standardised death rates for Aboriginal males are about 2½ to three times that for non-Aboriginal males in Western Australia. For Aboriginal females in Western Australia, the age-standardised death rates—which I can explain in a technical sense if you would like me to in a moment—are about three times the rate for non-Aboriginal females.

The main causes of hospitalisation of Aboriginal people in Western Australia obviously vary with age, but in children they are dominated by infections, poor nutrition, nutritional anaemias, intestinal parasites, and those diseases that are associated largely with poor living conditions, and contamination, and transmission of micro-organisms in the environment, whether it is from humans to humans, from infected animals to humans, or from contaminated sources such as contaminated food preparing areas, or from contaminated food, or from poor sewage disposal facilities, and from the generally unsatisfactory environmental conditions which are, I am afraid, prevalent in many Aboriginal communities, as you will see when you travel around them.

However, as you go through the age frames from childhood to later childhood, to

adolescence, to young adult life and to later life, there is a change in patterns of diseases. In young teenagers, for example, one is seeing very high rates of damage and death rates associated with alcohol, drugs, motor vehicle crashes, and with interpersonal violence. Suicide, of course, is an area for great concern, and this is something that is common knowledge, as you are very well aware. In adults at a later age, but even as young as in their twenties and thirties, we are already seeing very high rates of cardiovascular or heart disease, diabetes, overweight, and high blood pressure: all of these are thought to be related to very rapid changes in recent lifestyle, exercise patterns, and changes in diet.

So that overall the number one cause of deaths in Aboriginal people in Western Australia is cardiovascular or heart disease, ischaemic heart disease in particular, and between the ages of 35 and 45, the death rate from cardiovascular disease in Aboriginal people in this state is about 10 or 12 times what it is in the non-Aboriginal population. This is happening at a time when the rate of deaths from cardiovascular disease in the non-Aboriginal population is in fact declining, for reasons that we do not fully understand. But I find this really very disturbing.

We are also finding that deaths from diabetes, a particular form of diabetes called type 2 diabetes which is non-insulin dependent—in other words, potentially correctable by diet and exercise—is increasing very rapidly. This is a disease that has a very large number of potentially very unpleasant complications, including blindness, amputations, kidney complications, and a predisposition of diabetics to develop heart disease. There is a circle between lifestyle, diet, obesity, and cardiovascular disease. In many Aboriginal communities the prevalence rates of diabetes, depending on the age of the people involved, may be 25 per cent to 35 per cent. That means that in that age group in Aboriginal people in Western Australia about one-quarter or one-third of the population are diabetics.

This is of a similar rate of magnitude to what occurs in the North American Indians in New Mexico, and Arizona in the Pima and Papago Indians, and in Zunis and Hopis in the south-west of the United States. Research done there has suggested quite strongly that this is related to rapid changes in diets and in exercise patterns in their communities. Those people have tremendous and encouraging programs, I believe. I was fortunate enough to visit New Mexico late last year and to see what was called wellness programs being run by Hopi and Zuni Indians in their own communities. They have, not clinics but wellness centres, where they are fighting diabetes and heart disease through exercise programs and through altering their diet and through keeping alcohol out of their communities.

Touching on alcohol, I should say that alcohol-related diseases are a major cause, unfortunately, of illness, morbidity and deaths in the Aboriginal population, particularly after the age of, say, 30 years. These are related to alcoholic liver disease, and alcoholic diseases of the gastrointestinal tract. Alcohol also has very serious social impacts, as you know, and this is often related to violence, whether it is interpersonal violence or more

widespread violence, or whether it is related to motor vehicle crashes. The violence that we have documented is particularly male-on-female homicides and male suicides. Mental disease rates are much higher in the Aboriginal population than in the non-Aboriginal population, and much of this is attributable to alcohol as well, and alcohol abuse.

I should have mentioned that, across the board, the commonest cause of hospitalisation of Aboriginal people, whether it is in infancy or young childhood, right through to old age, is respiratory disease, including respiratory tract infections. In young children, this is probably related to overcrowding of living conditions and droplet spread of germs, particularly by people who smoke and who cough in confined environments. In later life, respiratory diseases in Aboriginal people are thought to be due largely to higher rates of smoking than occurs in the non-Aboriginal population at large. Is there anything else you want me to add?

CHAIR—All that is very sobering stuff which we are well aware of. I suppose what we are looking for is whether Western Australia has been able to succeed with better progress than other states. The detail you have given us is before us already, and that is probably what motivated us to form the inquiry, I guess. We are looking for clues as to whether Western Australia has been able to make better progress or found better models than other states. Thank you for the sobering statistics, but I am hoping we might be able to take it on from there and see what we can do as a committee to formulate a strategy for progress.

I do not want to underestimate the trauma that is confronted by indigenous communities, but we are well aware of those statistics. In fact, at our briefing in Canberra, our own performance was compared with some of those other communities you have mentioned—New Mexico, Canada and New Zealand—and we just stand out like a sore thumb in comparison to their statistics in terms of progress. So I suppose what we are about is to try and find good models or ways to break through some of this sort of inertia that exists in making progress.

Prof. Gracey—I should hand over to Shane. I have some ideas, but it is probably more appropriate for my General Manager to comment on that. There are some success stories in communities, and many of those relate to our associations with the communities, and even at the present time there are programs developing with improvements that are measurable. Of course, one of the difficulties with measurable health outcomes is that they take time, as you no doubt know. Even with things like vaccine-preventable diseases, and infant and maternal child health, where we have had very important measurable gains, they have taken many years to come.

A lot of the other areas that are disturbing will probably take quite a while, and they will rely, in my opinion, not just on programs that are devised, either by us, or in consultation with us and with the communities, but they will depend to a very large extent on community involvement, community participation, and community responsibility in

changing health within their own communities.

Mr QUICK—Professor, is there a statistical difference between urban Aboriginal health problems and results compared to, say, rural, and then compared to what we call traditional?

Prof. Gracey—Yes.

Mr QUICK—Is there a significant difference in the statistics, because they are all sort of lumped together. Do we need to look at them differently? Do we need three different health models? Do we need to go that far? Is one area working any better than the other in some of the health programs?

Prof. Gracey—Some of these reports are coming before you. I would say that, in a general sense, the health of Aboriginal people in the metropolitan area and in the south-west is in some ways better than it is in remote areas. This is probably because of access to clinical services, access to fresh food from food stores, and access to information about health, nutrition and hygiene. Of course, there is always a risk of grouping Aboriginal people as a single group of people. They never were a single group of people in Australia. Shane is not from this side of the country. Within Western Australia there are tremendous varieties in the make-up of Aboriginal people, so it is not wise to generalise.

We do have some strong information that expectancy of life in the Kimberley has been much better than in other parts of Western Australia. This may be because the effect of colonisation or the European impact on the way of life in Kimberley Aborigines has been much more short-lived than it has in the south-west. But despite the fact that most of the Aboriginal people in Western Australia in fact live in the metropolitan area, their standards of health, as Ted Wilkes will have told you, are really well below that of the rest of the population.

Mr Houston—Mr Chairman, I would just like to, if I could, very quickly touch on some of the sorts of things that Western Australia is presently engaged in that we hope will bring about some of the changes in the Aboriginal health status that you have said the inquiry is interested in. Some five years ago, this jurisdiction spent no money at all in Aboriginal community-controlled health services. We have fortunately been able to turn that around over the last couple of years, and increasingly the resources that the Office of Aboriginal Health has are being directed into supporting community-level initiatives. I think this can be exampled in the range of projects that I might just run through very quickly for you now.

In addition to those services which you would expect to be provided by the mainstream of the health system, the Office of Aboriginal Health is responsible for a fairly far-reaching program of environmental health for Aboriginal people in Western Australia. This is something I think worth mentioning, because to my view it represents a benchmark

for the rest of the country. It touches particularly on a number of the terms of reference of this committee and, most importantly, term of reference (a) in terms of the provision of services.

It has been an unfortunate fact that the operational relationship between Commonwealth and state agencies and governments around Aboriginal issues and around Aboriginal health has not been what it should have been. There have been too many examples, including very recent examples, where the Commonwealth government has resourced a particular initiative in the absence of discussion with the state, which has then created complications for the community or for service providers at the local level.

To be absolutely honest, Mr Chairman, there are also examples where the state has embarked upon a course of action in isolation from the Commonwealth which has caused problems for the communities. Environmental health has been one of those areas. There has been a litany of programs at Commonwealth and state level to try and address these issues, stretching as far back as the Aboriginal health improvement program in the mid-1970s. Recognising that as a problem, the state provided some $3 million to the Office of Aboriginal Health to in fact establish an Aboriginal environmental health program for Aboriginal people. At the beginning of that program we were conscious that there was a need to drive some of the efficiencies established on the collaborative frameworks that I have alluded to.

In doing so, we have created what we have now called the environmental health needs coordinating group, which is a group that is comprised of all of the principal Commonwealth and state agencies involved in the delivery of environmental programs to Aboriginal communities including, on the state side, the State Housing Commission, Homeswest, the Health Department of Western Australia, the Aboriginal Affairs Department, and others. On the Commonwealth side it includes ATSIC, the Department of Family and Community Services and a number of other Commonwealth agencies, the Department of Education, Employment and Training, to name another.

This committee has, interestingly, dealt with a number of the main concerns or the problems associated with coordination. It has moved to a single information base on which it now makes its decisions. Prior to the establishment of this committee we had ATSIC, with its national environmental information management program, running around surveying the country trying to get environmental health information. We had Homeswest conducting similar surveys, and the Health Department was conducting similar analyses. So there were a variety of people running around collecting information in different ways and, not surprisingly, it told them different stories.

What we have done is in fact stepped back from that and we have now agreed, as a group of agencies both Commonwealth and state, to collaborate in the conduct of a single Western Australian Aboriginal environmental health needs survey. That survey has been concluded and the information is presently being collated. It is the second survey that

we have conducted, the previous one being 2½ years ago now, and all agencies around the table have agreed that they will use that information, to both prioritise their own programs and to work out how they should work in collaboration with other agencies across Western Australia.

The extent of support for this, Mr Chairman, I might point out, at the Commonwealth level extends to ATSIC at the state level deciding not to be part of the national environmental survey that ATSIC is continuing to conduct in other jurisdictions, but, rather, investing its time and dollars in the conduct of a single survey here in the West. That environmental health needs survey will be used by the Health Department in prioritising a number of the initiatives that we presently operate, including the Aboriginal environmental health worker program. We are currently funding about 70 or 72 Aboriginal environmental health worker positions across Western Australia, and we are also engaged in the provision of minor repairs and maintenance work in Aboriginal communities.

At the very beginning of the program, Mr Chairman, the Health Department did something quite radical in that it actually started to build sewer systems. This was something that was unheard of before, for a health department to suddenly start getting into major capital works. We in fact funded five major deep sewerage systems in Aboriginal communities across Western Australia. The interesting thing that did was to actually force other agencies, whose primary responsibility it was, to think about those issues, and why should health be involved in these particular initiatives.

That little bit of a ripple allowed us to introduce and reinforce the notions of outcome-based planning for Aboriginal people, because we were very clearly able to point out that something like the excess morbidity and excess hospitalisation for Aboriginal people in Western Australia due to poor environmental conditions cost this state about $11 million, and $6 million of that is spent on kids under the age of five. We were actually able to then start to example that we were prepared to put our money into those communities where, obviously, there was the highest level of demonstrative need. Interestingly, other agencies then started to think about the same sort of an approach.

So the environmental health program, Mr Chairman, I suggest represents, and is generally recognised across Aboriginal health agencies, as a goal benchmark for the collaborative efforts that it has been able to strike. In addition to that, we have been able to stretch out and use a number of other partnerships with state and Commonwealth government agencies, and with the community sector, around programs of road safety for Aboriginal people, around health promotion services, alcohol and drug programs, and the provision of special services for Aboriginal people. On this particular issue, Aboriginal people have told me over my 26 years in Aboriginal health that they are sick and tired of being surveyed without any action coming out of it.

CHAIR—They told us that, too.

Mr Houston—Yes. One of the things that frustrated them most was that when specific disease-focused surveys lobbed into their community, they were poked, prodded, sampled, bled and everything, to try and get some information, and doctors would periodically come in and say, for instance, with eye health, 'You need those cataracts removed.' They would come back two years later and say to the same five people, 'You need those cataracts removed.' The people would say, 'You told me that two years ago. When is it going to happen?' Unfortunately there has been a significant breakdown between that level of assessment and surveillance and the actual provision of treatment.

In order to get around this, the Health Department of Western Australia has developed and trialled, in two locations, what we have called a community fund-holding model. The three examples where we have trialled this are in Wiluna in Western Australia, where we trialled eye health; in Geraldton we trialled ear health, and in Kalgoorlie we trialled laser retinopathy.

Basically, in Wiluna we identified five people who needed cataract surgery and who had been told year after year that they needed it, but they would never actually get onto the list and get into hospital and have it done. What we did was to work out what it would cost the hospital system to treat those people, and we gave that money to the community, and the community then went hospital shopping. They went to Kalgoorlie Regional Hospital and they said, 'We have five people that need cataract surgery. When can you do it, and how much is it going to cost us?' Kalgoorlie Hospital said, 'It will cost you X amount of dollars and we can do it in so many weeks.' The community said, 'Too dear, and not quick enough.' They went to Royal Perth Hospital, asked the same questions, and it was more expensive and a longer delay, and at the end of the day the five people from Wiluna were admitted as private patients at St John of God at Murdoch and had their eye surgery done within four weeks.

In Kalgoorlie we contracted 19 cases of laser retinopathy to Bega Garnbirringu, the local Aboriginal medical service there. We gave them the same amount of money that we would give to a public hospital to do that service for 19 people. At last count they had screened and provided preliminary treatment to 96 people and had treated 33 people with laser treatment for their eyes due to diabetes. So they are two very good examples where changing the way you do your business can in fact produce a substantially different outcome for people on the ground.

CHAIR—So there is a deliberate shift to a bottom-up consultation?

Mr Houston—Definitely so. The approach that we have deliberately tried to take is that we have got to move away from the notion of money historically following institutions to the point where we can actually have money follow people. That is the sort of approach that we are actually trying to trial in Aboriginal health in Western Australia.

The third committee, Mr Chairman, I might just mention was in Geraldton. They

did something in the order of 44 people that needed surgical correction for ear problems, at a price that was significantly less than that which we would have otherwise provided to the public hospital system. I think that is something well worth mentioning.

CHAIR—There is a Commonwealth coordinated care program that operates that way. How is that being received and utilised positively?

Mr Houston—Western Australia has one of the four Aboriginal trials within the coordinated care program. Ours is slightly different than any other. Ours, in fact, is a partnership between three community-controlled health services in Bunbury, Perth, and Geraldton, and the Office of Aboriginal Health. We are seen as equal partners in the trial. The development of the trial has caused significant changes in the way in which the communities operate and, in many respects, the way in which the Health Department operates. There still remain some significant problems to be resolved around coordinated care, and they are very significant, to the point where they may in fact derail the trial.

CHAIR—Run us through those, will you.

Mr Houston—One of the very real issues that we have got to come to grips with is the perception about cost. The Commonwealth has cashed out MBS and PBS allowances for Aboriginal people at the national average. Mr Chairman, I should acknowledge that that is higher than the Western Australian average, but the real fear that we have—based on our experience in Aboriginal communities—is that that in itself will not be sufficient. Doing some modelling, using the information that we presently have, we suggest that it will cost in the order of $1,500 per person per year to provide primary health care services to Aboriginal people. The Commonwealth is presently cashing at a rate—when you combine PBS and MBS—of about $357.54 per person per year, so it is significantly less.

That of course raises some significant concerns on the side of the state, because if we are embarking upon a program which will, in effect, identify more people—and we have enrolled in the order of 3,500 people in the trial in the three locations—then if we go to the position of developing care plans for these people, getting the care plan started, and then find that the level of contribution is inadequate, the trial itself will collapse, but the people themselves and the state will be left with a level of demand for service which it otherwise will not be able to meet. So there are some significant problems around the level of cashing out at that level. That in itself I think is going to have a major impact on the progress of the trial.

To date, the position taken by the state and by the trials themselves is that we will work to commence the trial, and that we will monitor the cash flows around the trial very closely and take some hard decisions a bit further down the track. We have taken the view that even if we get three or four months worth of the trial in, at least we will then have some good data on which we can authoritatively speak about these sorts of things, like the

cost of providing primary health care services to Aboriginal people, that we did not have before. But there are some other significant risks, particularly for the state, around continuing demand for services once the trial collapses. That is a major problem.

CHAIR—So that is only the one? And it is money? Is that it?

Mr Houston—Largely, yes.

CHAIR—It is always the same.

Mr Houston—That is certainly one of the issues. The other issue is the question of the Health Insurance Commission's processes around Medicare for Aboriginal people. Surprisingly, when we enrolled people in Bunbury—and Bunbury is a large regional centre of some 60,000-odd people—we found that 30 per cent of the Aboriginal people who enrolled in the trial were not registered with Medicare. They were not enrolled in the Medicare system. If that is the case in a large centre like Bunbury, what is it going to be like when we get to the more rural and remote locations across Western Australia? It is some of those processes also, Mr Chairman, that are going to impact on the way in which the trial is able to progress over time.

There are also some issues around that problem about risk sharing. If the state is responsible largely for the provision of health services for Aboriginal people, and there is a heightened level of demand for activity that occurs as a result of the trial, then the state is then left with the cost of doing that. The position that the state has taken is that while we are prepared to continue to work with the trial, this is an issue which we would expect the Commonwealth to come to the table and sit down and resolve with us before we get too much further.

Mr Chairman, I might just very quickly touch on a few other things. We have embarked upon a heart health program for Aboriginal people as well, and I might just say it has been a particularly interesting program, in that we have been able to do it slightly differently than has been the case in other places.

CHAIR—Could I just interrupt you for a second, Mr Houston. Can you give me some idea how long you will need to complete your presentation?

Mr Houston—Two or three minutes. I will finish very quickly.

CHAIR—That's fine.

Mr Houston—With regard to the heart health program, for instance, we know that three out of 10 deaths in Aboriginal communities from heart diseases are observed deaths. So we have invested a significant amount of time and effort in ensuring that the family members of high-risk Aboriginal people—people at high risk from heart diseases—are in

fact trained in first aid CPR. In Geraldton alone in the first 12 months after the program was conducted there, three people had heart attacks and were in fact kept going by family members who had participated in the CPR program's first aid training in Aboriginal communities. We have in the order of 2,000 people who have subsequently been trained in first aid in Aboriginal communities. Simple things like that, Mr Chairman, we believe are important, impacting on the levels of heart health in Aboriginal communities.

There are a number of other programs that we have established, but I might just mention one that is of particular importance, I think. It goes to a number of the terms of reference of the committee—and I touched on it earlier—about cultural security. There are two particular initiatives that have been established to try and help move us towards developing a more culturally secure environment for Aboriginal people in our hospital systems. One of them we have called an attitudinal survey, and that is about trying to capture and define in a clear way what Aboriginal people's views, values, and expectations are of the health system in terms of their cultural standards.

In doing so we have then been able to take the next step, and that is to actually sit down with providers of health care services and look at their work practices to decide what in fact compromises cultural standards and, where clinical practice allows it, how do we modify those practices to ensure that the services are provided in a more culturally secure way. An example of that, for instance, is that if you lob into the accident and emergency at Royal Perth on a Thursday night with a split head, there is not much of a cultural issue about how you get saved, how you get stitched up and treated. But if you're a woman presenting at Royal Perth or at any hospital for birthing services, there are a heck of a lot of cultural issues involved in doing that. We are now in the position of trying to encourage hospitals to change, for instance, their birthing practices so that Aboriginal people can in fact deliver in a more culturally appropriate way.

CHAIR—The Australian Nursing Federation referred to it as cultural safety, but it is all the same.

Mr Houston—It is the same sort of thing, Mr Chairman, yes. But I think what increasingly is becoming evident is that the notions of cultural appropriateness have been left in the past, and that we are trying now to more specifically define the sorts of environment that we believe should exist. Mr Chairman, I think there are a whole range of issues involved in that, including recognition of some of the rights that Aboriginal people have under a number of international conventions and covenants that Australia has signed, and certainly some of the issues that have been raised in the development of the Universal Declaration of the Rights of Indigenous People which has been going on for the last 10 years.

The cultural security program, or the cultural safety program, Mr Chairman, I think will have a great impact on this country being able to stand up in the international forum saying that it has met its obligations in respect of these provisions. Mr Chairman, I might

actually just leave it there and answer questions.

CHAIR—Just on that last point, that is a challenge for mainstream health services and in fact the rest of society actually, I think, from my personal view. What has been done in Western Australia to enhance that? When you go right back through to the training of health care workers, medicos, everybody, has there been a significant improvement in that aspect of the training element?

Mr Houston—We have had an arrangement in Western Australia for some years now at the University of Western Australia, which is the only medical school here, that there would be a number of designated places for Aboriginal people. In reality we did not get those places filled and where we did get people enrolled the drop-out rate was quite significant. In recognition of that, the University of Western Australia, the Health Department of Western Australia and others got together and have established the Centre for Aboriginal Medical and Dental Education. That centre is not only about providing support for Aboriginal students who enrol in medicine in Western Australia, but also about ensuring that the curriculum is in fact adapted to make it more relevant to Aboriginal health needs across Western Australia.

