HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

BRISBANE

Tuesday, 17 March 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

BRISBANE

Tuesday, 17 March 1998

Present

Mr Forrest (Chair)

Ms Ellis	Mr Allan Morris
Mr Jenkins	Mrs De-Anne Kelly
Dr Nelson	Mrs West

The committee met at 9.05 a.m.

Mr Forrest took the chair.

CHAIR—I am pleased to open this fifth day of public hearings on the committee's inquiry into indigenous health, as 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 services to indigenous populations have not resulted in significant improvements in the health status of these communities and that there still exists barriers to access to mainstream services for Aboriginal and Torres Strait Islander people.

The hearing in Brisbane today follows previous hearings in Canberra, Hobart, Adelaide and Perth and provides an opportunity to explore issues with the Queensland government and other locally based organisations and individuals who have made submissions to the inquiry. This will be followed by a further hearing in Townsville tomorrow and in other cities in the next few months. The committee is also intending to visit remote and rural areas in central and Western Australia to gain first-hand experience of living conditions outside major urban centres. This is particularly important where population levels are low and dispersed over large distances.

As I have already indicated on previous occasions, I would like to stress that the committee is seeking to conduct this inquiry in a spirit of collaboration and cooperation with Aboriginal and Torres Strait Islander people. Obviously, it is important to consult communities directly and combine the collective experience of everyone who has worked in this area to arrive at the best possible practical strategies to improve the status of indigenous health. It is also important to build on individual successes and to derive benefit from improvements achieved by communities themselves.

We have been very impressed with Aboriginal communities on the ground that we have met thus far. We think there are some obvious keys in engaging some of these good programs we have already seen. Most of that has been focused in urban centres so far.

I welcome the representatives from Queensland Health who are appearing before the committee today. Before we proceed, I point out that, whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament. I should also advise that parliamentary privilege applies to evidence given at committees such as this and protects witnesses so that they can give frank and fearless evidence to assist our inquiry. I would like to introduce our committee to you: Mr Allan Morris, member for Newcastle, a New South Wales coastal seat; Annette Ellis, member for Namadgi, a Canberra seat; I am the member for Mallee in Victoria; De-Anne Kelly holds the Queensland coastal seat of Dawson; and Brendan Nelson holds Bradfield, which is a Sydney suburban seat.

BLUMEL, Ms Debra, Manager, Public Health Planning and Research Unit, Public Health Network, Queensland Health, Queensland

HAYMAN, Dr Noel, General Practitioner, Queensland Health, PO Box 52, Inala, Queensland 4077

McCARTHY, Ms Laurel, Coordinator for Implementation of the Aboriginal and Torres Strait Islander Health Policy, Cairns and Surrounding Districts Health Services, Queensland Health, Queensland

RING, Dr Ian, Principal Epidemiologist, Manager, Health Information Centre, Queensland Health, PO Box 48, Brisbane, Queensland 4001

RUNCIMAN, Dr Claire Diana, Acting Director, Aboriginal and Torres Strait Islander Health Unit, Queensland Health, PO Box 48, Brisbane, Queensland 4001

TAYLOR, Ms Geri, Director, Health System Strategy Branch, Queensland Health, PO Box 48, Brisbane, Queensland 4001

CHAIR—The committee has received and authorised publication of your submission. It is already part of the published volumes of the inquiry. There is no need to attempt to talk right through your submission. We have already perused your submission, but there may be some salient points you would like to make in an opening statement before we proceed to questions. We are in your hands, Ms Taylor.

Ms Taylor—I understand our time is limited. Certainly, we would understand that you would want to question and query and ask comments of the representatives of Queensland Health here. I am going to give a brief overview and then ask different members of the Queensland Health party to provide a particular perspective. Hopefully, that will conclude in about 20 minutes and will leave sufficient time for you to follow lines of inquiry.

I would like to say at the beginning that the Director-General apologises for his inability to be here but parliament is sitting this week and he is there in the House just across the road at this time. We welcome the opportunity that this inquiry has in that it attempts to overcome some of the duplication and difficulties that we see very much in Queensland in trying to advance the health of indigenous people, the Aboriginal and Torres Strait Islander people. We would say, however, that we believe that we are putting in an infrastructure at a whole of government level in Queensland Health to try to overcome what is a very difficult challenge to all of us. We look forward to hearing the deliberations and the conclusions of this committee.

I am in the policy area of Queensland Health. Within that area we have an Aboriginal and Torres Strait Islander health unit which is responsible for the production of

the Aboriginal and Torres Strait Islander Policy 1994, which I will table, which has been affirmed by this present government. This puts in place an infrastructure which decentralises decisions and provides for opportunities to work with local communities and with local district clinical people in improving in discrete areas the health status of indigenous people. Our submission and all other submissions point to four overwhelming problems of indigenous people. Each member of the Queensland Health party will be able to talk to that. Ian Ring, because of his role as principal epidemiologist, will be able to talk about Queensland's particular position and some of the areas that we are interested in addressing.

I should also say that this document allowed Queensland Health through the Australian Health Ministers Conference via the Australian Health Ministers Advisory Council to step up some performance goals and targets whereby we lock health jurisdictions into working in a very concentrated way of trying to improve the appalling record of the health status for Aboriginal and Torres Strait Islander people. We are happy to talk to that. Our previous director was instrumental with the other heads of Aboriginal health units