This year we have got three new students in medicine, and I think in three years we have gone from one student in the two years prior to that to eight students enrolled this year. I think that is a significant gain, and I think that is largely due to the significant work of Dr David Atkinson, who is the director of the centre down there. I think due recognition should be paid to him for that.

CHAIR—How does eight compare, though, with the demand? There is probably a demand for hundreds, really.

Mr Houston—The problem is that Australia has a large number of doctors. We have more doctors than we need. The trouble is we cannot get doctors to where we need them.

CHAIR—Yes.

Mr Houston—An example is Ngaanyatjarra Health Services in Central Australia—you will no doubt meet many of the people from there when you visit Central Australia—actually had a funded doctor position, but could not fill it, and have subsequently abolished it and, rather, employed a dentist. Interestingly, they could get dentists out there but they could not get doctors out there.

Mr QUICK—The Education Department gets teachers out there. Why can't the medical profession get doctors out there?

Mr Houston—There are a number of reasons. One is the question of remuneration

of doctors. Secondly, there are questions around the recognition that is paid to doctors who specialise in Aboriginal health. Mr Deputy Chair, I think that it is a really important point that you have raised. In remote parts of Western Australia it is basically salaried medical practice. Doctors in general practice, in private practice, can make considerably more money than they can working for an Aboriginal medical service in remote locations. The average salary for a doctor in salaried practice in an Aboriginal medical service is between $80,000 and $100,000. Even a poor doctor in Perth can make at least twice that amount of money. That is one issue.

The other issue I think though—and it is one that we cannot underestimate—is that there are an enormous number of doctors out there who want to work in Aboriginal health, but who also have an interest in their professional career, and there is little to scant attention paid to the recognition of service in Aboriginal communities as an area that demands professional kudos and professional credit. It is unfortunate that it tends to be that the ilk of Professor Hollows, or Ian Constable in Western Australia, or Dr Torzillo or others who spend many years working in Aboriginal communities, finally get that recognition. But what we have to do is try and move that up-front of their career and start to provide ways where they can get some good strong professional recognition around that as well.

Mr QUICK—The Royal Flying Doctor Service says:

Mainstream health services have difficulty in recruiting and retaining appropriately trained health professionals due in part to poor living conditions—

the department could do something about that—

and lack of professional support.

Surely the department can do something about that too?

Mr Houston—The state of Western Australia employs the bulk of salaried medical officers outside the metropolitan area. Where they are employed by the state, they have an award which provides for them things like houses, on-call allowances, and all the other entitlements that go with that.

Mr QUICK—So what are the standards of houses in remote areas for doctors?

Mr Houston—High, but we do not have resident doctors in many remote and rural communities. An example of this is that in the north, in the Kimberley, the doctor that services Balgo and Yagga Yagga, which is over near the Northern Territory border, comes from Derby, and they are flown out to Derby and back.

Mr QUICK—Well, I come from what in Tasmanian terms is a remote area, and

we have trouble getting doctors in the southernmost part of Tasmania. We have a Scottish doctor. Do we need to change the rules and regulations to bring some of these doctors in from overseas who are prepared to go out and spend some time out there, rather than sitting in the cushy CBDs of the five big cities in Australia?

Mr Houston—Western Australia has taken the stand that every Aboriginal medical service in Western Australia is designated as a place of significant need, and they are in fact able to access the provisions for bringing in doctors and giving them limited practising rights, so long as they continue to stay in those remote locations. That has had a measure of success. But we should not underestimate the difficulty of living in a location where you are the only medical practitioner for, in some cases, several hundred kilometres, where you are on 24-hour call. The demands of a general practitioner in an Aboriginal community are not the same as the demands of a general practitioner in metropolitan Perth. You are very much part of the community.

Mr QUICK—We understand all of that, but we need to do something to address it. It is fine to say that that is the case. Okay, now what do we do? Do we say, like we do with the mining guys, 'Six months out and six months back, and you get some special deal'? The Flying Doctor Service also says:

The high turnover of staff severely restricts the continuity of care and the possibilities for addressing health concerns . . .

Now, if it is catch-22, we need to put something in place to say that, irrespective of where you live in Australia, if you are an indigenous person you get the same health attentiveness whether you live in the CBDs, in Redfern or in Perth somewhere.

Mr Houston—Mr Deputy Chair, I do not disagree with you there. There is a need for us to do things differently, because if we continue to do what we have done, we are always going to have the problem. It is going to remain.

Mr QUICK—So have you got any trial programs to say, 'In place A we have had a doctor there for four years and he has developed a rapport with the community, and we have some achievable outcomes. The incidence of all these diseases goes down because we've given him X and Y and Z. That works. That's an effective trial. Let's go and replicate it around Australia, and use it as a model. We'll get the money not only from the Health Department, but from the Education Department, from the housing department, from Transport and so on, so we have got adequate roads, we have got adequate waste management; we have got all these things that we know are concerns addressed for this particular area.'

CHAIR—Could I just offer the suggestion that the issue of getting country doctors is much wider than just where we are now. It is a complex matter in which I think the Commonwealth has got a role to play as well. I know and I respect the direction of Mr

Quick's question, because his electorate has similar problems to mine, but it might be more useful if we focused on the indigenous health aspects.

Mr QUICK—Yes, but, as I said, I am quoting from the Royal Flying Doctor Service which is talking about mainstream health services.

CHAIR—I think a lot of the clues to resolving that difficulty belong with the profession themselves. Maybe those questions would be better directed to the representatives from the Flying Doctor Service when they get here. I mean it is the Australian Medical Association. We have already heard from a young undergraduate regarding what his perceptions are—'We just wouldn't want to go out there'—which is often a perception that is not correct.

Mr QUICK—I am a former teacher and I taught in some remote areas, and there were incentives and, in some cases, there was bonding which dictated, 'I'm sorry, but you've got to do three years out in the wilderness, and you're not going to get punished if you go out there, because when you want to come back into the city we've still got a place for you.' I see that as a role of the state health departments. It is no good saying, 'We've got a high incidence in a remote area'—and we don't do anything about it.

Mr Houston—Mr Chairman, I am happy if I can just touch on this very quickly. The Commonwealth is totally responsible for the provision of salaried medical staff for Aboriginal medical services across the whole of the country. That has been the case since the first Aboriginal medical service started in December 1970 in Redfern. But I think the issue is about how do we ensure that Aboriginal communities in remote and rural parts of Australia receive the level of health service commensurate with their level of need? I think what we have to do is look just beyond the question of the provision of doctors' services, to the provision of the total package of health services to those people.

That includes, for instance, Mr Chairman, the provision of Aboriginal health work services, where increasingly in the Northern Territory and in Western Australia, Aboriginal health workers are more of an independent practitioner, and in some cases the sole practitioner in Aboriginal communities. There has been a significant level of effort over the last couple of months to improve the competence of Aboriginal health workers across Western Australia. We have some Aboriginal health workers who in remote locations provide a full range of service and who are supported, by radiotelephone or by phone, by a doctor based elsewhere in the state. So I think it is a question of us looking at Aboriginal health worker services.

We are improving, through the efforts of people like CRANA and other people, the skill level of remote area nurses. We are also doing something about improving the level of access to general practitioner services. The RFDS, the Office of Aboriginal Health, Aboriginal health services from Balgo, Jigalong, Wiluna, and Kalgoorlie and Ngaanyatjarra Council are participating in a current review of doctor-based services in the

remote part of Western Australia, and are about to make recommendations about improving the level of services which would see, as a general rule of thumb, about one session per community per week. Now, that might not sound like much, but in many places that is a significant improvement on the level of servicing that they presently have.

In the Ngaanyatjarra Council area, for instance, the general standard that we are embarking upon is one five-day session per fortnight for the 11 communities in the lands. That would be a significant level of improvement on the level of services that are presently provided. So if the real issue is about getting adequate medical and health services out to those communities, we have to look, not just at doctor services, but at Aboriginal health worker services, at nurse services, at health promotion services, and environmental health services as well. So it is about trying to capture all of those, and measure how much of each you need to put into each community to achieve the desired result.

CHAIR—I know Mr Quick will not be satisfied with that response, but it is really a deeper issue. It is not just the problem you are confronted with in indigenous health; it affects the mainstream rural communities as well.

Mr Houston—Mr Chairman, if it helps, I am happy to provide the committee with a copy of the report that is currently being prepared for that review of doctor-based services in remote locations. It actually lists, by community, the types of services they get and when.

CHAIR—Good. We would be pleased to receive that. If you could just have ongoing contact with the secretariat, that would be very useful.

Mrs JOHNSTON—Actually, I think some of my questions have been answered, but could I just ask this to either the professor or to you, Shane. We are talking about the cultural aspects that Aborigines face when they go, for example, into hospitals and so on. I am not sure about this, but you may be able to help me. Is there a psyche within Aboriginal or indigenous people which says to them that, 'If I get sick, I will not get better'? And if that is the case, how do we overcome that from a Western point of view? I can understand that we can help in making people aware that you need exercise to prevent heart diseases, and that smoking is not very good either. Those sorts of things we can do. I may be incorrect in assuming there is an inbuilt psyche, but could you explain something along those lines for me, please?

Mr Houston—It has certainly been the case in my visits—and Michael can add to this if he likes—that a lot of people simply see hospitals as places you go to die. That is a major problem. How you get around that involves a whole range of issues. There is a perception that hospitals are things that everybody knows about, but that is simply not the case in many parts of Aboriginal communities.

Just in the last couple of months there was an example of an older man coming down from the north of the state to Royal Perth. Royal Perth is a multistorey building, and he had to get in a lift. He refused to get in the lift, and people had all sorts of trouble trying to convince him to get into this lift. They eventually got a woman who was a social worker, who happened to be an Aboriginal person, to come and talk to him. The problem was, as he told her, that he had been sitting there watching this lift and he saw one man go in there; those doors closed, and he came out a woman. That to us is a bit humorous, because we know the environment, but for that man it induced dread. He was loath to get into that lift. There are other examples of that sort of an environment.

Part of the problem is about the distances in a state like Western Australia. We have one of the most dispersed Aboriginal population of any jurisdiction, and all of our tertiary services are based in Perth. That is a significant problem that we are trying to turn around. We are trying to say that those services should be sent back to places closer to their home. If people are not far from their home, are not far from their support services, then there is a greater likelihood that they will feel comfortable in accessing those services.

Birthing services for women is a good example. In Western Australia we have a policy that all Aboriginal births are high-risk births, and that they therefore should be delivered in a regional hospital. Many people, including myself, have a personal view that that policy is flawed, and that not all Aboriginal births are high-risk births. Aboriginal communities increasingly are saying they do not want to put up with that. We have the example in the east Kimberley, south of Halls Creek. People were refusing to present for antenatal care because they felt that if they went up and tried to get antenatal care they would get targeted and whisked off the 500-odd kilometres to Derby, and would have to spend six or eight weeks in Derby, away from their family, worrying about themselves and worrying about what was happening to their family.

The upshot of it was people would not present for antenatal care, and we saw a significant increase in unplanned emergency deliveries at Halls Creek Hospital, which was ill-equipped at that stage to deal with those problems. So the more we are able to get these services back to places closer to where Aboriginal people live, to where their support systems are, to where their families are, I think the better the opportunity we have of actually doing it. Making that happen is not necessarily an easy thing, but I think that has got to be the goal that we work towards.

Prof. Gracey—Could I make a comment which I hope might help. Aboriginal people, in my experience—which goes back now nearly 30 years—are initially quite suspicious of non-Aboriginal people who provide them with clinical services, whether they are doctors or nurses, for example. I think this is rather offputting for the average health professional who feels that they know what is best for the Aboriginal person. This is why it has been hard to get the right sort of people to work in very remote areas, or it has been one of the reasons why. I think we have to overcome this in our training of

undergraduates, and in postgraduates, and Shane has already touched on that.

I am involved in training another group of health professionals at Curtin that include nutritionists, physiotherapists, dentists and so forth. I think we have to make them aware of these sorts of differences in attitudes between Aboriginal and non-Aboriginal people in relation to their health, and services that they are being offered. I think we also have to acknowledge that when we are wanting to train Aboriginal people to bring them into the health industry, we have to be much more flexible than we have been in the past. I was, just the day before yesterday, in Jigalong, which is east of Mount Newman. There was a lovely little 18-year-old Aboriginal girl there who wanted to be a health worker. She was highly intelligent and very interested, but she was terrified at the thought of coming to Perth for her training. She could not get into Broome for her training.

We have to be much more flexible in the way we approach this, because these people are the people who are required to try to overcome the sort of cultural differences between Aboriginal people and non-Aboriginal people in providing services that are needed in the communities on the spot.

Mrs JOHNSTON—Could I just ask one more question. Yesterday it was suggested to us that in Bunbury, which you very rightly pointed out is a very large city, there was not one bulk-billing doctor. So in other words indigenous people would not have access—and obviously other people would not either. From the statistics you have or that the department keeps, is that correct? If so, what is the department going to do about it? I cannot believe that there is not one bulk-billing doctor in Bunbury.

Mr Houston—To be honest I do not know whether there is or not. I do know, however, that the South-West Aboriginal Medical Service has raised significant problems around the fact that people do not have the dollars to go and pay for medical services and then go and get it back off Medicare. I know that in Bunbury, however, with the coordinated care program—and this goes to the question about what can be done about it—they have embarked upon an interesting approach.

Rather than employ salaried doctors, they would establish a series of preferred providers—there are three or four doctors who Aboriginal people feel very comfortable with—and they will enter into an arrangement with those three doctors whereby all of the business of the Aboriginal Medical Service that should be provided by a doctor will be directed at those three doctors exclusively. That is a way of trying to manage it. The coordinated care mechanism then provides them with the opportunity to negotiate a price for those services, which might be significantly less than that which the doctor might otherwise attract as a bulk-billing fee, but the advantages are you get it up-front.

Mrs JOHNSTON—It sounds a bit like competitive tendering, which nobody wants to have. That point is well made.

Miss JACKIE KELLY—You talked about money following the people, Mr Houston, rather than money following the institution. Yesterday we were very impressed with the attitude at the Perth Aboriginal Medical Service. It was really such an enthusiastic group. They talked about empowerment of Aboriginal people. Is that a significant part of the approach that you have taken? Is it going to continue and do you think it is successful? My second question would be, what do you see as the one thing that the Commonwealth could do to improve Aboriginal health?

Mr Houston—The question about empowerment I think is at the absolute centre of everything that we do. The view has to be—and it is something that Aboriginal people have seen for ourselves time and time again—that we have to do it ourselves, rather than have someone do it for us. That is absolutely critical. I think the Perth Aboriginal Medical Service, Mrs Kelly, is one of the best examples—you are right—of that process. We need to encourage people to take on the responsibility to do something for themselves. Really what we are doing is affecting behaviours. We can spend time and effort in providing education services that equip people to know about something, but then actually getting them to do something is something that they then have to take on themselves.

The notion of developing an ownership by the communities themselves is absolutely critical. That is why the very great bulk of resources spent by the Office of Aboriginal Health is in fact directed at community-controlled health services. A classic example—I think the Perth Aboriginal Medical Service is a good one of this—is that we have established what we call an Aboriginal family futures program. That is an interesting program in that we have now stopped allocating staff to hospitals and to health services and to community health centres, and we are now allocating staff to Aboriginal families.

The Perth Aboriginal Medical Service, having recognised that its historic development has been at the centre of Perth, but the nature of the population in the Perth metropolitan area having changed, are now decentralising their operations to Midland, Koondoola, Girrawheen, and Balga in the north, and to Armadale and Kelmscott in the south, and they are in fact establishing, using resources provided by the office, an Aboriginal family futures program out there. It is one where they are working very closely with the Swan District Health Service.

What is critical in that partnership is the respect that is necessary amongst all of the players for the level of Aboriginal community ownership of the issues that we must come to grips with. By changing the way the services and the resources are organised, moving them out of institutions into family groups, we in fact hopefully will be able to make sure that we get a far greater level of participation, a far greater level of ownership and a greater level of compliance around the development of health initiatives.

The other thing about the family futures program I should point out also is that the allocation of health workers to family groups allows us to implement what we have called our central health events program. It is not a new idea but it is like running a hurdles race.

You have got a dozen hurdles you have to get over in life, and the central health events program is about making sure that you get over each of those hurdles successfully so that, interestingly, you can die healthy, if I can put it that way. The Perth Aboriginal Medical Service I think is a very good example of how they are able to strike and achieve a great level of local ownership, at a family level, of those sorts of issues.

What the Commonwealth could do to improve Aboriginal health—where do I start? I believe that the Commonwealth needs to think very carefully about its position around Aboriginal health. Is it a purchaser of services for Aboriginal people, or is it a funder of services? I think they are two entirely different things. To my way of thinking, a purchaser is someone who sits down and negotiates with a provider of services, a level of activity, the general specification of that activity in terms of quality, in terms of emphasis, and then monitors to make sure that that gets done. Purchasers generally report and account to someone else. The Office of Aboriginal Health, as a purchaser, must account to government as a funder for how we spend the resources they provide to us.

And if I can make this distinction, a funder is someone who does not actually negotiate with providers, but is someone who is concerned with the appropriation of the funds, the gathering up of the resources necessary to allow things to happen. They might set very broad-based specifications, and an example might be that they might seek to, as we have done recently, reduce the age-standardised mortality rates for Aboriginal people by 20 per cent over the next 10 years. They might set that as the goal, and then their job is to hold the purchasers accountable for the achievement of that objective, and in turn the purchasers work with the providers to make sure that happens also.

For them to work out that issue would provide a great degree of certainty. Even though there is a good degree of goodwill between my Commonwealth counterpart, Helen Evans, and the Office of Aboriginal and Torres Strait Islander Health, and other Aboriginal health agencies across the country, there still remain significant problems in actually making that goodwill work on the ground. We still have problems where Aboriginal health services have multiple accounting requirements. One organisation we know had 27 funding sources and they had to produce 27 annual reports, 27 activity reports, 27 times four quarterly financial reports, and 27 times four quarterly activity reports.

We have been trying to get to the situation where the Commonwealth and the state could in fact pool their resources and get one contract that they could strike with Aboriginal health services that would govern the provision of funds from a variety of sources which would then make it easier for the providers to get on with the job. Because people like Ted Wilkes unfortunately spend most of their time reporting to people like me, and less time being what he should be, and that is a manager of a health service, we have to do something about changing these sorts of structural arrangements.

Unfortunately, goodwill notwithstanding, there are still some significant problems

in getting the policy-makers and the legal eagles, if you will, at either end to agree. Mr Leslie was involved in a series of negotiations where we were that close to making it happen in Western Australia, and legal objections from Canberra have now derailed the entire process.

CHAIR—We are constantly confronted with that message.

Mr ALLAN MORRIS—Mr Houston, you referred earlier to data being available and transparent. If I can just quote some figures to you first to give you a context, about 30 per cent of Aboriginal people are living in remote areas compared to three per cent for non-Aboriginals.

Mr Houston—Yes.

Mr ALLAN MORRIS—The per capita expenditure on indigenous Australians is 10 per cent higher than non-indigenous Australians. Those figures on spending on the surface look like Aboriginal people get more dollars per head, but when you take into account the actual remoteness it is almost certain they actually get less per head on any form of statistically valid figure. So it depends what you put forward. I mean, putting forward the data that you collect may in fact be quite misleading, because it may be that that data has not been appropriately adjusted to take into account how it has been collected, and what is involved.

Mr Houston—Yes.

Mr ALLAN MORRIS—So I agree with you, and what I wanted to ask you was, how do you take into account that expenditure? How do you compare the expenditure in the health budget in a remote area per capita to the expenditure in, say, Perth per capita?

Mr Houston—Health systems generally across the country are ill-equipped or unable to provide detailed information about the level of expenditure on Aboriginal health programs. We are able to articulate or identify that expenditure which is provided on specific services to Aboriginal people, such as through the Office of Aboriginal Health, or other specific Aboriginal health programs through HACC, or other programs. We are able to estimate in-patient services provided to Aboriginal people because the morbidity data system is very good, using DRGs. However, we know very clearly that the DRG costings for Aboriginal people do not take into account the high morbidity rate of Aboriginal communities. There is a significant Commonwealth report on that matter.

We are not able to capture information about services provided to Aboriginal people in community health settings, nor are we able to provide information about services provided to Aboriginal people in accident and emergency services in any hospital in Western Australia, and in those clinics that we also run. So there are some significant gaps in the data that is available. I agree with you. I think we have to do something about

improving that level of data. This is how I think we should manage that situation. Making sure information is transparent is one thing, but people actually have to be able to understand it, be given an opportunity to pull it apart, and also be given the opportunity to challenge it. That is something which we believe is very important.

Along those lines, the state now provides resources to the Western Australian Aboriginal community-controlled health organisation to establish a secretariat which allows them to focus, to develop some of the technical expertise which would equip them to argue with us better about the information that we have. We have also, over the last couple of years, set up a process where we fund four meetings a year. The way it is written is that we actually buy advice from the community sector through four large-scale meetings a year where all of the health services come together.

The other way we do it is make ourselves available to be slapped around, and the community-controlled health services are very able and willing to do that. They do often challenge the basis on which decisions are made, and to my way of thinking that is a productive end because it actually means we have to think more seriously about the position that we take, and at the same time we get informed, because their being closer to the reality often gives us access to insights which can only really be gained from being there. We are then able to benefit from that.

So I think there are significant gaps in expenditure. We have, as I said, good information in those areas that I have mentioned, and bad information in those other areas. But, warts and all, the important thing is to get that out and to allow people an honest opportunity to pull it apart, and then also to make ourselves available to actually debate the process, and then to be willing to take on board the sorts of results of that debate in both a policy and a program format.

Mr ALLAN MORRIS—I think that is laudable, but, be wary, because the public perception is that Aboriginals get a lot of money thrown at their health, an awful lot more than anybody else gets—and they are getting worse—when what I have just told you, in fact, says that is actually quite wrong. So there is a great danger with statistics floating around the countryside. I was of that view myself until last week. I only found this out last week after how many years in the parliament? It has not been available. It has not been even canvassed. So transparency and accountability are really important, but process is important.

My second question was about education and training and location. From my own personal experience with constituents in the medical faculty at Newcastle, I came across a problem with the state governments and the Commonwealth regarding Abstudy and state programs to encourage education. The Queensland government runs a program to pay health volunteers—it is a kind of scholarship for health students—which in turn disqualifies them from Abstudy. The rules, as you would imagine, are rigid, and the boundaries and the fences are pretty high. Yet clearly from what you are saying, and from

what we have been hearing from others, we need to educate people from rural and remote areas in the health field.

Mr Houston—Yes.

Mr ALLAN MORRIS—Whether it be doctors, nurses, health workers, nutritionists, or whatever. But the obstacles there are quite monstrous, certainly, apart from the educational barriers in terms of TER and school results and so on.

Are you working with your state departments and the Commonwealth funding departments—mainly DEET—to try and see if you can find alternative solutions, saying, 'For every year we pay you at university you serve at least one year for us where we send you'—a kind of indenture or bonding system where you get paid up-front so you can more comfortably do your course, but you pay afterwards by being available professionally? That is not available now because of the problem with Abstudy—or it does not work. Have you any ideas on what we could suggest to the federal department to allow them to be more flexible? What can we do to try and help the Commonwealth and states combine to offer incentives to Aboriginals and non-Aboriginals as well? It applies to the whole community in remote areas. They have all got a problem.

Mr QUICK—Something as simple as saying, 'Look, you can waive your HECS fee'?

Mr Houston—I might ask Mr Leslie just to talk about the scholarships in a second. But what I would say is that until very recently we were in the invidious position of having all of the health education around Aboriginal health in Western Australia being conducted in Perth, and for remote rural locations that had a significant impact—the sorts of impacts that Professor Gracey has alluded to. What we have done is, we have said, using state resources, that we have got to turn that around. An example of that would be that with the family futures program there is a significant training component involved, because we are employing about an additional 50 Aboriginal health workers, and they need to be trained. If we were to use the sorts of processes that were currently available, they would end up in Perth.

What we have done, using state resources, is we have actually said that we are putting out a tender now for people to provide accredited training, and one of the specific requirements of that is that it has to be delivered on site. That means now that training, rather than being done in Perth, has to be done in Port Hedland, Fitzroy Crossing, Albany, and also here in Perth. That is going to go part of the way, because what we have found, particularly in remote and rural locations, is that people are happy and are willing to do training, but they do not want to come to Perth. So if we can move it closer, there is more chance of them doing the training and then being available in their community. In most cases, they are prepared to stay in their community to do that sort of work.

We have also funded, for instance, the Kimberley Aboriginal Medical Services School of Health Education to provide additional training places for Aboriginal health workers from rural and remote locations. We are currently negotiating with Ngaanyatjarra Health Service about providing health service training for Aboriginal people on the lands, given the particular circumstances in which those communities find themselves. So I think part of the issue about bonding and retaining people in the communities is about making it easier for them to get the training, and then to stay there and to get the professional support around them. I think that is one of the issues. It is also about making sure that they get a decent salary, and that they get the sorts of ongoing education and development that they themselves would like.

Mr Leslie—The Office of Aboriginal Health has this year established a scholarship program for medical students, students in nursing, and students in allied health. We are offering three scholarships in medicine, and two in each of the other categories, and one other scholarship in dentistry. The scholarships are set at a level where it maximises the amount that they can receive without affecting their Abstudy benefits. I think it is set at $6,000 a year. They receive a scholarship and it does not affect their other entitlements. The applications for those scholarships have gone out and they will close this Friday, and we expect to probably receive about two dozen for nursing, about five for medicine, and about another dozen for allied health.

Mr ALLAN MORRIS—If you are talking about the indenturing of people, for $2,000 a year, who is going to—

CHAIR—It is $6,000.

Mr ALLAN MORRIS—No, for $6,000, you could not; it is the maximum they can earn per year—

Mrs ELSON—The threshold.

Mr ALLAN MORRIS—Yes. But Abstudy has this rule about scholarships. Have you actually talked to Abstudy? Abstudy give different versions, I can tell you. It is a very difficult issue. But I thought they could only do it at the earning level, which was a lot less than $6,000. I thought it was only a couple of thousand.

Mr Leslie—We have been advised by DEET that that is the limit.

Mr ALLAN MORRIS—Is that in writing and from senior levels? The person I am talking about was advised by a DEET officer, took the scholarship, and then got told afterwards that they could not have it because it is a state scholarship, and because it is called a scholarship they are disqualified.

Mr Leslie—We have spoken very closely with Dr Atkinson at the University of

WA, and he does not believe that there are any problems, but we will follow that up with DEET.

Mr ALLAN MORRIS—Well, I urge you to do that, because a letter from the minister said that because it is a scholarship—they are on a scholarship—they are automatically not included in Abstudy. It is the phraseology and it is the approach, and it certainly needs to be resolved. I think it is just simply one of those things that has sat there over the years so there was no cost shift. It is an anti-cost shifting measure, I suspect, which is now just quite inappropriate. Given the time of the year with university starting now, I am just concerned that I may get a whole stack of more students at the Newcastle medical faculty in the next month or in two months time who have the same problem as this guy had. If it is happening there, it will happen elsewhere. But Queensland DEET advised this young man that he was absolutely eligible for Abstudy, no problem at all.

CHAIR—Mr Morris is speaking from first-hand experience there. You can take that on board.

Mr ALLAN MORRIS—I would be grateful, Mr Chairman, if Mr Leslie could in fact let us know what happens, because it is one of the things I certainly will be following up on.

Mrs ELSON—I just wanted to know how many divisions do you have within your department that cater for Aboriginal health, and how many staff members do you have to cater for those divisions?

Mr Houston—The Office of Aboriginal Health is a stand-alone division specifically dedicated to Aboriginal health issues. I am just trying to think of the other divisions. There are operations, mental health—there would be half a dozen other divisions. Each of them has a responsibility to consider Aboriginal health issues within their core business.

The mental health area is a particularly good example. Our mental health division is a new division, and the Office of Aboriginal Health and the mental health division have an ongoing relationship where we are actually developing a joint program. It really has to be accepted at some stage that the health system as a whole has a responsibility to service Aboriginal people as citizens of this country; it should not just be an Aboriginal health division that does that. One of the real problems we have got is that across the board, Commonwealth and state, the minute you mention something Aboriginal it gets flicked to the Aboriginal part of the department.

Our budget is about $15 million annually, and that is, I might point out, a significant increase. Five years ago it was about $375,000. There is a tendency, if it has got ‘Aboriginal’ in it, to flick it across to us. Part of our job is about saying, ‘Hang on a

minute, as citizens of this country they have an entitlement which you are obliged to meet. We will help you improve the quality of the product you are currently offering so that it does address Aboriginal people's needs.' That is a significant problem.

Mrs ELSON—How many are in your particular section?

Mr Houston—We have a staff establishment of 28.

Mrs ELSON—How many Aboriginals?

Mr Houston—About half. At the senior levels we have four SES members—and they are all Aboriginal—the general manager, myself, and three other managers are Aboriginal. Ian, in a former life, was the manager of our corporate services, and Professor Gracey is the manager of our information and evaluation. As I said, the majority of the management is Aboriginal.

Mrs ELSON—We have heard from Aboriginal health workers that their problem is they want ownership. They do not want to be sitting here knowing there is a problem out there. When they go to say a department like yours, put that plan forward and have it rejected, they are back to square one again, and this is how they perceive that Aboriginal health is not being catered to correctly. If we got rid of that division, and gave them ownership to look after their own, it would be more successful. What is your opinion on that one?

Mr Houston—Aboriginal health workers in Western Australia are actually employed by health service providers. We do not employ any of them. So the Kimberley Health Service or the West Pilbarra Health Service employ their health workers. The process that we are trying to set in place is that as a result of the bilateral agreement we are establishing a series of regional planning processes which will in fact define the big blocks, if you would, around Aboriginal health gain in each of those regions. Our intention is to take that product and use it to develop the specifications which we will demand of health service providers.

Aboriginal health workers, having been part of the regional planning process, will then be able to claim ownership of a significant element of that plan that will be translated into the specifications for the mainstream, and the mainstream will be required to deliver against those specifications. Hopefully, Aboriginal health workers will have a much better opportunity of getting the sorts of resources that they need to do their job. That is how it would work in theory. I do not for a moment kid myself that there are not going to be significant problems in making it work.

The health system is a very complex and large beast, but there seems to me to be a great deal of willingness on the part of management of health systems, certainly from what I have found personally in Western Australia and other parts of the country, that if

we can in fact give them a clear idea about what it is they should be doing, and how it is they should be doing it, and show them that they have got the resources to do it, they are keen to get on with it and do it. So it is a bit about all of that.

There is also an element about using information in a more constructive way. It is often the case that people would react to health wants rather than health needs, and we have to in fact be able to sit down and consciously make decisions about investing resources in those areas that are going to make a difference. It is no good us mounting a program that is about making people feel good if in fact it does not improve the health of the communities. So there is a bit of that balancing that has got to go on in the process as well.

Mrs WEST—How many Aboriginal people are there in Western Australia?

Mr Houston—It is now about three per cent. Herein lies the problem: do you believe the 1996 census or not? In Western Australia the estimated resident population is 54,055, according to the June 1996 census.

Mrs WEST—It seems on one hand that—correct me if I am wrong; maybe I have misheard it like before—you want all Aboriginal people to be treated as citizens and have access to all facilities that are available, but your statistical evidence earlier proved that they are not accessing mainstream health services. They are dying at a higher rate than our non-Aboriginal community. Therefore, wouldn't you say that more specifically targeted funding and programs are the best way to go, rather than saying, 'Oh, but we've got these mainstream services. We don't want to treat Aboriginals any differently from anyone else in the community.'

Mr Houston—Mrs West, I did not mean to give you the impression that I am a supporter of—or for that matter Western Australia is concerned about—simply investing in mainstream activity. $14 million represents a significant investment in special programs. In fact, we spend more on specific Aboriginal health programs in the West than does the Commonwealth Office of Aboriginal and Torres Strait Islander Health Services. I very much agree with you that, if we are going to make a difference, we have got to do something about knocking off the differential between the health of Aboriginal people and non-Aboriginal people across this country. That is going to require special services, special initiatives and special resources.

At the same time, however, we have found that it is not possible for us to achieve the totality of what we desire to achieve, if we just concentrate on that. An example of this can be seen in terms of the relationship between the primary level of servicing and the secondary level of servicing. The movement in the relationship between those two different levels of servicing is one of the most vexed issues that Aboriginal communities have to face. I dare say it is an issue that health systems around the world are trying to come to grips with. I know that, for instance, the UK national health system has that

relationship—listed as one of its six national priorities.

So we have to do something about improving the way the health system operates generally, because what we do not want to do is a lot of work improving the primary level of health care servicing only to see that there is a breakdown of the secondary and tertiary care end of services that, in fact, dissuades people from accessing those services which are made available. It is also a point about us that we accept the health system has largely emerged from an environment and a society which is not Aboriginal. It has been influenced by economic, social and political forces which are not Aboriginal. So in order to ensure that it properly responds to our views, we have got to do something about making it now respond to those factors in an Aboriginal sense.

Mrs WEST—It seems, on evidence that we have been presented with in recent visits and talks with the community, that the total health system is totally alien to the Aboriginal community—or by and large to a large percentage of the Aboriginal community. As such, all the dollars and cents that have been poured in over the last 200 years, or whatever length of time, have been a wasted effort in the sense that they have not understood the community that they are dealing with. That is one of the primary sources of concern, that the two communities do not even understand, and we are only just starting to appreciate the differences in Aboriginal health history.

The moves that you have had towards coordinated services have been a feature of all of the submissions that we have received to date—the lack of coordinated efforts on behalf of state and Commonwealth jurisdictions, higher education, the universities, the medical schools. We have got all these people out there doing wonderful things but they are not even strategically addressing the problem, and it has been like this for how long ?

Mr Houston—Yonks.

Mrs WEST—For 20 years at least.

Mr Houston—If I can tackle that last part first, because the notion of intersectoral collaboration has been a hobbyhorse of mine for years. Western Australia has done a couple of things and they are very much in an embryonic sense. The environmental health needs coordinating, as an example. Perhaps the best example that I could give is about how we are trying to change that—although I might allude to some changes which are presently being considered. The Office of Aboriginal Health has been developing a package of goods which are meant to try to address the very point that you have raised. We have tried to look at real intersectoral collaboration and I think it is important to draw a distinction between past experience of that and people often mouthing the word, and actually what it is in practice.

In reality—and I will give you an example—in this jurisdiction a joint Commonwealth-state initiative in the north of the state, which was meant to address the

specific needs of one community, had 54 people at it. Only six of them from the community. Two results happened. The community sat back and said, 'Well, we don't need to do anything now because we've got all these people who are going to do it for us,' so there was no community ownership of it. That meeting, at phenomenal cost, spent a day agreeing that they will meet again. What we have often done is we have confused the notion of good intersectoral collaboration with random conferencing, and we have got to get rid of that experience.

The way to do that, I think, is to take very much the strategic approach. Real intersectoral collaboration, from our perspective, is about understanding and identifying the key linkages between the different sectors of government or of a society that impact on human development. We know, for instance, that if we improve the formal education of young Aboriginal mothers, the health of babies improves. So that is obviously a link that we, as a health agency, should be interested in with the education system.

So we have got to go through and we have got to define these linkages carefully. There may be a good number of them. We need to select ones which we will concentrate our attention on and then we need to do something about making it happen. The package that we are soon to put together includes four key elements. One of them is a policy statement about what intersectoral collaboration is as opposed to what it is not. It includes a discussion document trying to describe to people what it is, and provide a level of understanding and educate the people about what it is. It also includes a program base on which a number of approaches could be developed. So we have identified some of those key links between health and education, education and police, health and education, health and housing, health and police, health and the prison system, for example, and we have tried to describe how that might work.

The fourth component I think is a very important one, and that is we have defined what we have called, at the beginning, crown objectives but we hate the word 'crown' and we are trying to think of words like 'prime objectives' or 'principal objectives' or something like that, but we do not want to call it crown because in the current debate it is possibly not the right word to use. The notion is we want to be able to get a level of bipartisan agreement in parliament about half a dozen absolute priorities for the whole of government—and we wanted to stay away from calling it 'whole of government objectives' as well, because that is a tired, hackneyed, overdone phrase which means nothing to people these days. They talk a lot about it, but it has just been wrapped up in inertia.

So we want to use these crown objectives to define half a dozen absolute priorities, and they are not general priorities. They are about specific priorities, about improving, say, the relationship around the education of Aboriginal women and babies or about heart health or something very specific, at the level of parliament agreeing that and, from there, having government agencies obliged and compelled to specifically account in terms of their allocation of resources and their activity against those. The accounting for them

would be done in a way which is given the same weight that other agencies are held accountable for their other objectives, that are described in Western Australia in our Treasurer's program statements.

The Auditor-General in Western Australia, the Public Sector Management Office, the Treasury, the Department of Finance, would all be engaged in a process which would hold agencies and chief executive officers accountable for delivery against those specific objectives and how they work with other agencies. One of the key lessons that we have learnt from intersectoral collaboration is that there has to be an authority to coordinate. If we do not do that, then people basically just slip into this random conferencing agenda again and we lose all of the momentum and all of the goodwill that we have built up over time. I think that is critical in the process.

Prof. Gracey—Mr Chairman, I have a point of fact just to answer for you; 3.1 per cent of Western Australia's estimated resident population is Aboriginal. That is according to the 1996 bureau of population.

Mrs WEST—What is the number though?

Prof. Gracey—How many people? I would have to look that up in another table.

CHAIR—Perhaps you could take that one on notice.

Mrs WEST—Could I just ask one last question and have answers of five words or less from each of you. Do you believe personally that we are able to improve the current statistical evidence and improve the health outcomes for Aboriginal people in our community?

Mr Leslie—There is such a great level of investment by the state that we cannot afford not to improve it.

CHAIR—We need to wrap it up there. We have gone well over time but it has been a useful exchange. Professor Gracey, if you could just indicate the documents that have arrived—if they are already published, there is no need for us to publish them again. We will use them as a source document. If there is unpublished material in there, you will need to let us know. Do you have a list?

Prof. Gracey—I will table them for you, Sir. They are all in the public domain now.

CHAIR—We will use it as a source. Could I thank the representatives from the Department of Health, and please note my comments earlier.

Mr Houston—We certainly will.

CHAIR—We would appreciate if you could just send that message back about competitive tendering.

Mr Houston—I will.

CHAIR—We look forward to your detailed submission, and there may well be the need for a future exchange.

Mr Houston—And I am more than happy to do that.

[11.37 a.m.]

VIDOVICH, Ms Marea, Nursing Research and Development Officer, Australian Nursing Federation (WA Branch), Level 2, 322 Hay Street, Subiaco, Western Australia 6008

WILLIAMS, Ms Gail, Member, Australian Nursing Federation (WA Branch), Level 2, 322 Hay Street, Subiaco, Western Australia 6008

Ms Vidovich—We first of all tender the apology of Ms Kathy Quartermaine, who is unable to be with us today.

CHAIR—There are just a few formalities. Before we proceed, you will need to find out that the committee does not swear its witnesses, but 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, therefore, would be regarded as a contempt of parliament. We have your very good and comprehensive submission. It is so far the only submission we have really received with some detailed constructive comments in respect to nursing training. There may well be more as the inquiry proceeds. We are still at the early stages. We thank you for that. It is part of the public record, so you do not need to feel you have to read it all again, but there may be some salient points you would be prepared to make in a summary statement, and then my colleagues will have some questions to ask on some detail.

Ms Vidovich—Thank you, Mr Chairman. First of all, in our submission we have referred to a concept that has been pioneered and utilised in New Zealand in the education of people who are entering the health professions, and in particular the nurses in New Zealand have attempted to produce registered nurses who have a bicultural approach to health and health care. We did refer to that in our submission, and I have now brought for the committee some further documentation about what is referred to as cultural safety, and I think that would be quite useful to members of the committee.

In addition, the Australian Nursing Federation nationally received some funding from the Commonwealth government to hold the first forum for Aboriginal and Torres Strait Islander nurses. When they came together they made some recommendations about the sorts of things that they believed ought to be done, and we have brought that document with us so that the recommendations are available to you.

CHAIR—Would you like to table those?

Ms Vidovich—Yes, please. In addition to the things that we have said in our submission, listening to the representatives from the Office of Aboriginal Health in Western Australia brought to my mind that bureaucratic-type language that they use. They talk constantly about holding people accountable for the funding that is provided, and I am

constantly conscious that we in the Australian Nursing Federation never get to hear what this means and whether being held accountable has any sanctions attached to it. What happens if a service provider receives funding but does not in fact meet the goals that the bureaucrats have set? What sanctions are applied? What happens? Do they not get money next year, or what? We set off on a path and then it all becomes dissipated further down, and there is no end to that path as far as we can see. Whether sanctions are applied, we don't know. One of your colleagues did ask about the statistical evidence and how confusing that is. The public does not get to know whether any sanctions are applied to people who do not meet those responsibilities or goals that have been set.

We heard also from their submission a lot—and a lot of questions—about why there are insufficient doctors in particular in remote Aboriginal communities. I think our experience over a long period of time would suggest that there are never going to be, and that perhaps it is time that, as we said in our submission, we looked at some other form of approaching this issue.

Mr Houston referred constantly to Aboriginal health workers, and not very often to nurses. I will ask Gail to comment on that. I think it is possible for Aboriginal communities to perceive that they do not have access to well-qualified, highly-qualified staff. Is that a reflection of how the community views their importance? Does that mean that somebody who has, say, 12 months training is meant to be providing all of the health care—as Shane says, the sole health care in some areas—to that community? Does that send some sort of a message?

So we would be looking to increase the number of people undertaking nursing education from the indigenous population. We recognise that there are huge barriers, seemingly, to that happening, but we do not know of any definitive research that demonstrates what those barriers are. We could assume that to be able to pay for fees and courses and travel would be a barrier. The Western Australian government is looking to offer some scholarships for that—only two for nursing, we understand—and while offering three for medicine and only two for nursing seems to us to be somewhat skewed, given that, I would think the requirement for nursing service is probably quite high.

We believe that the availability of more registered and enrolled nurses of Aboriginal descent could well reduce that mismatch that currently exists between white providers of health care services and the Aboriginal communities. The concept of cultural safety would go part of the way to overcoming those gaps, but also the provision of more people from those communities would certainly assist. Gail, would you like to make some comment about the role of Aboriginal health workers versus registered nurses, although they all work together.

CHAIR—We do have your submission, and my colleagues will have a number of questions which will probably tease out some of what you have to say.

Ms Williams—At the primary health level, the grassroots level, Aboriginal registered nurses—where there are Aboriginal registered nurses—and health workers work together in tandem. But I feel that there has not been enough commitment to placing Aboriginal registered nurses, to training Aboriginal registered nurses to work in the community. In the Great Southern Region I am, as far as I am aware, the only Aboriginal registered nurse there, and there has been little commitment to providing permanent employment for myself in the health service.

I have been employed on a contract basis and, given the state of Aboriginal health, I think this is a ludicrous situation, that an Aboriginal person who has been through four years of university training is not able to secure permanent employment in Aboriginal health, and the positions are given to Aboriginal health workers. Something is not working. Fair enough, Aboriginal health workers have been around for 28 years. They have done a wonderful job, you cannot deny it, but we are here now—Aboriginal nurses are here now. We need to be recognised. We need to be slotted into Aboriginal health. We need a position in Aboriginal health, and at present we are not recognised.

A good example is I applied for a position in a health service in Albany in the mental health unit, and I was told there is no work there. The funding was only to go to an Aboriginal health worker. That is a shame. It is sad. It is ludicrous. Aboriginal mental health is shocking. It is the crux of the situation—Aboriginal mental health.

Mr QUICK—Can you explain for me, and perhaps some of the other committee, what sort of training an Aboriginal health worker does, and where do they stand on the totem pole?

Ms Williams—As far as health care is concerned, on the totem pole, they are on the bottom level, so presumably that is all Aboriginal people deserve—Aboriginal health workers—but they are the bridge. They have been the bridge in health care for 28 years.

Mr QUICK—Do they go to a TAFE college and get an associate diploma? Do they have any actual qualifications that will enable them to go the next step up which might be nursing?

Ms Williams—No.

Mr QUICK—Or social worker?

Ms Williams—In Western Australia there are two places. They can either go to MarrMooditj or Pundulmurra in Broome to train to become health workers. It is a year-long course. At the end of it they are given an advanced certificate, I think, in health work. They come out as level 2 trained health workers, I think. I am not absolutely positive on that. They are taught primary health care studies, clinical skills, temperature, pulse, blood pressure and weighing, and those sorts of clinical skills. They are at the

grassroots level.

Mr QUICK—So how many health workers does the Perth Aboriginal Medical Service have that you know of, and how many Aboriginal nurses do they have?

Ms Vidovich—They have one that I know of.

Ms Williams—I have been speaking to Kath. There were three that I know of, and several health workers, but the health worker course can get them into tertiary studies at Curtin.

Ms Vidovich—The other difference is that their education is different across Australia. It is not the same education. The only state which regulates their practice is the Northern Territory—sorry, I should not call it a state. That is the only jurisdiction where, for instance, if you are a registered nurse or a medical officer you have to be registered with a board, and the board then is the regulator of that practitioner's practice, and any misdemeanours are reported to that board and remedial action taken.

Mr QUICK—Are you talking about Aboriginal health workers here?

Ms Vidovich—Aboriginal health workers are not a regulated profession in areas other than the Northern Territory.

Mr QUICK—So if you are a trained Aboriginal health worker in Western Australia and you want to go and work in the Northern Territory or South Australia or Queensland or New South Wales, what is the story?

Ms Vidovich—In the Northern Territory you would have to front up to be registered, and whether it is immediately registrable or not I am not sure about, because there is now mutual recognition. Mutual recognition says that, for instance, if a registered nurse is registered in New South Wales, then they must automatically be registered in Western Australia, but because there is no agreement across Australia that Aboriginal health workers ought to be regulated, then I doubt that that law would apply.

Mr QUICK—But, Gail, if you want to go and practise anywhere in Australia, you are fine?

Ms Williams—As a registered nurse, yes.

Mr QUICK—Sorry to interrupt.

Mr JENKINS—Can I tackle Mr Quick's questions from a different end and ask you to comment on nursing. First of all, what numbers of indigenous nurses are there throughout Australia?

Ms Vidovich—I do not know about Australia, but in Western Australia there are about 30.

Ms Williams—I think it is around 200 nationally.

Ms Vidovich—About 200, yes. It is not very many.

Mr JENKINS—And how many of them would have higher qualifications?

Ms Vidovich—Quite a few of them would have a bachelor's degree. Others would have had the hospital-based curriculum, which predated university education for registered nurses.

Mr JENKINS—I am very pleased that you have followed on from the Health Department's appearance before us, where we explored the difficulties of getting medicos into especially remote indigenous communities, because what your submission does pose is that perhaps we need to step back and have a look at a different role and a different model. In fact, Ms Williams's experience of having qualified and not being able to get a position is a highlight—that here is a person who has qualifications, but because of this mismatch in a perception of what is going to be provided is not placed. Your submission talks about, and I quote:

It is fashionable for non-nurses to claim that nurses practise in a "medical model".

Your submission goes on to describe certain things.

For these reasons, the role of nurse practitioner must be seriously considered and traditional doctor/nurse demarcation re-examined in the light of the issues discussed in our submission.

My experience of this is a number of parliaments ago when I chaired this committee and we did quite a comprehensive inquiry into pharmaceuticals. We reported in three parts, and the only reaction we got to one part was from the AMA highlighting a recommendation where we deigned to suggest—and I think it is in your submission—that nurses might have limited prescribing, and the limited prescribing that we suggested was very relevant to this inquiry, because it was remote locations.

It really was prompted by evidence we received from nurses working in indigenous communities, where all we suggested was that there could be a list of drugs for this limited prescribing. Now, several years on, you still have it as—'Well, can you suggest one thing that we might like to look at?'—and it has not progressed any further. How do we as a committee have a look at things and perhaps get an idea of something concrete that we might be able to suggest about this role thing?

Perhaps the first question I need to ask is how would you describe nursing? Is it a

health model, is it a wellness model? What model besides a medical model should we describe it as?

Ms Vidovich—Yes, it is a health and wellness model, and the difference, if I could describe it, is that in simple terms people regard medicine as about cure and nursing as about care, and that the care provided by nurses is not necessarily directed only to cure, but to a whole range of other things. Nurses who work in isolated communities are very committed to the primary health care model, which is that everything happens from a community base, not from an imposed base. The issue that you are talking about, the prescribing—interestingly, in Western Australia, the chief medical officer in the Health Department has in fairly recent times issued a list of drugs appended to the Poisons Act, which says that nurses in certain designated remote communities—and they are named—'may prescribe the following drugs for the following conditions'.

It is an interesting development because it then assumes that the nurse can diagnose, because in order to prescribe the correct drug you have to have made a diagnosis. That is an interesting development. Our problem is always that nurses are doing this work, but they have no legislative base to protect them. This Poisons Act now presumably will protect them, although we do not know, because it has not been tested legally, what happens if the nurse has made a misdiagnosis—how liable the nurse is going to be for having prescribed a drug on the basis of his or her diagnosis.

As to what the Commonwealth can do, as everybody else has said, the division of powers just makes life so difficult. However, there is the Australian Pharmaceutical Advisory Committee, APAC, which advises the Commonwealth government on matters to do with pharmaceuticals. Our organisation is represented on that, as is the AMA, as are the pharmacists, and I believe that this committee could well make some sort of recommendation that all jurisdictions undertake to provide legislation which underpins nursing practice in prescribing for certain conditions.

My organisation, for instance, would argue quite strongly—and be shot down in flames, I know—that the address at which the nurse practises is irrelevant and that if you can diagnose and prescribe in Oombulgurri you ought to be able to do it in West Perth. However, we know that everything is a step-by-step process. The Western Australian government is just, next week, going to set up a committee to look at these issues under the rubric of nurse practitioners. They have waited for New South Wales to utilise Commonwealth money in its pilot projects and so on, to wait and see what happens there, but they are now going to look at that.

In addition, we have very recently—a week or so ago—spoken to Mr Houston seeking the minister's approval of the appointment of an indigenous nurse as an adviser to the Health Department, and we were given the usual run-around. The minister passed the letter to Mr Houston, and Mr Houston told us that the Office of Aboriginal Health tended to support initiatives rather than to initiate them, and that it was his opinion that

indigenous people ought to be at the sharp end of health services, and not in bureaucratic positions as advisers, because they were liable to become distanced from the sharp end. I am paraphrasing somewhat, but that is the gist of his response.

We have also asked that an indigenous nurse be designated and appointed to the Nurses Board of Western Australia, which is the regulating body, and Mr Houston has said that the minister has agreed and he thinks that would be a good idea, but it requires amendment of the legislation of the Nurses Act.

Mr JENKINS—I want to try and get this straight. Are you suggesting that a nurse practitioner might be a step up; that it might be something that would require further training, a further qualification?

Ms Vidovich—It is not necessarily a step up, but certainly a parallel kind of career move. It requires good skills in physical assessment. It requires skills in pharmacology. The basic education to bachelor degree contains those things, but if we were looking for a nurse to work in the intensive care unit, we would expect some further education from the basic education, so it is no more than that, really.

Mr QUICK—Could it be incorporated, as you have suggested about this concept of cultural safety that New Zealand has got? Could we add this rural and remote nursing component as part of the training, as a compulsory unit, to say, 'All Australian nurses, irrespective of where they are trained, have been introduced to some special component', worked out so that if they do go out in remote areas of Tasmania, compared to remote areas of Western Australia, they have got some idea and some training and we can go to the AMA and say, 'Look, you guys don't necessarily have to be the be-all and end-all'?

Ms Vidovich—I do not think that is something that my organisation would be looking to basically because to try and cram so much into a three-year program is fairly difficult, and what the education program aims to turn out is a beginning practitioner. If a beginning practitioner goes to a remote area community they need to be working with an experienced practitioner, as they would in any other setting. That would be my response to that.

Mr QUICK—By 'an experienced practitioner' you mean an experienced nurse practitioner?

Ms Vidovich—Yes. We would not be looking for someone straight out of their education program to go into remote and rural practice without having a mentor.

Mr QUICK—As a former teacher, I know that quite often you were sent out by yourself as a teacher, you were on your own, and you either sank or swam. Does this happen with the Western Australian Health Department with nurses that go out on their own without a mentor, to your knowledge?

Ms Vidovich—There are certainly some communities where there is a single practitioner, and we have known of nurses who have been imported from Ireland, for instance, and are told that they will find the Kimberleys very like Ireland. They have gone from Dublin to Derby and then from Derby to somewhere else. They do not stay very long. The turnover in those posts is fairly rapid. That is as much to do with living conditions as anything else there, because the living conditions are not particularly good and, as opposed to Mr Houston saying that for doctors in those areas the standards are high, the same could not be said for the nurses. Their standards are pretty bad.

Sometimes it is as much a failure of the employer to provide a proper orientation as it is about what your knowledge is. Your knowledge might really be quite good, but the location is such a shock to the system that everything you know goes out of the window.

Mr QUICK—One last question from me for a while: if we had the ideal community where you had this mentoring nurse practitioner with some years of experience in rural and remote medicine, who had this additional flexibility to administer drugs, do we really need doctors in these remote communities, considering that we have got this excellent Royal Flying Doctor Service and if there is an emergency in rural and remote parts of Australia, virtually within an hour, or less in some cases—or a couple of hours—they are into the main hospitals in Perth, Alice Springs, Darwin, or wherever it might be? Is the AMA putting a furphy out that we do really need doctors out there?

If we had the ideal mentoring nurse with a couple of nurse practitioners coming through gaining these mentoring skills and a wide experience of what it is like to be out in some of these godforsaken places, would that be enough? Would the health standards improve if we had people like Gail, with her experience and her cultural awareness, operating under a mentoring system? If you did not have a GP, would it be a case of, 'Who cares? We're still getting excellent service?'

Ms Vidovich—That certainly happens at the present time.

Mr QUICK—Can you give us an example? We are going to be wandering around Australia later on for a couple of weeks at a time and we would like to go and live and breathe for a couple of days in some of these communities to experience at first-hand what it is like.

Ms Vidovich—I have just recently been speaking to a registered nurse who works at One Arm Point, which is a remote community. There are people at various similar communities where the nurses are the only people on deck at any time, and they use communication systems to get advice from a medical officer. A nurse cannot be a doctor.

Mr QUICK—Yes, I understand that.

Ms Vidovich—That is not what they are there for. They do not want to be doctors;

they want to be nurses, and that is why they have chosen to work in the way they do. We now have technology called telehealth, or telemedicine, which permits consultation to be undertaken at a great distance. We have recently had visitors from the United States who are working in remote and rural areas where they are using this telehealth and the nurse practitioners carry the day-to-day work, and if they are unable to diagnose or there is an emergency or they need medical assistance, they obtain it. Indeed, many of Gail's and my colleagues work that way this very day.

They do need medical backup—there is no question about that—but in a survey published in the *Australian Medical Journal* several years ago doctors were surveyed about where they practise, why they practise there, why they are not practising in rural areas. A large percentage of them said that in spite of the fact that they earned what they believed were much lower salaries in an urban setting—because there were so many of them—they would rather starve in the city than go to some of these remote areas. That is a little elderly now, but I do not know that anything has really changed, and I think that whatever incentives the AMA dreams up are probably not going to change that situation. Gail, do you want to respond to that?

Ms Williams—Yes. I am a cervical screening project officer for the lower great southern region. Whilst where I work is not a remote area, it is a rural area. When I started in the project about nine months ago there were only about two or three Aboriginal women every year having pap smears in the lower great southern region. That is according to the H Care statistics. Since I have been doing the project I have actually assisted, transported, approximately 20 women to have pap smears. If you are asking: are nurses going to make a difference in the remote areas, I would have to say yes. If we make a concerted effort to train Aboriginal registered nurses, yes, it will make a difference.

CHAIR—Just on that question of nurse practitioners, the committee has had a fair bit of involvement with the issue. Mr Jenkins made reference to it even way back, but last year we tabled a report in the parliament on telemedicine and the issue of a nurse practitioner one end of a videoconference consultation and a specialist or doctor the other end. There is some reaction to that from the medical profession itself—being quite threatened by all this. It seems to me there needs to be a debate in which the AMA and so forth engage, so that they understand this is not about pseudo-medical taking over their role; it is designed to meet a need. They seem reluctant to want—as you have said—to go out there and they would rather starve in the city. I just found that amazing and unbelievable. But you are right; it is almost reality.

My question is: how much involvement does your association have at that professional level debate so that we remove some of these sorts of perceptions and threats that the medical profession seem to have regarding nurse practitioners? Is that something you can do at the professional level? I will preface what I am saying. Mr Quick has raised the issue again today about doctors going to rural areas. It has to be debated in the professional arena itself. They have to do that debate there. It is going to be difficult to

get sticks out or conscript in today's modern age. But it seems to me that engagement has to go on.

Ms Vidovich—Yes. First of all, to respond to your question about whether my association does anything like that, we certainly are involved in a multitude of committees with the AMA—for instance, APAC, and the committee in New South Wales, which was about setting up these nurse practitioner pilots. What happened in that particular case—and no doubt the New South Wales people will tell you this story—is that at the table there was a general agreement about how the nurse practitioner pilot programs would proceed. Then a report was written with recommendations, and it was only after the report was published that the AMA started saying they did not agree with it.

So there is a bit of a difficulty there. I am not doctor bashing. It is just that the way it happened there was not very constructive. They seemed to keep agreeing as we went along, and then at the last minute—I am not sure whether that was a failure in the reporting of the representative on the committee to the council of the AMA, or what, but anyway, they spat the dummy after the event. Yes, the ANF engages constantly in debate about these issues. The medical press constantly publishes articles about how nurses are wanting to take over and that sort of stuff. There are two issues. One is fiscal: that a nurse, for instance, like Gail poses a threat in that she would be taking away a fee-for-service if she provides a pap smear in her service. But the fact is that they are not being done anyway, so that is the counter argument to that.

The other is this: nurses have ambitions and if they want to do medicine, why do not they do medicine? Our response to that is always, 'Well, they would. Anybody who wants to do medicine will do it. But these people do not want to be doctors; they want to be nurses. They like working in that nursing model and that is what they want. They have no other ambitions.'

CHAIR—Your request is for a recommendation for some legislative framework to cover the very real legal issue, and you are right about that concern. I have it, too, but to overcome some of those concerns you would need to legislate the kind of clinical environment, wouldn't you? What the doctors are worried about is the Perth-based hospital being full of nurse practitioners. That is not the intent of it.

Ms Vidovich—Of course, in some of those pilots that was the intent, and what we have to bear in mind is the difference between the fee-for-service doctor and the salaried doctor. In Western Australia you have got this huge conglomeration of different kinds of employment modes for providing health care to the Aboriginal communities. As we said, I think, in our submission, in some areas you will have a fee-for-service doctor, and some employee nurses, and the difficulties there; in others you will have a salaried doctor; and in others you will not have any doctor at all. It is a bit messy trying to legislate that province.

Mr QUICK—Could we not do it by saying that X kilometres from the CBD there is this semicircle, or this circle, and if you are in that region there ought to be this sort of service, and then 300, 500, 1,000 kilometres from Perth that—

Ms Vidovich—We have Tasmania and Western Australia, you know.

Mr QUICK—But we do it in lots of other areas. For example, we were talking about pilots and all these sorts of things, but let us work on one area. Western Australia, Northern Territory and Queensland come to mind pretty rapidly.

Ms Vidovich—Yes.

Mr QUICK—And say, 'Let's develop a model. If you live 500 kilometres out of the Perth CBD, this health model to deal with Aboriginal health consists of community of X plus, so many mentoring and so many other nurses. If we can't get a doctor, too bad, because we have got the Flying Doctor Service to whack you out down to Perth anyway,' and see how it goes.

Ms Vidovich—That is the only way I think that it will develop.

Mr QUICK—Because the guy who was in charge of the Health Department who spoke at great length seemed to suggest that there was all this flexibility and interdepartmental, intersectoral agreement. If that is not a load of hot air, let us come up with some of this and say, 'Let's do it.'

Ms Vidovich—There is another issue there, though. It is happening in one of the models in New South Wales. What is happening, or has happened, in the Derby Regional Hospital is that they actually use nurse practitioners in the hospital. Their role in Derby was to be in the ambulatory services, the accident and emergency centre. People could arrive there, and under the normal circumstances the rules say that any person who walks into the emergency centre has to be seen by a doctor, because if that does not happen then there is the danger that this person is going to walk outside and drop dead and the hospital will be sued. So there are those rules applying.

At the Derby Hospital they appointed a couple of nurse practitioners to work in the less acute area so that the patients could in fact elect whether they would wait for the doctor, which would be an hour or two, or whether they had something which they could refer to a nurse practitioner. If you had an ulcer on your leg and you needed some advice about how to dress it, you could easily choose to go to the nurse and not wait for the doctor. That is another model that can be used, so having a blanket model is a bit difficult. I am not trying to make difficulties but we have to be, as Shane would say, flexible about it.

Mr ALLAN MORRIS—So if you have, say, nurses aides who may assist with

primary health care, bandaging wounds, very simple things, I understand in Western Australia you cannot actually delegate that; you cannot actually have people working under nurses in the health care field. Can you clarify that? I am not being precise because I am not clear about it.

Ms Vidovich—Yes, I understand the question, Mr Morris. Section 50 of the Nurses Act, the statute under which nurses practise, says that a registered person—a person registered with the board, I think it says—may not delegate nursing to an unregistered person. The problem with that is that it does not say anywhere what 'nursing' is. When nurses approach the Nurses Board and say, 'What does that mean? What does "nursing" mean?', the board says, 'It means what you believe it to mean.'

To give you an example, a registered nurse may today ask an unregistered person to take a person to the shower and that would not be regarded as unlawful delegation, provided the nurse had made the assessment that this was possible, that the worker had the skill to take this person to the shower. Tomorrow, if the registered nurse is looking after someone who had surgery this morning, and has several drips and drains, and she said, 'Take this person to the shower,' that would be totally unlawful delegation, and the nurse could be prosecuted.

It is certainly in black and white in the Nurses Act, but it probably does not apply, for instance, to Aboriginal health workers who have some skills and training, and the registered nurse knows what they are, and if the registered nurse is satisfied that that person has sufficient skills to do what it is they have delegated, then they are relatively safe. But they certainly run a risk where employers currently are seeking to reduce their wages bill by employing untrained people in positions where there used to be registered or enrolled nurses. Our legal advice is that the nurse may be prosecuted, but the director of nursing who employs the people, which causes the nurse to have to delegate, would also be liable to prosecution.

Mr ALLAN MORRIS—Just to clarify that very briefly, what about the nurse within Home Care or the HACC system, for example, who helps with personal hygiene—showering—and bandaging? Would bandaging or changing a dressing be seen to be a 'nurses only'?

Ms Vidovich—It would be seen as nurses only.

Mr ALLAN MORRIS—So this is a territorial dispute between professionals. You are concerned about non-professionals taking over your role; I understand that. But at the same time it would mean that your people cannot act as a guide to people who are doing non-professional work.

Ms Vidovich—No, the Nurses Board—not the Nurses Act—makes some provision for those kinds of workers to work under the direction of a registered nurse. The onus is

on the registered nurse to be satisfied that the unqualified worker, or unregulated worker, has sufficient skill. If the registered nurse has imparted that skill and has checked that it is understood, or is satisfied that the worker has come with, say, a TAFE certificate of some kind and the skill is sufficient, then they may delegate those duties. But, again, it is a matter of judgment for the registered nurse.

Mr ALLAN MORRIS—It is a bit of a minefield, isn't it?

Ms Vidovich—It is, yes.

Mr ALLAN MORRIS—Is anything written on that by your organisation at all?

Ms Vidovich—Yes, we have quite a bit written by us, and I could certainly provide you with it.

Mr ALLAN MORRIS—Will you pass it on? It just may be of relevance.

Ms Vidovich—Yes.

Mr ALLAN MORRIS—It may be different in other states, you see. Thank you.

CHAIR—I would like to thank you both for making your submissions. I am reading the challenge you have put in front of us which is for:

. . . policy makers to step over the barriers which have so far diverted attempts to attack the problems in innovative ways.

Thank you for that. This issue of nurse practitioners you have raised is one which our terms of reference, point (c), does allow us to address. As I have said, it has cropped up before, so we very much appreciate your willingness to make a submission to us today.

Ms Vidovich—Thank you very much, Mr Chairman.

CHAIR—To Ms Williams, we wish you all the best in your profession, and hope we can recommend some way in which you have some longevity of tenure to look forward to in a professional way. My wife is a nurse and you guys have my utmost admiration.

Ms Vidovich—They are everywhere. Thank you.

[12.24 p.m.]

CRAFT, Ms Kath, Consultant, Health Services Outcomes Project (Primary Health Care), Royal Flying Doctor Service, Western Operations, 3 Eagle Drive, Jandakot, Western Australia 6164

STOTT, Ms Barb, Project Manager, Royal Flying Doctor Service, Western Operations, 3 Eagle Drive, Jandakot, Western Australia 6164

CHAIR—Thank you very much for your time today. Before proceeding 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. Therefore any deliberate misleading of this committee could be construed as a contempt of the parliament. We have your submission before us, and have perused it. I would like to give you a brief opportunity to address in a salient way the essential points you are making, before proceeding to questions—in any order you prefer.

Ms Craft—Thank you. Just by way of explanation about the submission, as we indicated we were not making reference to any of the terms of reference, but it seemed an opportunity to outline the project and the outcome of the project that was undertaken, looking at health services that were being provided by RFDS in regards to primary health care. It came from the national strategy that was done by RFDS called back to the bush, or the best for the bush, and a recommendation from that was that RFDS look at how it might take on more of a primary health care focus, because it is world-renowned as an emergency aero-medical service, and non-emergency as well. That was not under debate, and there was no intention to change that focus, but to say, 'Hang on, apart from doing that, RFDS also provides numerous primary medical clinics to remote and rural communities.'

That means on a regular basis doctors are flown into communities, provide a medical clinic, the average duration is about three hours, and then they move on to another community. So in a day they may go to one or two communities, and in some places if they are going out along the Eyre Highway, for instance, they might go to six or seven communities. They just fly in and see—because there may only be one or two families living there—and fly out. But RFDS flies doctors, whether they be employed by the RFDS or whether they be employed by the Health Department, into approximately 35 remote Aboriginal communities in WA.

We were looking to see whether it is possible, while they are there, to provide more than medical care. We actually came up with a model then, which you have got there, about enhancing the services that are provided, with the medical clinic being provided by the medical officer, and maybe we could supplement that or enhance it by another little team of people, mostly with a nursing background, and if possible being of indigenous background. That is where we came with our model point of view. We actually

consulted with a lot of people in lots of ways. We had lots of calls for written submissions. I actually went out to quite a few communities and talked with people, Aboriginal people. Also, as you would be aware, the Health Department endeavours to provide remote area nurses and Aboriginal health workers into a lot of these communities. There is a big turnover in that. Others have alluded to the reasons for that: isolation, lack of adequate housing, and the major issue about safety for staff is always an ongoing concern.

RFDS was not keen to be seen as saying, 'We are mainstream health providers. We could take over this.' This was a whole issue of, 'How can we do something better in partnership with the mainstream health providers?', because we are a regular service, we do provide that continuity of care. RFDS seems to have quite a good record for maintaining staff, retaining staff, medical officers. I have met some who have worked in RFDS for up to four years, which is quite a long time to work in an isolated situation. They are well supported by RFDS, and of course they have a real variety in their role because they can work in the hospital, say, at the main place like Derby. They may be there, or if it be Port Hedland, if Aboriginal patients come in from an isolated community then they care for them. So there is continuity there when they get into the hospital.

So they have hospital input, they have radio contact with remote area nurses and clients and so on, and then they have those flying duties. There is a diversity in their role which may be the reason why they stay longer, and the fact that there is that sort of professional interest, and—dare I say it—some dedication to accomplishing improvements in health. That is why we made the submission; not to be suggesting things about Aboriginal health, apart from saying this is a model that we think could work, but we have in a sense had part of it working already out of Derby.

Barbara is well aware of and can speak better to it, but there was a joint arrangement between the Health Department and RFDS to employ a community nurse to work with the remote area nurses and some of those Aboriginal communities to improve women's health. She was actually there supporting the cervical screening program and doing some other STD-type work and immunisation and so on. That actually was a 12-month pilot which has just been completed, and the outcomes have been very encouraging. However, it has not been able to be continued because the funding from the Health Department has not come forth and RFDS cannot maintain that service by itself without funding from other places. It is my understanding that unfortunately that position has ceased to function.

Mr QUICK—How much money would you need to continue?

Ms Craft—You would probably need about $70,000 per annum, because you need $45,000 for the nurse's salary and then the cost of travel and accommodation and contingencies would probably be $25,000 or $30,000.

Mr QUICK—If we assume that we implement the model, do you need more than that?

Ms Craft—To implement the model we would, because we are proposing an Aboriginal health worker and a community development officer, who we hope would be Aboriginal as well, to be that little team. When I went out to the communities and talked not only to the community members but to the remote area nurses as well, the community members were saying, 'We're very happy with the primary medical care service we get. We'd like it to be of a longer duration, we would like the doctor to stay longer and come more often, but we would also like very much to have some people who come out into the community, sit down under the trees, sit in the buildings and help us look at what the health issues are in our community—even though we know what they are mostly—and look at strategies to address them in a community development type of role.'

Taking away the medical things, saying, 'Okay, we have diabetes as a major problem in our community. Thirty per cent of our women have got diabetes. How can we address this issue? Apart from getting the medical treatment so we know which pills to take and when, let us look at the factors that cause this problem to occur and work right at the grassroots. Help us look at getting the proper food into our stores so that we can buy it.' I went to one place for potatoes and to buy one potato was $1, to buy an onion was 50c, to buy an apple was $1.20. But to buy a bottle of coke and a packet of chips is cheaper. That is what they do. There is a limited amount of money, so that is what they buy.

Mr QUICK—Who runs and funds the store? They are private enterprise, are they, within the community?

Ms Craft—My understanding is they are run by these Aboriginal corporations.

Mr QUICK—So despite the Aboriginal community realising that they have got these major health problems—

Ms Craft—Yes. Some of the stores were really good—I have to say that—and they were really making an effort, but there are forces at work; different people with different agendas, presumably. But there is that lack of knowledge and skills at the community base level, so that the Aboriginal people themselves recognise they don't have the information, the knowledge and the skills needed to address the issues, and that is what they were saying. The remote area nurses and the Aboriginal health workers that work in the clinic—and you will find this when you go out—have a constant stream of people through their clinic door, and so they do not have—as much as they would like to—the opportunity to get out into the community and do that community development stuff.

When they are employed as a remote area nurse they think that is what they are

going to do, and yet they do not have the time to do that. They are on call 24 hours of the day, and day after day after day, in the living conditions they have, and then, with this constant stream of people coming with their minor ailments and so on, they do not have that opportunity to really do health promotion type work in the community.

When we talked to the Aboriginal people, that is what they said they wanted, and the remote area nurses said, 'Gee, if RFDS had some way of providing a kind of a link with us to help support us, even give us some education as well'—like the nurse from Ireland for instance—'then we would work as a team.' It is like a partnership; it is an enhancing of what already happens there. RFDS does not suggest in any way that it takes over the role that—

Mr QUICK—So you work collaboratively with each of the state health departments, but you need some additional money—if one of our recommendations was that you guys get X number of dollars to enable you, right across Australia, to work collaboratively with the state health departments to do better what you are currently doing?

Ms Craft—Yes. Currently it is my understanding that in the Health Department the rural health policy unit manages a contract with RFDS and the funds come through the Health Department to RFDS to provide the services it provides. When we showed this model to Mr Shane Houston he was saying, 'Yes, that's quite an interesting model. We could probably support that.' But I think he felt that it could be seen as being in competition with Aboriginal community-controlled health services, and also Health Department type services.

So he was saying, 'Well, we have a whole pile of Aboriginal communities that have no health service at all,' and that's true, because there are 280 or 240—something like that—what they call out stations, and they may only have one or two Aboriginal families in them, and they're way out in the desert. They have not even got a proper gravel road to them, and that is their choice to do that. No-one can provide a health service to them, and they know it, and they come into wherever the closest place is. But Shane was suggesting at one stage that maybe we look at taking a conglomerate of this lot and putting this model in.

Mr QUICK—So assuming we give you the money, what percentage of the Aboriginal population, say for example in Western Australia, could we cover effectively with a view to cutting down the morbidity and mortality rates of Aboriginals in a whole range of health areas?

Ms Craft—I am not sure I can answer that question.

Mr QUICK—Could you take it away and think about it?

Ms Craft—Yes.

Mr QUICK—You are right that we have these out stations, and quite often when the international media or *Current Affair* or *60 Minutes* go out, that is where they go and look at this appalling thing, and the average person in the five big cities in Australia does not realise the complexity, and they do not see the positive things that are happening when people do drive for seven hours. We have been out to Kintore and seen what it's like out there, but that is not remote compared to some of the other places in WA.

Ms Craft—Yes. RFDS sort of covers the Kimberley and the Pilbara and the goldfields area. For the south-west it more or less covers four aero-medical emergency type stuff, so it is really above Geraldton, I guess, and out to the border with the Northern Territory and South Australia, I guess.

Mr QUICK—The Sandy Desert, are you out that way?

Ms Craft—Yes.

CHAIR—We would like to lean on the accumulated expertise of the service, if we could, for advice. Your submission goes straight to the training issue, and I was just wondering what difficulties the Royal Flying Doctor Service has in its recruiting of health workers and its medical doctors. Is it difficult? Do you have to offer additional carrots to get people involved?

Ms Stott—There are no difficulties employing medical officers and/or nurses, simply because of the diversity and interest in the work, particularly for medical officers, and nurses as well. What was the second part of your question?

CHAIR—I am just wondering, if that is the case, what is the degree of satisfaction with their capacity to practise within those cultural difficulties with Aboriginal people? Have you had to send them off to do crash courses?

Ms Stott—One of the criteria, in particular for nurses and/or for nurses but particularly for nurses, is that they come in with a great deal of experience. Usually because of the experience required, both on an emergency and a primary health care level, they have already come up against and been educated in cultural awareness, both Aboriginal and other ethnic communities, because we have got a great many number of diverse communities across the Top End, particularly Muslim these days. So these people are not beginning practitioners; they are coming in at an experienced and high level, and that is really important.

Ms Craft—I guess one of the recommendations that I did make in the report was that RFDS look at this ongoing education about cultural issues, because some of the medical officers made that clear to me, that they did not really understand, whereas the

remote area nurses have a better understanding because they are with the community all of the time, and the communities made note to me that the traditional healers in the community and their own medical ways were not always appreciated, and that just got back to a lack of understanding of them. If RFDS was able to spend more time in each community, they would certainly become very aware of that very quickly, and be able to work with those people, because they're all from not only the traditional healers, but they are part of the leadership usually in the community.

So RFDS is aware that it needs to do better as far as cultural awareness—be that an old term now; I had not realised that until I came in the door. I have now got to call it cultural security. Is that right? So I think there is always recognition that RFDS can do better about that, but it does recognise that it needs to do it, and to make sure it is ongoing, as Barbara said, for people.

CHAIR—It must have to be a very dynamic thing, though. I mean an indigenous male is injured and a woman doctor and woman nurse front up. The cultural security of that is tenuous when the alternative is to send the males and it is a few hours away. How on earth can you cope with that? We heard earlier about the difficulty of getting an indigenous man into an elevator in a hospital. You must have enormous problems to convince him to get into an aeroplane. How does the service deal with some of these complexities?

Ms Stott—Interestingly enough with remote Aboriginal communities they have lived with aeroplanes. It is like people here in the city. Aeroplanes to them are like cars, so it is not something foreign to them. In Australia, not just Western Australia, RFDS has been coming for 60 years, and if you look at that, it is two generations, so it is something, and in terms of when there have been difficulties in some of the communities, and certainly ones that I have experienced at a regional level and local level where some people are barred from the community, like police and others, RFDS has been able to go in because we're seen as a neutral sort of body and there to help anybody.

CHAIR—It's obviously well respected.

Ms Stott—Yes.

Mr QUICK—Do you have any idea how much the Western Australian government allocates to your service for provision of the services?

Ms Stott—Yes, I have. It's an interesting process which is under review at the moment. In Western Australia, $6.2 million is allocated by the state Health Department and $6.2 million by the Commonwealth. There is a shortfall of around about 27 per cent of our operating budget.

Mr QUICK—What is that in money terms?

Ms Stott—I have probably confused it a little bit there, because I am also thinking of capital expenditure. Already at the moment we are at $2 million in terms of our budget projected costs—$2 million at the end of this financial year. We are going to have a shortfall. We have not had an increase in funding in Western Australia for four years and, interestingly enough, if I may point out, with the increasing mortality and morbidity of indigenous health, in particular in remote areas where we have seen a reduction in medical services, this has had an increase on the requirement for inter-hospital transfers. We have had a 20 per cent increase this year alone in inter-hospital transfers, mainly—certainly from remote areas—of Aboriginal people who are not able to be cared for in the remote and rural areas, and we have no additional funding to cope with that. Our primary role, as it was 60 years ago, is to provide primary health care services and primary evacuations, not inter-hospital transfers.

Mr QUICK—So in light of this wonderful model that you have developed, with obvious benefits, do you see that in the forthcoming budget you are going to get more than $3.6 million?

Ms Stott—No.

Mr QUICK—What about the Commonwealth?

Ms Stott—$3.6 million? It's $6.2 million to each.

Mr QUICK—From each, yes.

Ms Stott—And there is that shortfall of about $2 million.

Mr QUICK—So you basically need what?

Ms Stott—It costs us $17 million, without capital expenditure, to run in Western Australia alone per year.

Mr QUICK—As you are.

Ms Stott—As we are.

Mr QUICK—But if suddenly someone said, 'You've got this wonderful model, let's implement it,' what would—

Ms Stott—We are unable to, with our present funding structure.

Mr QUICK—So you would probably need $25 million in WA alone.

Ms Craft—Probably. We have not costed it out, because that was another whole process. When we went to the Office for Aboriginal Health, we were looking to actually

develop a business plan to implement this model, but because of this funding problem we have not gone down that track. We have not developed our business plan for the model because that costs money to do, and if it was not being supported, then it was not seen as an appropriate thing for RFDS to go away and do. In fact, if we produced a business plan, it was possible for the Office of Aboriginal Health to look at it and say, 'Right, okay. Well, we might ask an Aboriginal community organisation if they can do it cheaper,'—I use the term 'competitive tendering'—or whatever. And RFDS would have done the whole work of working out the business plan to find that it was not allocated the funds, if you understand what I mean.

Mr QUICK—Have you any idea how much is spent on Aboriginal health in Western Australia by the state Health Department?

Ms Craft—I could not answer that.

Ms Stott—In terms of our services?

Mr QUICK—No. We should have asked Mr Houston this morning.

CHAIR—I think it might be a bit beyond their ability. We can get that from the Health Department, I think.

Mr QUICK—Yes. In my layman's mind, you would not be asking for, in percentage terms, a great amount of money to provide some additional services which would have a huge impact in dollar terms on the health of the Aboriginal people in rural and remote parts of Western Australia.

Ms Craft—RFDS would be looking to making sure that the accommodation, for instance, for its staff—if we had the small team that went out maybe three days a week, or flew in and flew out but for three or four days—was appropriate, because that is an issue on remote communities. Even though a previous person said for medical officers it was high, that they were provided with good accommodation, that is not the case in remote communities, and you will see that as you go around, I'm sure, if you have not seen it already. So there would be those needs—to provide safe, appropriate accommodation.

Mr QUICK—Have you got any documented evidence in relation to the results of the years of work in things like waste management, reticulated water supply and adequate housing, to show that these things have changed in certain communities? We can use these communities as best practice examples of when so-called outsiders come in and liaise over a period of time with Aboriginal communities. We can say to them, 'Well, look, there's 26 people living in one house, and you're out digging holes for your sewage, and the water supply is absolutely abysmal. We'll work with you to introduce those from outside sources.' Once that is done, the communities say, 'Hey, look, our kids are not dying. Mother does not have to have eight in order to have two that are going to live past five.'

Have you got any documentation to show that?

Ms Craft—I do not believe RFDS would have, but I do believe that the Health Department has that. In my former life I used to work in the Health Department, so I'm aware that they have got some fairly good statistics about those changes that have taken place in Aboriginal health. Mr Houston alluded to the environmental health committee that they have got together to look at that. I have seen a draft of one of their reports about that, and they do go into all of what is provided in every community and what the outstanding needs are. So it gives a very good picture of where the gaps are for particular communities. But RFDS would not have that sort of information.

Mr QUICK—Could you give us a list of the worst-case and the best-case scenarios of places we ought to go and see when we are out wandering around in WA? I'm serious about that.

Ms Craft—Yes, I'm sure somewhere we could.

Ms Stott—We certainly can.

Ms Craft—Will the Health Department not provide that for you?

Mr QUICK—Being a cynic, I would like to ask as many people as possible, and then you overlay the answers, because quite often if you ask the Health Department, 'Where do you go to see the best and the worst?' it depends on whether they are realistic and fair dinkum or whether they just want to do a snow job on you. But you have got no axe to grind really, and I know the wonderful work you have done because I used to live in Port Augusta. So if you could give us a list of the best and the worst case, we would take it on board.

CHAIR—We are currently labouring under the liability that we do not have a submission from the Health Department here in Western Australia, and they have assured us this morning that it is coming. We propose to talk with them again after reading that.

Mr QUICK—Especially after visiting some of the communities.

CHAIR—That is why I was saying earlier, leaning on your expertise a little. We are happy for you to supply that in consultation with the secretariat as we proceed.

Mr QUICK—You have been sitting here patiently listening to the other people. Is there anything that we have not asked you that you would like us to ask you, or is there anything you would like to tell us?

Ms Craft—I would like to say something about the Aboriginal health workers. When I went around various places in the Kimberley it became clear to me, or I was told,

that there are quite a lot of trained Aboriginal health workers who live in the Kimberley who choose not to work as Aboriginal health workers because the Health Department's pay rate is so poor that they can do better in other areas. So the community actually has quite a few health workers there. So it would be very interesting, if we did get funding for our model, to put it in one place and see whether we in fact got applications for Aboriginal health workers and community development officers of Aboriginal descent to take on the positions, because we would endeavour, I hope, to remunerate them appropriately.

But I do have a concern. I share what Gail Williams, the previous person who is a registered nurse—and I had the delight to work with her on certain things; to hear the pain she has of being a well-trained person who cannot get a job because of the ethos that we must have, Aboriginal health workers, and the pain that she experiences. Is that the best we can do for Aboriginal people? Why have not they got the very best? Their health is the worst. Why do not we provide the very best? That is just a personal comment really; it is not to do with the RFDS. It is my personal feeling about the whole thing. But I do know that there are Aboriginal health workers who are not employed as such because the conditions are not appropriate for them, and they can do better.

Mr JENKINS—Is part of the problem that they are like other professionals that we have been talking about; that they have to be work isolated?

Ms Craft—Not usually, because they usually work in the community from which they come. They are mostly keen to do that.

Mr JENKINS—I suppose what I am saying is that they are a one-off worker, though.

Ms Craft—Yes, and despite the fact that Shane is saying so many of them want to work as independent practitioners, that is not my experience. My experience is that they very much like to have the support of a remote area nurse and a medical person coming in that supports the decisions. They can certainly do a lot of that grassroots stuff and help the registered nurse and people to understand what is going on in that particular family and so on, but they are not keen to really take on the registered nurse's role. That is another personal comment, from my experience, I guess.

Ms Stott—Could I just make a comment, and I will try and be as brief as possible. I have spent 20 years in the bush, and it is just my observation of having worked in remote areas for so long, that from what I see the Commonwealth and state health organisations appear to be working in conflict. Certainly organisations like the Aboriginal medical services, who are Commonwealth government funded primarily, are criticising the health departments at a state level. The communities themselves, the Aboriginal communities, have a degree of social dysfunction and they are confused.

They have got this duplication of services—people get confused at the community level with the introduction and the granting of government for the homeland movement. We have seen an explosion of outstations across the region. Health departments' other essential services are unable to keep up with people moving into remote areas, and I think that the Aboriginal people themselves are in conflict at some levels. That needs to be understood. The CDEP program is abused at the moment, and that needs to be perhaps looked at with Aboriginal health worker training. That is an observation.

CHAIR—Thank you very much, Ms Stott and Ms Craft, for your time today and your willingness to make a submission. It's very useful, and we will be leaning on your advice as we progress with the inquiry.

Proceedings suspended from 12.57 p.m. to 1.19 p.m.

ATKINSON, Dr David, President, Doctors Reform Society of Western Australia, PO Box 467, Subiaco, Western Australia 6008

CREAGH, Dr Alison Ruth, Secretary, Doctors Reform Society of Western Australia, PO Box 467, Subiaco, Western Australia 6008

PAUL, Dr David John, Treasurer, Doctors Reform Society of Western Australia, PO Box 467, Subiaco, Western Australia 6008

CHAIR—Thank you for appearing today. Before we proceed I need to point out that whilst this committee does not swear its witnesses, you need to understand that the proceedings are legal proceedings of the parliament and warrant the same respect as the House of Representatives itself, and that any deliberate misleading of the committee would be regarded as a contempt of the parliament.

Your submission is before us and already forms part of the public record so you need not feel any compulsion to read all of that into the public record. But I would like to give you an opportunity just for some brief and candid comments about the salient points you would like to make to us. I reiterate again how appreciative we are for your willingness to come and talk with us. In whatever order you would like, we are in your hands.

Dr Paul—We would like to make a few introductory comments. I am sure you have heard repeatedly about the current state of Aboriginal health in Australia. All three of us have had extensive experience working within the area in various capacities over the last 15 or 20 years. Some of what we would like to say is informed both by our personal experience as well as some of our theoretical experience from dealing with other people's perspectives and dealing with various reports that have been produced over the years.

I am sure you are aware that recently—I think it was in 1997—the Bureau of Statistics, along with the Australian Institute of Health and Welfare, produced a report which detailed the current status of Aboriginal health in Australia. It showed that there has actually been a decline in comparison to the health status of the broader community, which is quite a concerning trend considering some of the things that people have been trying to address over the years.

What we would like to highlight is that internationally there has been some good evidence to show that health status is reflective of the broader structural components within society. It is not necessarily a problem that is related to the community in question. It is actually a societal problem and it is related to inequities and access issues. Some of the things we would like to talk about are particularly related to the inequity and access issues that we have experienced and come across, and try and provide some structure to

what we think would be a useful approach to some of those issues.

This is an inquiry into Aboriginal health and what we would like to make sure people understand is that you cannot just deal with the issue by looking at health care services alone. You need to address the broader issues that help influence health status, as well as dealing with health services. If you deal with health services alone, you are going to get much slower progress than if you have a more integrated approach to dealing with the issues. Some of the things that we would like to highlight are some of the barriers that people experience if they are Aboriginal and trying to access health care services. Those barriers are not just located in issues of access because of geography, they are actually functions of past experience, people's difficulties of accessing services because they have been denied access in the past, because they have had an unpleasant experience in the past, or because the services do not actually exist where they live. Things need to be addressed on that broad context, not just creating a health service in a location but looking at the quality of that health service being provided.

Current structural changes that exist in this state, and it is happening around Australia, mean that health services are now being organised more and more on a regional basis. You get decisions that are made that say the area health board—which is generally in control of the metropolitan area here and you have got a number of major teaching hospitals—they are the people that are actually making the decisions of what is going to happen for the area in which they have got control. Their priorities, as far as having a major interest in servicing the machinery of their hospital, means that their interests are not necessarily going to be focused on the two and a half per cent of people in their community that particularly need their health services more. So their focus is not necessarily based on need, it is based on servicing their particular infrastructure—and that needs to be changed.

Some of the ways that we see that it can be changed is to try and focus more on funding community organisations directly rather than funding a large institution that then makes decisions about whether they will give some money off to a small organisation and they do not necessarily understand the structure or the process or the benefit of funding that organisation because they have got a large debt for their CAT scan or whatever that they are trying to deal with at the moment.

Having all worked in community organisations, we have got lots of different stories we can tell about the experience that people have that come to us. I used to work at the local Aboriginal medical service in East Perth during the 1980s and I would have people who would drive from 200, 300 kilometres away to come to Perth to see me because they had had such bad experiences in their local community trying to access a doctor. They would be sitting on the step because they were not allowed to wait in the waiting room and they may or may not get seen, depending on the current attitudes or feelings of the practitioner that they were seeing at the time, and that is not an isolated example. There are other examples we will give you about what goes on today rather than what went on

in the eighties.

CHAIR—Are you all still currently engaged clinically?

Dr Paul—Yes.

Dr Creagh—The example I have become aware of—and in fact had a subsequent discussion this morning—is with a member of the DRS who is working in a small country town in Western Australia. When she arrived in the town as the solo general practitioner she became aware that the Aboriginal people in the town were not accessing health care very early in the course of their illnesses. She subsequently discovered that one of the reasons for that was that they were actually being turned away by the hospital staff. This particular doctor felt that a lot of the times the people were turned away, she should have been called. It was quite neglectful of the particular staff.

She tried to address that by discussing it with the staff, by discussing it with the manager of the hospital, found no changes were occurring, has gone to the local area health board and has found that the response by them has not caused any changes to happen. The main problem that she has found is that there is a big disparity between what happens with non-Aboriginal people attending the hospital and what happens with Aboriginal people attending the hospital. It is something that has been happening, she has been telling me, over the last couple of weeks and it is still happening at the moment.

Dr Atkinson—My background is that I am currently an academic at the University of Western Australia employed by the medical faculty to work in Aboriginal health. I recruit Aboriginal medical students, as well as doing some clinical work with the Perth Aboriginal Medical Service. I also keep in touch with other staff of the university, and an example I would like to relate to you for this part is of a remote town of about 2,000 people where I used to work where the population is 90 per cent Aboriginal. The Health Department actually commissioned a report, which was finalised I think last year, called Marnin Business, which looked at how the health services were operating—so this is actually the Health Department commissioning a report into its own operations.

In that town, when I was there, there was a 12 or 13-bed hospital, about 2,000 people, mostly Aboriginal. It has not changed much, but the things about the hospital have actually got substantially worse. Examples include the door is locked before the sun goes down and Aboriginal people are treated as someone to be fearful, so they are reluctant to approach the hospital during the hours of darkness. There is actually less Aboriginal staff employed in the hospital. It employs 20-plus people, and at the stage of this report there was only one person working in the hospital. There used to be a few more. It has never been very good about employing local Aboriginal people, but it is actually employing less than it used to. They have a single room in the hospital with different furnishings that are reserved for the non-Aboriginal patients when they have them, and that is more discriminatory than it was 10 or 15 years ago.

They do things like refuse to organise a male nurse when they have initiation ceremonies. The local Aboriginal people like to have a male health care worker to deal with when they have any problems. At the time of this report being carried out, all of the health staff, including the doctors, were female. The local community organisation had to pay itself to bring in a male nurse to provide some sort of service while men were doing men's business.

Those sort of examples you can find all over the state all of the time, and they will fluctuate so some places will improve and some places will get worse, but essentially if you have got state run or private practice where Aboriginal people and Aboriginal health services are often a peripheral concern—as David said earlier—then you don't really get that focus on ongoing attention to all of these difficulties that make it almost impossible for a lot of Aboriginal people to access services in lots of areas.

The only way we see for that sort of thing to change is to fund local Aboriginal community-controlled organisations, and they can negotiate then with the health services and the health services then have to respond because their money depends on it. If you do not place those financial restrictions on hospitals, whose main job is other things very often, then you don't get change in their behaviour. We see that as very important.

CHAIR—Are you happy with that as an opening statement? I know my colleagues are always champing at the bit ready to get into questions. Can you just talk about some models that have worked with a really good outcome that you have had experience with. You have mentioned empowering a local community, and that is certainly a message we have heard. This is only the fourth day of our inquiry but it is a message we have heard loud and clear already. What about some good examples of good outcomes? Can you give us some of those?

Mr QUICK—Can you name towns? I would have loved you to name the two towns because we are going to be wandering around Australia and we might wander into this town.

Dr Atkinson—Yes, it is reasonable actually. The town I am referring to is Fitzroy Crossing, which you could find out if you found out something about me, and that is in the Kimberley. Because of the current situation for our other colleague here it is—

Dr Creagh—I am in a slightly difficult position at the moment as I work in the town.

Mr QUICK—Are there places that we can go to that are best practice, or haven't we got to that stage yet?

Dr Atkinson—There are places where services certainly work better and there are places where they work worse. That does change from time to time but, for example,

Kalgoorlie Aboriginal Medical Service is doing some pretty good things at the moment. They have some integrated projects with other organisations. They have got some good links with the local health services, so that is a place where some good things are happening. Broome Aboriginal Medical Service and the Kimberley Aboriginal Medical Service generally have been doing a pretty good job over the past 10 or 15 years, but I guess the problem is about control because they might have money to run their particular services but in terms of changing the overall health system that they have to respond to, they do not have that level of control.

So there might be good people in the Health Department at one time because it seems things are working a bit better in the Kalgoorlie region at the moment, but the structure is such that as soon as the person changes or the people in the head office in Perth who are encouraging good practice change, then the power relationship is such that the health system will revert. That is what I have observed over 15 years. Good things happen at times because good people are doing good things, but the structure actually encourages the opposite.

Mr QUICK—Quite often this happens. I am a teacher and this used to happen in the education system, depending on who got further up the totem pole and what sort of philosophical base they came from. But this is a national inquiry and we would like to think in all honesty that we can come up with a recommendation and a series of models.

I am pushing three models: one for the traditional Aboriginal community, one for the rural and remote areas; and one for the urban Aboriginal community. Can you give us examples of those sorts of places, or what sort of model we can come up with, irrespective of whether we have got a racist Queensland or Western Australian government or a really benevolent one, that we can push some sort of model. We hear about all this synergy between various departments and things and we would like to see that is the case and we can put a model in practice, so if it is Fitzroy Crossing, and similar places around Australia of the Fitzroy Crossing ilk, then we can say, 'Look, here's a model that we—that you're going to do. I'm sorry but'—you know.

People this morning spoke of sanctions. I would be interested in your views on that; that if you do not meet certain criteria, there is a sanction. We are talking about nuking someone in the next couple of days because he has not met UN sanctions, but when it comes to our health we have people from outside saying, 'United Nations standards are absolutely abysmal.' There might be sanctions about the Olympic Games in the year 2000 because of the way we are treating our Aboriginal people as far as health goes.

Dr Paul—The effective models for health care delivery, are as far as we are concerned, have to be community-controlled health services. I am sure Ted will be able to tell you the good places to go and visit in this state and nationally, because that is his particular interest and his particular expertise as far as how things are working at the

moment. If you are not going to have community controlled organisations, you are going to have great difficulty providing appropriate services for people that they will feel acceptable.

The key point about the value of integration and working with the state systems or the federal systems and how well health departments work with community controlled organisations is very much dependent on the personalities involved in the state or in the federal department, and it does change and it has changed continually during the relationships since there has been community-controlled organisations. There is much better cooperation these days than there used to be 15 or 20 years ago, but it is still problematic and very personality based and unless you can get a system that enshrines better cooperation and greater control, then it is not going to change.

Mr QUICK—What do you think about sanctions?

Dr Paul—I think you need to be able to have incentives that ensure that there is a more positive relationship that is supportive of working together and having an integrated model working rather than a divisive model that is dependent on an individual's actions.

Mr QUICK—We have heard today that the gaps are widening and we have spent, God knows, how many hundreds of, well, billions of dollars on health.

Dr Atkinson—That is a little bit of a myth in that I think the evidence is not good that substantially more money per head has been spent on Aboriginal people. Those figures may be debatable but certainly we mention that in our submission, that the Medicare funding for Aboriginal people has always certainly been less but it is very hard to identify because it is not all recorded as whether it is Aboriginal or not. Overall funding may or may not be greater for Aboriginal people but, given their level of health need, it is actually substantially less for a person with a given health need compared with a non-Aboriginal person. They actually get funded less and I think that is something that the committee should look into because there are actually reports being prepared on that at present.

Mr QUICK—We come up with the hoary sort of argument that we don't know who Aboriginal people are. There is some cultural sensitivity to the fact that people are being asked to fill out a medical form, 'Are you an Aboriginal or Torres Strait Islander?'

Dr Atkinson—Sure, and that is why a lot of the information is hard to collect because not everybody is recorded in the system.

Mr QUICK—How do we get around that?

Dr Atkinson—I don't know that you need to. It needs a different approach. It is not necessarily masses more money, although I think Aboriginal health is underfunded, but

it is about the approach of the funding being allocated to community-controlled organisations who can then negotiate with the Royal Perth Hospital.

An example from Perth, which I think Ted could expand on, is that at the Royal Perth Hospital I was involved in a review looking at their services to Aboriginal patients a year or so ago and there were a number of aspects in the way in which they treat Aboriginal patients which discouraged them and scared them away—Royal Perth is a big hospital in the centre of town. The Royal Perth Hospital was quite cooperative and wants to do something and in particular individuals within it who are quite keen to do things. They have had meetings with the staff of the Perth Aboriginal Medical Service and they are trying to actually change some of those things.

It has not got very far yet but one thing that would make it move a lot more quickly is if the Aboriginal Medical Service had some financial power to have an equal relationship with some of these large-scale health providers, whereas at the moment they are dependent on goodwill. Shane Houston and Ted get on well. Their Perth Aboriginal Medical Service gets funded for certain things. If they system changes within the state government, those sorts of things will not continue to happen necessarily, and I think if more funding is directed directly to the community-controlled organisations, even if it is in terms of purchasing hospital beds and things like that—there are all sorts of creative ways of doing that, and that is getting back to what you were saying about sanctions. It is about who has got the money.

That is what power and control is all about. And even if they cannot spend it on anything they like, if it is to purchase health services, then the hospital will have to respond and provide appropriate services, or they will not get paid. That's how the rest of government operates.

Mr QUICK—Would that solve Fitzroy Crossing's problem, because there it is attitudinal?

Dr Atkinson—But I think the problem in Fitzroy Crossing is that the Health Department is reluctant to act to do anything about the staff they have got in those positions. In a town where most of the people are Aboriginal, the local community should have some control over the sorts of people they have in their hospital. In country towns that are mostly non-Aboriginal in Western Australia, if they have got a problem with their doctor or the matron of the hospital, it ends up on the front page of the West Australian, and something is done about it, whether it is through due process or whatever, but if there is a hospital board that disagrees with what is going on, they fix it. In a place like Fitzroy Crossing, the local community does not have any say in that. There is a boss in Derby and it is a very hierarchical structure, with a Health Department boss in Derby who is in charge of the hospital in Fitzroy Crossing, which is not beholden at all to the local community.

Mrs JOHNSTON—And there is no board in Derby?

Dr Atkinson—I do not think so. I had better not say I know for sure. Last time I knew, there was not any such board.

Mr QUICK—So what Aboriginal medical service is responsible for that area?

Dr Atkinson—There is not an Aboriginal medical service in Fitzroy Crossing, although there is a service that's being established, which is attempting to look at health in a more holistic manner, and to look at more cultural aspects of health, but it has not got a say in the health services, so there is no actual Aboriginal medical service in that area, which is one of the reasons why services in that area are not as good.

CHAIR—Could I just go back to a point you made about empowering local communities. We have got a program funded federally in coordinated care trials, but your submission is still critical of that as well, so you sort of wonder how on earth we will ever get something that people are satisfied with. I think there is a lot of goodwill here, and people are trying to do things, but it runs into criticism, no matter what. What is the problem with coordinated care trials? That they are only trials? Is that the criticism?

Dr Atkinson—No. The criticism we made, and it was a specific criticism, was to do with the time scale, and I think that's what David alluded to in the introduction. The principle and the idea that these things be coordinated is something that we very much support, and the Perth Aboriginal Medical Service has been heavily involved in that. So the principle, the idea, is very good. It is just that the time scale in terms of setting it up, getting it operating and finishing it is such that you cannot really demonstrate any great changes to health in that short time frame. The two years is ticking already. The process is only just being established, because it takes a while to establish new ways of doing things. There are a lot of people working very hard on it, and doing everything they possibly can to make it work, and our criticism in our submission is of the time scale.

You try and achieve proof that something does or does not work in two years. If you judge it at the end of two years from when the funding was first applied, it will have barely been operating for 12 months, really, by the time the two years is up. It is an evolutionary thing, it will improve with time, and if you kept it going and looked another couple of years down the track, it might be achieving all manner of amazing things.

CHAIR—But, for example, some of it is measurable within two years. Even just measuring the number of attendances for women for breast cancer screening or pap smears is a measurable thing. You can say, 'Well, this little initiative will improve that?' You have got to have a bit of stick sometimes to drive some of these things, so: 'Okay, in a two-year period show that that can work.' But basically you support the principle?

Dr Atkinson—Yes.

CHAIR—It is just that you are worried that at the end of two years someone will say, 'That did not work.'

Dr Atkinson—Yes, exactly.

Dr Paul—And it is that throughput model. If you are going to look at judging effective health service delivery and you are looking at just numbers of people that you have seen or numbers of services done, it doesn't necessarily give you a good understanding of whether any health changes happened, and health change, particularly when you are dealing with the health of a group of people that is particularly poor, is going to take a long time for significant change to happen. If you want a real measure, you need to look at longer-term process.

CHAIR—So are the measures that are put in place inappropriate, so: 'Well, look, after two years this is how we will measure it'?

Dr Atkinson—The details of what are actually being measured I am not sure of, because that has been a subject of some negotiation over the past 12 to 18 months or longer. There are people who know more about the detail.

CHAIR—We will be asking the representatives from the community support centre later, but you have actually made reference to it. I needed to understand what the criticism was.

Dr Atkinson—With new programs, to try and do something differently, I think the principle of trying them out and seeing how they go is very important, but our concern is the level of commitment at the top end to give these things a go for long enough to see if they really do work, and to not expect those quick outcomes within a three-year term of government or whatever the other constraints—the realistic constraints—of life are. So that is our concern. Other initiatives in Aboriginal health have also been judged to be a failure without ever really being tried. Community controlled organisations are always under this pressure to prove that they have done X, Y and Z. The non-Aboriginal health services are never under that sort of pressure.

Most of the non-Aboriginal health services that are provided do not have to justify their existence at all, other than counting the number of people who go through, but whether they improved health or made it worse or whatever is not a factor. The fact that the caesarean section rate in Western Australia continues to increase year after year, which is not necessarily improving anyone's health, but is increasing the amount of money going into certain doctors' pockets, is not a health outcome. Mainstream services are not placed under the sort of scrutiny that community-controlled services are. I think scrutiny is a good idea. I think you do need to know what the outcomes are. But you have to be realistic about what can and cannot be achieved.

Mr QUICK—I understand that. We do have certain sections of the Aboriginal community—I am being devil's advocate here—screaming and saying, 'The situation is getting worse and the disparity is getting larger,' and then we have some other people in our community,who shall not be named but we all know who we are talking about, who are saying, 'They're getting too much, and there's no justification, and they're not accountable,' and the like. So how do we have this happy medium between improving the disparity which is getting wider and wider and wider, and actually achieving some goals?

Third World countries have got greater immunisation rates for their children than Australia. Schools and preschools and child care centres are saying, 'If you don't show some sign of record of immunisation, you don't come in,' so there are some sanctions being introduced, so with some of these coordinated trials there are achievable results well within two years, to say, 'Every Aboriginal child in the Perth CBD has been immunised, quicker and more efficiently than non-indigenous children.'

Dr Atkinson—If you focus on a sort of narrow thing like immunisation, you can. The Kimberley used to have great figures for immunisation, but we look now and they still have not got terribly good figures on Aboriginal health. They used to have all the kids organised on a database. They just did not necessarily do a lot of the other things. I think if you want to just focus on one or two indicators, you can achieve results quickly, but that is often at the expense of setting up a good system that will deal with the broader issues. The main causes of Aboriginal mortality—cardiovascular disease, death through injury, accidents, violence, whatever, suicides, renal disease, kidney failure, all those sorts of things—do not respond very well to immunisation. Programs to deal with them are complicated.

Mr QUICK—I understand that, but we are talking about various pipelines. We have got to deal with the end of the pipe, and also we have got to cut off the supply at the other end, so how do we do that? We have got an obvious thing that there is a whole bunch of 14 and 15-year-olds kids in Fitzroy Crossing busily sniffing glue and petrol and the like, but their siblings are coming through, and there is peer pressure—not pressure, but when they get a couple of years older they are going to be doing the same thing as their older siblings. So how do we deal with those two problems to put in place some sort of medical approach to that to deter the eight-year-olds, but pick up the kids who are real day-to-day threats, the 14 and 15-year-olds?

Dr Paul—Internationally the positive experiences have come from strategies that have ensured equity of access to resources—and various resources I am talking about—so that you get even distribution throughout the community of access to essential health care services, useful and appropriate education, food minimums, and the other infrastructure that you would normally expect to be able to access, and you ensure that it is evenly distributed. You do not have a situation where you have got a section of the community who can't access some services, and another section of the community who can.

If you look at various communities around the world, that is the way they are creating very rapid change in very poor communities that have actually developed better health outcomes than much richer communities. Unless we do that in Australia, we're going to continue to have sections of the Aboriginal community who are going to die 20 years younger than they should.

Mr QUICK—One of the questions I was going to ask, but did not, to the state Health Department was: is there a baseline for an Aboriginal community to ensure that there are sealed roads to the centre, that they have an adequate power supply, reticulated water, adequate suitable housing and adequate waste management? So we say for every community of 500 and above that that is what is a given, to start with, because a lot of them do not have that, and once we say that that is what they are going to have, and all the people—for example, the local government authority, the housing, the education department and the like, or whoever is responsible for all those things that we say must be given to the community—all put their hands in their various bags of money and say, 'For a community of a thousand people, that is going to cost X hundred thousand dollars to do that,' but once that community has got it, there is the basis upon which we start building these building blocks to ensure that their health improves.

If those are givens—adequate housing, reticulated water supply, adequate power and adequate waste management—of course their health is going to improve, because that's basically what I have got in my community 10 kilometres out of Hobart.

Dr Atkinson—You are correct, in a sense, but one of the problems is that there are people in Perth in the urban community who do not have that. There are a lot of people in Perth who do not have housing, who do not have appropriate services. It is not just because someone is 500 kilometres away that they have not got those sorts of services.

Mr QUICK—But we say to the government, 'That is what they're going to have,' so to Homeswest we say, 'Pull your finger out and provide it,' because there is a Commonwealth state housing agreement, right?

Dr Atkinson—Yes.

Mr QUICK—I live in one of the worst socioeconomic areas in Australia, and I have hundreds of houses that are empty, and yet there are 4,000 on the waiting list in Tasmania, and we are jumping up and down and saying to people, 'Go and squat.'

Dr Atkinson—I just wanted to bring in the issue that urban Aboriginal health is as bad, if not worse, on a lot of indicators than remote and rural health. The issues are different, and often they are more complicated in urban areas. It is more difficult to deal with. Yes, the remote areas do not all have those services. It is marginally better in WA perhaps than the NT. But there are still lots of communities in WA that just do not have

those sort of services, and yes, the government should be required to at least provide that.

CHAIR—But as practising physicians, it is not your task to respond to what Mr Quick is asking for. That is for us to drive, I think.

Mr JENKINS—Mr Quick is just expressing a frustration we all feel, I think.

Dr Atkinson—Yes, we share that frustration.

Mr QUICK—Yes. Why cannot it be done?

Mr JENKINS—If Mr Morris was here, he would be referring to some information that ATSIC provided us about an 1989 survey of undergraduates at the Queensland University that indicated that 90 per cent of those undergraduates thought that Aboriginals were to blame for their own health problems. Your submission directly goes to training aspects to try to engender attitudinal change. Can we have further expansion about what is required. Specifically I am interested in the scenario where the Royal Australian College of General Practitioners put together an indigenous health curriculum, then shelved it, and then watered it down. So I want a more general answer, but I am interested in that specifically.

Dr Atkinson—Do you want me to start with the RACGP one?

Mr JENKINS—If that is a quick answer.

Dr Atkinson—I do not want to be running down all our professional colleagues, but the Royal Australian College of Gps did the right thing. They got together with the Aboriginal community-controlled organisations, they employed consultants, and they developed a comprehensive Aboriginal health curriculum which, at one level, was agreed to. That was circulated in draft form several years ago. I hope I got the date right in the submission that it was 1994. That curriculum was for graduate education, so this is doctors after they graduate from medical school, so it is not really addressing the same thing as Dick Copeman was in that article. So that is what happened.

Because of objections from within the college, I think—and I was not privy to that—it was shelved for some time, and then it was finally released in a very different form last year. More limited training, which is still valuable, has been implemented. But certainly in Western Australia they have not done enough of involving Aboriginal organisations. They have involved one employee of the WA community controlled health organisation in their training, to the best of my understanding, but it has really been, 'Well, we've got to do this,' and someone from the eastern states employs a non-Aboriginal doctor to deliver it. So it has been a theoretically good process that started off with all the right intentions, but then when it comes down to it, it is having some effect, but not as much effect as it could have if it had been implemented as it was originally

intended. That was, I guess, the point I was trying to make in the submission. What was the other question?

Mr JENKINS—I might go to an even more specific question about the type of training that is required. You refer to indigenous health. Early today when the Nurses Federation was here, they gave us the proceedings of the National Aboriginal and Torres Strait Islander Nursing Forum, and just flicking through that—I have not read it—I picked up something about where there was a recommendation:

> Education for all nurses include a mandatory subject in indigenous history, identity, culture, health and principles of self-determination in management.

It talked about indigenous studies. Now, in Adelaide in the public hearing I raised this scenario. My electorate is in outer urban Melbourne, and has a very small indigenous Australian population, but very large immigrant population. I am more likely to be confronted with the problems of an Iraqi refugee, or a Somali or Eritrean. I have always been concerned that in educating medical practitioners we have not trained them to be culturally sensitive, and I went on to say, 'Could not indigenous cultural awareness be part of that context?' But here at this forum they said that indigenous studies are not to be included in multicultural studies, and it went on to say, because they were speaking as indigenous practitioners: We are first nation peoples who have been, and are still being, colonised. All I am saying is, it helped me in my education, for the background. But from you three people, because you have had a better connection with indigenous peoples and their health problems, I am seeking comment about how indigenous studies, indigenous health, should be taught.

Dr Paul—It needs to be taught as a beginning point, because it is not as yet. For many years at the local medical school, UWA, they had one hour of Aboriginal health in six years, and that did not always happen. When I worked for the Royal Commission into Aboriginal Deaths in Custody, we wrote to the UWA medical school, trying to get them to answer how did they deal with informing medical students of Aboriginal health issues and being culturally sensitive, and they sent back a very glib few-lines reply, saying that all their contacts with people are culturally sensitive, and of course their medical students pick that up.

That was in 1990. Now they have actually employed people like David Atkinson to actually increase the number of Aboriginal medical students in the medical school, and also to improve awareness within the faculty of Aboriginal health issues. Probably you should talk about that, David. There is actually a changing arena going on, and people are starting to understand it. They need to address it, but how many hours do they do in Aboriginal health now?

Dr Atkinson—It is still only six or eight hours over the six years—that is what is currently taught. We are implementing a new curriculum next year and in the new

curriculum it will start off with the issue of difference, and different groups in society, and people coming in contact with their own cultural identity, because we have a multicultural medical school in terms of the students, and then some specific teaching on Aboriginal health, general issues about Aboriginal people and then Aboriginal health more specifically once they get closer to the clinical years.The new curriculum, should it be approved in the next couple of months, will incorporate substantially more directed teaching to address some of those misconceptions that occur. What other medicals schools might tell you is, 'Yes, we do lots of it.' They see Aboriginal patients, but often just seeing Aboriginal patients reinforces stereotypes rather than actually changing attitudes, and that teaching needs to be early in all these courses. The Royal Australian College of Gps curriculum is too late. They have been through six years of medical education and it is a good idea, but we need something right from the beginning for every professional group that is going to work substantially with Aboriginal people—social workers, doctors, nurses, physiotherapists, psychologists, whoever—and that is the sort of thing that I am involved in working out at UWA.

What I think could be recommended in that area is some pressure from outside, because it is much easier to get the people of goodwill within institutions to change things if they have got someone backing them up from outside saying, 'You must do something in this area.' That applies both to indigenous students within all these courses—you will only get your money if you start getting Aboriginal students into your courses—and in terms of teaching the non-Aboriginal people who are going to deal with Aboriginal patients on a regular basis.Six to seven per cent of our teaching hospital patients are Aboriginals. It is not as if they wo not meet an Aboriginal person if you are training in medicine or nursing or whatever, you will. You will deal with lots of Aboriginal patients and a lot of people are not at the moment very well equipped to do that.

Mrs JOHNSTON—I would just like to try and get a comment from you. Obviously we are all very concerned about this widening gap that we have heard about, and this morning we heard about the problems with, say, cardiovascular diseases, and you yourself have just mentioned it. You also went on to say that this does not necessarily just happen in the rural areas, but also in the urban areas. That is understandable. When this comment was made this morning it was suggested that one of the reasons why there is a higher rate of deaths from cardiovascular diseases in Aboriginal than in whites is that there may be a change in their diet or a change in their lifestyle—these could be contributing factors.

Given that what you have just said is that Aboriginals in urban areas are equally affected by this, could I put it to you that they do not necessarily undergo a sudden change of lifestyle or diet; they will have lived in those urban surroundings for quite some time, and probably like many of those who are white, black, brindle or whatever, are also in a certain socioeconomic structure of our society where stress, poverty and other factors lead to potential problems with your heart.

How are you going to address something for perhaps just one section of our community which may not necessarily go to the other sections of our community? On the one hand you are arguing and saying there is too much going to the top end of town, and you are saying there is nothing going or only a small amount going to Aboriginals. Possibly with rural areas I can accept that, but when we are looking at the urban situation there are many people in the same level of socioeconomic structure of our society. Could you expand upon what you base your evidence on when you say that Aboriginals are at a higher risk of cardiovascular disease and being fatally affected by it, I assume, if you are looking at those contributing factors?

Dr Atkinson—First of all the evidence: there is really not much doubt and the figures in Western Australia are fairly conclusive about that; that actually in terms of heart disease things are worse for Aboriginal people in Perth than they are for Aboriginal people in the Kimberley. Part of that is the historical thing in that changes of lifestyle happen perhaps at different times for different groups of people; and another part of it is that we do not know all of the causes for all these things, and any medical person addressing you on those sorts of issues should acknowledge that we know a lot about the things that contribute to cardiovascular disease, but as to how it affects a whole population over the whole of their lives, there are aspects we do not understand as yet. So on the evidence there is no doubt.

The difference between the poorest non-Aboriginal people who live in perhaps the same outer suburbs of the city as Aboriginal people: if you look at them there is still a dramatic health difference. It is true that the poorer non-Aboriginal people have worse health outcomes than richer non-Aboriginal people. The difference there—between the richest and the poorest sort of 20 per cent or whatever of the non-Aboriginal population—is marked, but nothing like the difference between even that lower group of the non-Aboriginal population and the Aboriginal population within the same area. So there is a big difference between these two groups. That is because superficially it might look like they live in the same environment, but really they do not, because their environment is their whole history of themselves, their mothers and what condition they were in when they were born, the previous two generations. There are all of those factors that contribute to the health of an individual now.

I am the product of my life from birth, but also my mother's life before birth. I am shorter than I should be because my mother used to smoke heavily. The rest of my family are taller. I was the last child. There is a whole range of factors that affect health, and Aboriginal people in the city do have substantially worse health. There are things like diabetes, where there is a question of how much of that is genetically determined, and that is an open question—we do not really know to what extent—but really it is about that environment.

For many Aboriginal people—for people my age—they were taken away from their families, they were brought up in institutions, they were born and lived in very poor

conditions when they were young, and that adds to the fact that people smoke, or people eat high-fat diets, or people do not exercise, which is acting on them now. It all acts together.

Mrs JOHNSTON—I understand that, but we also have mechanisms in our community that do alert people. There are awareness programs, and we discussed this yesterday when we were with the Aboriginal medical services. When we are talking in these terms are most of the findings that are presented to us on empirical or anecdotal evidence? Which would be the larger percentage?

Dr Atkinson—When you are looking at mortality figures and hospital morbidity figures, the state Health Department can provide you with detailed empirical evidence for some of those statements I have made—not every single one of them. They have many other reports, too, so if the figures do not seem to be in that one, you might like to ask them again, because they have produced a number of reports on that.

CHAIR—You have left us with a plethora of stuff here to digest, but we still do not have their written submission yet, either. It is coming. Colleagues, could I leave it there. We have still got to talk to the community support people yet, and a visit out to Edith Cowan University this afternoon. Can I thank Drs Paul, Atkinson and Creagh for giving your time to come along and talk to us today. It says a lot about you. Maybe we will talk to you later as we progress. This is, as I said earlier, only our fourth day of this inquiry, so we are right at the start. Thanks again for your time.

[2.10 p.m.]

D'ANTOINE, Ms Heather, Deputy Director, Perth Aboriginal Medical Service, 154 Edward Street, East Perth, Western Australia 6004

WILKES, Mr Edward, Director, Perth Aboriginal Medical Service, 154 Edward Street, East Perth, Western Australia 6004

CARMODY, Ms Sheryl, Management Group, Aboriginal Community Support Service, and Executive Manager, Daughters of Charity Services, 27 Cleaver Street, West Perth, Western Australia 6005

WRIGHT, Mr Michael, Manager, Aboriginal Community Support Service, 27 Cleaver Street, West Perth, Western Australia 6005

CHAIR—This is a formal hearing, 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. That therefore means that any misleading of this committee could be considered as a contempt of the parliament.

We have a variety of submissions and we were very grateful to visit the Perth Aboriginal Medical Service yesterday and met with Mr Wilkes and Ms D'Antoine. I have to say to both of you how impressed the whole committee has been with your approach out there. I think I speak on everyone's behalf to thank you for that time. What I propose to do is for you to just make brief opening statements, in whatever order you would like to. My colleagues will peruse the information you have placed before us, and then we will have some questions, with the objective of getting to the bone on some of the nitty-gritties, to find out why there are so many barriers in the way for your sorts of organisations not to get on with the job, which we all aspire for you to achieve. So in whatever order you choose—Mr Wilkes will be champing at the bit.

Mr Wilkes—I will. I just want to start so that it makes Michael feel a little bit more comfortable, I suppose. I just want to say that three years ago maybe, in all of my life with the Perth Aboriginal Medical Service, there has certainly been an effort to embrace mental health in its entirety, and that has started to happen and Michael Wright is here today as the manager of that particular program. Certainly the Perth Aboriginal Medical Service have identified that it really needs to have an in-depth look and an in-depth way of trying to deal with mental health, and so that is what we are doing here basically, chair. Michael, I will hand it over to you, having said that.

Mr Wright—I welcome the opportunity to speak before this committee, although I find it a little bit intimidating. I did not know what to expect when I came.

CHAIR—I apologise. Actually I have been apologising to all our witnesses. This is a little bit like the Inquisition—us up here and you down there. It is not the environment we wanted, but we are stuck with the venue so bear with us for the day. If we come back to talk to you, we would like it to be much more informal. It is a little bit like seven High Court judges sitting up here.

Mr Wright—That is what I thought.

CHAIR—Please do not feel intimidated, Mr Wright, be comfortable.

Mr Wright—I listened with interest to the previous presentation, knowing David and actually working in partnership with him on that attitudinal study last year, so we have done a degree of work in the past. I am here to talk about our program and I was interested to hear your concern in relation to Aboriginal health but also, as well, an interest in trying to look and find some kinds of solutions or, more importantly, models that could work.

Ted is actually the director of the program that I manage, and, as he has already pointed out, that is one of the many programs under the PAMS umbrella. How we came to be was that three or so years ago there was a situation occurring within the Perth Aboriginal Medical Service with clients of the service who used to present almost on a daily basis very distraught, obviously traumatised. A lot of their physical needs were being met, but in fact there were other issues, and a lot of those I can talk about during the course of what I am about to say.

This was disconcerting, to say the least, to the GPs at the time and it was up to them—with the agreement of Ted and others in the agency—to look for a type of intervention that would meet their needs. As it was, just around this period Sheryl Carmody and the Daughters of Charity had developed a program that had developed a model, which we call the Inreach model of working. It was decided that maybe a similar model could work within the Aboriginal community. That is not to say that we were not already doing that but we had not given it a name as such. It is probably more easily recognisable by the name of Community Development or something similar.

It was from that point that the whole program began, and we were initially funded through the Mental Health Division, through the Health Department here in Perth, and we continue to be funded through that department. Our target group are people with serious mental health problems or people with a diagnosed mental health disorder. I just want to briefly describe our work. What I have provided to each of the members on the committee, as well as the absent members, is an overview of what we do and how we do it. I would like the opportunity for questions to be asked of us, or the panel at least, at one point.

Generally speaking we call it the Inreach model, and it has three characteristics

basically that we like to think of as intensive, comprehensive and long term. By intensive we mean we work with small numbers of clients, so then we are able to give intensive intervention to people over any given period of time. Comprehensive means that we look at all their psychosocial needs. 'Psycho' in that regard is that we are not clinicians ourselves but we work in partnership with psychiatric community clinics and also with the GPs at PAMS—more along the lines of the social issues that are often presented to us.

I was really interested to hear Mr Harry Quick's overview—very eloquent as well, I must say, because I agree with everything he said—that everyone should have appropriate accommodation. Accommodation is always an issue for us and it has become, sadly in this state at least, a major issue within the local Nyoongah community. I speak for the Nyoongah community because I am a Nyoongah myself. I would say that it is actually wider—the problems that we experience along those lines. We work with trying to advocate, facilitate and create an environment where people are either not evicted from their home or, in the case of an eviction, we try to arrange that they can actually get other short-term accommodation or looking towards more long-term accommodation. As you can imagine, that takes quite a deal of our time at this present time in this present environment.

Probably the uniqueness of our program has been the partnership: we are an Aboriginal agency and the Dr Paul group is a non-Aboriginal agency. In the beginning no-one knew if it would work or not, but everyone concerned embraced the concept at least. What we have found is that not only has it worked but it has developed into an efficient agency and, as someone said, it is operating from good practices. It has been really very much a developmental model that started quite small, and from that point of view we incorporated a lot of training for the workers, and then it has grown to its present size. I am the manager and we have four other support workers.

I think Dr Paul mentioned this in the previous presentation. The major problem that we have found in the work that we have been doing is that the people we work with essentially are referred to us because they have a mental health problem or a serious mental health disorder. Quite often they have many health problems, ranging from diabetes to cardiovascular illness as well, and so what we endeavour to do is we employ, as we call it, care coordination. We actually work with a person as we are engaged with them, as I said, with those three characteristics in mind, intensive and long term. We are actually able to follow up with that person, making sure that they are linked to whatever services they need to have. So if housing is a priority, say, we work with them until that is resolved, to some point at least.

We make sure that their health needs are being met, and we make sure that they are actually going, whenever they can, to have their psychiatric needs met. That has had a dramatic impact on some people. To provide one example, I always think about what Ted said at one point. Prior to our service coming on board he used to say that there was not a day went by that someone was not knocking at his door, saying, 'What's happening? I

want something done.' He said he does not have that any more—or very rarely at least. I know that the impact we have had is that we have reduced the admission rates into hospitals dramatically. We have not got those figures as yet, but that is mainly because the people who are meant to give us the figures are dragging their feet with that. But we know, and our own figures show, that people are not going into places like Graylands as often as they were before our intervention.

Mr QUICK—So if the Justice Department refers people to you—

Mr Wright—I was going to get on to them.

Mr QUICK—do they provide you with any money?

Mr Wright—No.

Mr QUICK—Or do they just say, 'Look, we'll refer person X to you, and hopefully you'll pick up the pieces. We do not want to see them back'?

Mr Wright—I am sure you can appreciate that the Ministry of Justice think it is a mental health problem so it should be met by the Health Department; the Health Department have an argument that they are part of the Ministry of Justice, and the Ministry of Justice should. So while departments are actually arguing with each other as to who should pick up the tab, we just get on and do our work.

Mr QUICK—We heard today from the state Health Department that we have got this wonderful intersectorial agreement and everybody is benefiting. The place is rosy.

Mr Wright—Well, okay.

CHAIR—They are trying to be positive, Mr Quick. Could I just intervene here and ask if it would be appropriate for you to tender the submission that you have given us here to be admitted into the evidence. Advise me how much longer you need before we get to questions.

Mr Wright—I can collapse it further if you like. I have provided in the documentation I have given to you two case studies. I find that when people read actual case examples, it gives a much clearer picture about what we do and how we do it. So I will not go into that any more, other than to read that and maybe you can direct questions to me, or to any of us, about that later. I would just like to talk generally about the model, and it is also about the partnership, and what that has meant to our service overall. In the beginning—I think as Ted has already mentioned—it was a whole new area for us to venture into. We did not have many models that we could actually refer to and get directions from, so it has been pretty much going out there, trialling it, working it out, coming back, reflecting on the process, developing it further along those lines.

In doing that we have actually created, or developed at least, an environment in which we actually skill-up the workers so that their own professional development is at a point where they can make those kinds of assessments I spoke about earlier. They are not clinicians, they are not psychiatrists, neither are they social workers, but they have been trained to make those kinds of assessments where they now know how to recognise mental health symptoms, and then provide a greater intervention service to our clients.

The other thing I would like to mention just generally is that we have made major linkages to the mainstream services. We have become the bridge. I think Dr Paul alluded to this earlier. Aboriginal people have not been accessing mainstream psychiatric services, and there is a stigma around psychiatric services in the Aboriginal community. People have had good reason to have concerns about the treatment they have received in the past from the mental health system. The major reasons for that have revolved around the lack of cultural awareness and cultural understanding about Aboriginal people from the mental health system itself, and a lot of misdiagnosis has occurred in the past. I do not know how accurate this is, but when I have asked for admission rates at places like Graylands, something like 10 per cent of the admissions into Graylands are Aboriginal people. That is going to reduce dramatically because they have actually now got a service in the Kimberley region.

But generally speaking, that is still high when you consider we are only two per cent of the population of this state, or just over two per cent, and 10 per cent of the hospital population are Aboriginal in a major psychiatric facility like Graylands, and it has just been enough to get out of those institutions without following up with long-term care. What we have been able to do is actually build those bridges; break down some and demystify what psychiatric care is all about to the community, and our workers have actually done that over a period of time.

I pick up on what Dr Paul said too: we have achieved this in 2½ years, three years. This is not achievable in 12 months or two years. It needs support, it needs to be funded with the recognition in mind. We have to go each year to the Mental Health Division in this state. We do not get recurrent funding; we have to go and we get a contract each year, which I think is ludicrous under these circumstances. To fund a program like ours and to keep it effective, we do not need the stress and the trauma of actually thinking, 'Well, are we going to be funded for the next six months and that's the end of it, or is it going to be ongoing?'

We have been funded through national mental health strategy money, which finishes at the end of this financial year. There is no guarantee we will be funded after June of this year. So it is those kinds of restraints that we have. The MOJ example I will talk about very briefly. In the last 12 months we have had a number of referrals from the Ministry of Justice. We know that something like 18 per cent of the prison population is Aboriginal. A significant number of that prison population, we feel, may have a mental health problem of some kind. We know that nothing is happening for those people at the

moment, other than what service we can provide.

Mr QUICK—You do not have an outreach service into the gaols?

Mr Wright—We do. When the referral is made to us, we go in. But again we are a non-government agency. There are statutory agencies, statutory concerns. There are those concerns which do not always give us that open sort of exchange. We do not mind that arrangement at times.

Mr QUICK—You do not visit gaols on a regular basis?

Mr Wright—Yes. I will give you one example. We were given a referral of a young guy last year. I picked up on the referral, and we stayed with him. He was on parole. During that period I worked alongside of him. He did actually go back into gaol. We visited him regularly when he was in gaol, set up support when he came out of gaol, and that is the kind of arrangement we do. I have given an example in one of the case scenarios of a young guy where we were given a referral, and I was talking to his support worker today. He has been part of our program for four months. We do not have a doubt in the world that if we had not been part of his release and involved with that person—we were not part of his parole conditions; we do not want that as we do not want to set up an adversarial arrangement between us and our client—we feel that he would have gone back inside. He had a history of reoffending, but generally speaking, this is the first time he has had a consistent management of his mental health problem. He has schizophrenia. He has been managed for his illness, so alongside of that he has not needed to reoffend. He has had a support worker working alongside of him. We know that if he had not had that, the chances are 90 per cent that he would have reoffended.

CHAIR—In your submission there you have actually used a first name. Are you happy that that will end up in a public record? Is that a real name?

Mr Wright—If you read through there I have said that I have asked the people concerned. They have looked at it, they have agreed to those scenarios being put into that report, but they are not their names.

CHAIR—That is good. I propose to incorporate the document from the Aboriginal Community Support Service, dated 19 February 1998 and presented today. Is it the wish of the committee that the document be incorporated in the transcript of evidence? There being no objection, it is so ordered.

The document read as follows—

CHAIR—Those case studies in our report are a way in which we can convey the story we get, so thank you very much for that. Are you happy to proceed there?

Mr Wright—Just one concluding thing: this is not a home visiting service. I want to make that point. What we provide is a clear therapeutic professional service to our clients, and the goal of our work is that we are able to model appropriate behaviour which will then affect eventually where people will actually go—if they need to alter lifestyles and move from where they were previously, whatever situation was happening for them. So it is not just going there, making sure everyone feels good. We do some of that; often people feel good that we're there. Well, more than often; they actually do feel good that we're there. But it is more about being a part of their daily life so that it is actually affecting where they will be whenever.

CHAIR—Mr Wilkes, would you like to make a contribution? We have been looking forward to your coming to see us today after talking with you yesterday.

Mr Wilkes—Mr Chair, I do not know whether I can add much more than what we talked about yesterday. It might be more appropriate, if you want things on the record, for you to ask pertinent questions. I am hoping that as a result of yesterday's visit that certainly we would have instilled some of those pointers in the memories when you get to the final stages of writing up your conclusions and your document. That would have been the way I would have hoped we would have had an impact on you. So if Heather wants to add anything else—I certainly would look forward to being questioned.

Ms D'Antoine—I would certainly like to add the fact about the program is that although it is an intense program, it does not need highly skilled workers. You do not need people with a lot of training in mental health. There is very much a trust relationship between the worker and the client. Certainly the social issues, which are often the most pressing things on the client's mind, are addressed, and I guess with a lot of the medical model-type programs, they more often revolve around the health professional needs rather than the client's needs. With this support program, I think it has worked really well because it is a grassroots initiative. It is being addressed by people who can see the immediate need. It is not a grand scale program or anything, and there has been a commitment from both sides.

It is a program where I have seen that the aim is to restore a lot of order into people's lives. Instead of coming to us with lives in disarray, their housing is sorted out. We have seen people who could barely get out of bed in the morning looking at going off to TAFE, and the services of the mainstream psychiatric services are used much more appropriately, and I am sure they would be very satisfied with how the program is going.

CHAIR—So it is actually operating right on the periphery. There will be a long time before the health benefits manifest themselves though, wo not there? If you can get somebody starting to feel good about themselves now, it will be a long time before the

health benefit shows up in any statistic, would not it—decades?

Mr Wright—No, not necessarily. I think you can answer that question in two parts. In terms of those who provide the funding, they often see what they consider to be positive performance indicators, if you like, or positive outcomes. We have demonstrated we have reduced the rate of readmissions in the hospital. Again with the Ministry of Justice we can show again that people are not necessarily re-offending, and they are actually going back into the community. So that is part 1. Part 2 of that question would be that when people feel good about themselves, obviously it is going to have a general impact on the wider community overall. If people are not having to access tertiary health facilities three, four or five times a year, then that is going to reduce the impact on the cost of whatever it is; you know, however you rate that.

I think we have seen incremental improvement over a period of time, but some of that is quite dramatic, and just to give an example of that, we did have a client who we picked up in the early days of our service, one of the clients I spoke of earlier who used to come daily to the service, to the Perth Aboriginal Medical Service; very distraught and quite traumatised often; not only with a mental health disorder but also a lot of other health problems as well. These health problems were being managed quite well from the PAMS doctors' point of view, but her quality of life was just getting up in the morning when she could and just going into PAMS and spending the whole day there. In the time that we worked with this person, she's actually now enrolled in TAFE She hardly ever goes to PAMS. She goes to a clinic, a community psychiatric clinic. If we are talking about successes, she is really one of those success stories for us.

CHAIR—That is actually the scenario 1 example you have given us.

Mr Wright—No.

CHAIR—It is another one, is it?

Mr Wright—That's another one. We have got a few.

Mr Wilkes—Mr Chair, can I just add to that one by saying—and I now know who Michael is referring to—it is certainly an indicator that Michael picked up before; these indicators when people become directors of AMS, and Aboriginal people and Nyoongahs come to know that you are the main person, is certainly a situation where a lot of clients that now are people that Michael is working with used to come to me, and I can tell you that this particular person is a person that continually came to me. My frustration was in trying to get the doctors to deal with it and say to the doctors, 'Well, look, this is a health problem. I do not know how to deal with it,' and the doctors saying, 'There's a little bit more than just the physical health problem, there are also some other aspects there which we need to deal with.'

In the early days of the Perth AMS we did not have that, and I can tell you it is more than noticeable. I am starting to think of other people that would have fronted me at the office, in my office, who are now being steered towards Michael, and it is certainly an indicator which I am pleased to say is proving that this unit is a very successful one, and has the potential to be even more successful. That is one little indicator.

Mr ALLAN MORRIS—With the absorption of the community support service into PAMS, what happens with the Sisters of Charity? Do they still stay involved?

Ms Carmody—Yes. At the moment the service is located with us and it has been for nearly three years, but once it relocates with Perth Aboriginal Medical Service we will keep an associate-type relationship, mainly to keep sharing and supporting the service, and because ours is a much bigger program ACSS can benefit from our reviews and whatever.

Mr ALLAN MORRIS—How will that occur structurally? Will there be a formal process? Will someone from the Sisters of Charity be part of the board, or part of the coordinating committee?

Ms Carmody—No. We, at this stage, have not seen that as necessary. We have got a couple of months to draw up a plan for the future partnership. We have had a plan for this three years and then we will be drawing another one up, but it will have some quite significant differences.

Mr ALLAN MORRIS—I just wanted to raise it in the context of the empowerment things we spoke of previously, and that kind of constructive collaboration. Perhaps Mr Wilkes may have some ideas. On one hand I think people have been saying they want empowerment and self-management to help own their own problems, but the input from people like Sisters of Charity has obviously been valuable. Have you got a model that actually gets the best of both worlds in mind, or do you just hope to have good collaboration or good liaison? That may well depend on the individuals rather than on the structure.

Mr Wilkes—The ongoing effort is certainly an effort which we need to continue in partnership and all of us have recognised that. If you have started a partnership up and one of the partners has to diminish its input, it is not as if we want that partner to completely diminish away from us. We are saying, 'It is part of your baby, too.' This thing came out of the recognition that there was good intent and a good partnership started. We certainly made it known to the Daughters of Charity in the early days that the intention was that Aboriginal people would have to be empowered enough to eventually take this whole program over, and that is the line that we have drawn. Somewhere down the track we recognise that eventually we will do that. It is like saying, 'Do not throw us out just yet, or we do not want you to throw the baby out with the bathwater'—and we said that the other day. It is a matter of continuing that goodwill which we started.

We will be working with Michael and other people who have an input into this unit to draw up what might be the next strategic sort of time frame. That is because it is only just coming to an end now, because this program is running towards the end of its first stage, and we have already had the first meeting and there will be other meetings to make sure that we continue that effort. I might just add that as a result of talking to you yesterday, you must be more than aware that these partnerships and this good intent is something which Aboriginal leaders are now starting to pick up on, and I would encourage this committee to entice other people, particularly from the non-Aboriginal community, to jump on—if we call it a bandwagon, let's call it a bandwagon, but it is a bandwagon of good intent and partnerships.

Aboriginal people are more and more now wanting to be involved in that sort of arrangement, as long as there are some riders which say, 'Ownership and Aboriginal community control are the underpinning philosophy of what we are on about.' Somewhere down the track we are saying to people, 'We will use our expertise together'—knowing the Aboriginal community do not have expertise in certain areas—and we talked about the pools yesterday in relation to Aboriginal expertise and we know that we do not have a big pool of Aboriginal doctors, we do not have a big pool of nurses, we do not have a big pool of social workers and we do not have a big pool of psychologists. In fact, some of those pools are very small. The intention is to build those up, but also to use wadjela, for want of a better word—we used the word 'wadjela' yesterday—wadjela expertise to complement the endeavour of Nyoongah people and to bring about appropriate and positive change.

I think what is happening is that that started maybe a couple of years ago and it is starting to build up the momentum, and I am hoping that in five, maybe 10 years time, we will see the results of that good intent. Maybe I will stop there.

Ms Carmody—Could I comment a bit further on that? The thing is that non-Aboriginal agencies that are either asked to join a partnership or invited need to also be checked for a number of things, because for a program to work it needs commitment at the leadership of both organisations, it needs its staff to be culturally sensitive, and it needs to have an infrastructure and needs to know about good practice and have a strong sense of the common good that is trying to be achieved. I think in a lot of programs in our community there is not enough assessment of whether there are enough good things in place to make something work.

In the case of our ourselves, we are also a new generation of non-Aboriginal people, as are some of the Aboriginal people that we started off in the initial committee, where we do not want to repeat the history that has happened so often between Aboriginal people and non-Aboriginal people. But in our community, as you would have heard from the previous group, it is not widespread yet and I think programs like ours show that it can happen and there is a way forward, and in many ways stories like ours should be documented, because whether it is on policies or our actual model or how we have worked

with public psych services or how we have worked with the leadership of Perth Aboriginal Medical Service, we have carefully done it over three years, and there has not been a blow-out amongst us. We basically have not ended up in any serious conflict. We are not interested in holding on to it; we are interested in being available long term as much as required. Money is thrown into areas, but it is not enough to say, 'Are there enough ingredients there to make it work?' I guess we had enough ingredients to make it work.

Mr ALLAN MORRIS—I am sorry, I called you Sisters of Mercy, didn't I? That was my fault.

Mr Wright—I would like to say as well that it has been my experience that this whole initiative was undertaken with a degree of maturity that I have not witnessed in many other places in the time I have been working. As you can see I have got a few grey hairs, so I have been around a little while, and I must say it is a credit to both Ted, as the director of PAMS, and also Sheryl and the executive officer also at the de Paul group, where there was no competitiveness set up at all at any point in time. There was continual mutual respect shown to each party and an awareness that there were cultural differences that needed to be recognised at any given point in time.

I feel that it is just a natural progression then, to answer Mr Morris's question, that the relationship partnership will just go into another phase—it will be different. There will not be any need for it to be the same as it was, and for that reason that sense of maturity and the way that people have carried this project through to where it is at this point is just a natural progression and natural development. What I have been pleased with is that people have not had a sense of either grasping and hanging on to it, wanting to tinker with it or to manipulate the situation but to allow it to grow and develop naturally. Then once we move across—and we will under the PAMS umbrella physically—then that is where we should be, and that is what it is all about.

I think the previous presentation pointed to this, too, in the whole of their presentation, that Aboriginal health needs to be controlled by Aboriginal people. We have been aware of that. That has been the topic of many conversations that we have had in this partnership; that there would come a time and that it was necessary and that was what it was all about; that we had to own our own destiny in that regard, in terms of the health and wellbeing of our own community. That has really been the hallmark of this partnership.

CHAIR—That is a good example.

Mr ALLAN MORRIS—Mr Wilkes, can you just enlighten us a little bit about the significance of cultural issues on solving Aboriginal health problems—the sense of culture and the role of culture in terms of your community relationships in your community structures, if you like, and how they function.

Mr Wilkes—There were two questions, and Mr Quick did ask one of me previously. That was to say that the reference to the joint planning forum that I think the Health Department personnel might have been talking to you about this morning, and the indication that certainly the Aboriginal community have the opportunity through that process to be involved in another partnership is certainly true. But again you need to understand that these joint planning forums that operate at the state level are a tripartite arrangement in a sense; they are the Aboriginal community and the Commonwealth government and the state government getting together at this level.

That is well and good, but certainly the indications of the past have been that the two government corners have certainly used the power, knowing that they have the dollars in their corner, to bully the other one around. The Aboriginal community have walked out on those arrangements in the past, and I think this committee needs to understand that if you are going to have a proper partnership at that level, you have also got to understand that there are cultural imperatives that everyone has to take on board. We know that governments have responsibilities, we know we have to be accountable to you mob, but governments have to be accountable to us, too, at that level in particular.

I do not know if you had any concerns about it, but I would not want you to rush into thinking that the joint planning forums are working wonderfully well around this country and that the one in Western Australia is the bee's knees. It is certainly not that at this stage, but it has the potential to be that.

In relation to culture, if you are living in the city of Perth it is certainly a different experience to call yourself a Nyoongah man and to hear about Aboriginal people and what is Aboriginal culture and how do we adapt to continuing being a Nyoongah man. Michael and I and Heather, being Aboriginal people living in an urban setting, knowing that we might have been born and come from areas outside of Perth—it certainly presents us with a dilemma which we have, in our own communities, tried to solve. It needs to be said that there are restrictions placed on Nyoongah people, or people living in an urban setting, which we do not have much control over. They are acts of parliament which demean and diminish our capacity to carry out our cultural obligations, and I am talking about particularly fishing and hunting rights. I am also talking about trying to manifest changes in the cultural appreciation in the broader community, and non-Aboriginal people certainly need to be aware that Aboriginal people in the main do not want to be middle-class Australians. We do not want to end up being, I suppose, Westernised to the extent where we become very material.

Some of the differences in the way that we look at life are because of our obligations to things which are very cultural. There is the extended family, for instance. In the Aboriginal world, the cultural appreciation of the extended family needs to be analysed apropos of what it means to our health. The fact is I have 84 first cousins, or I might have more. At the age of 42 I have got eight children myself, and I also have some grandchildren, so that extended family keeps on getting bigger the older you get, and

certainly other Aboriginal people have big extended families, too. The obligation to look after those in not only a cultural way but in a humane way is a most frustrating thing and can also be very hard to do, in the sense that the income coming into those families is not substantial enough for them to do some of the things they would like to.

I suppose there needs to be recognition that in the south-west and in the southern parts of Australia there is the colonisation process. I did say to you mob yesterday that a lot of Aboriginal people call that invasion, but as a result of the colonisation process a lot of our culture has, as I said, diminished, and languages have disappeared. A lot of the people have been forced into areas to live where they would not necessarily live if they had another way of living, and as you know with the modernisation of the farming world and the modernisation of other worlds, it has meant that Aboriginal people, as a labour force, are no longer are required to cut the wheat or drive the tractors so they have moved to places, as I said, where they may not necessarily want to live.

A lot of them have come to live in Perth and we have a population which we call a multi-Aboriginal or a multicultural Aboriginal population in Perth. There are Nyoongah people here, Wongi people, there are Yamatji people and there are people from other parts of the state as well. That diversity within the city needs to be understood, too. Aboriginal people still want to play didgeridoos, we still want to get up and dance, we still want to be able to walk along the rivers and do our things along the side of the rivers. We are restricted because, as I said before, there are acts of parliament which look after the broader community. I do not deny that some of those acts of parliament are very necessary, but I certainly would like to impose my will on those acts of parliament to say, 'Can you appreciate that as a Nyoongah person and a Nyoongah man, I want you to rearrange those so that my culture can live on.'

Mr ALLAN MORRIS—Impact on health?

Mr Wilkes—Certainly. The self-esteem within an Aboriginal man to be able to say, 'I am a Nyoongah man and I'm proud of it,' is certainly going to send good vibes to my body and make me feel good about being a human being living in Australia. I think if we can bring that about you are going to see a lot of Aboriginal men in the south-west being able to live a lot longer, because they know they are not trespassing on land when they go hunting for kangaroo, they are not going to feel intimidated because they are sitting on the side of a river catching marrons, or they might have caught a couple of extra marrons, or they might have caught a couple of little ones for other purposes, and those sorts of things. We are not asking for the world to be stood on its head. We are asking for some simple commonsense to allow Aboriginal people to live a life which allows them to have the esteem to continue their cultural upbringing.

CHAIR—It seems to me on that we have just got a long way to go in terms of mainstreaming. When you mention the fishing, back where I come from in the Murray River Aboriginal people do not have to have a fishing licence—we have got that far

actually—where mainstream do. Mainstream Australia do not understand why that should be so. They say, 'We're all in this together.' I think you have got your statement on the record, but we have got a long way to go in the terms of understanding what you have said about access to the river.

Mr Wright—How important it is.

Mr Wilkes—Very important, yes.

CHAIR—We have heard how important it is.

Mr Wilkes—Can I say to you, I am not sure whether I agree with that. I have got to tell you that the media in this country can change the mood of this country very quickly, as is seen in relation to the discussion about the republic and as has been seen in relation to the discussion about Asian immigration. I believe that if the media and the government were to work together to bring about positive change it could happen very quickly. It is how much guts the government has got to put it on the media barons in this land to bring them into line with what we, as human beings, want for Australia.

CHAIR—You are right about that. We saw that happen with firearms. Anyway, that is another debate we wo not open up here. We will wrap it up there. We are due out for an inspection at Edith Cowan. I have a feeling that we will be back to talk to you all. We have appreciated the last couple of days, especially Ted Wilkes and Heather D'Antoine. Michael—to you today—thank you very much for your effort and your contribution, and Sheryl Carmody, thank you. It is good to see a good model that is working and delivering. We will be looking for more of those, as Mr Quick points out, floundering around out in the countryside—but we will be back to Western Australia to have a look at some on-site examples, and I just want you to know that we appreciate your time and effort.

Mr ALLAN MORRIS—Could I also add to that the comment made yesterday afternoon: if with the benefit of hindsight there are things you did not say that you think might be helpful for us to have on the record, you could send a note or letter of any form. In other words, you are still welcome to write to us if you think it will help us.

CHAIR—Nothing is closed off yet. You will be sent a copy of the Hansard for you to peruse and read what has been said. Thank you very much.

Resolved (on motion by **Mr Forrest**, seconded 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 3.00 p.m.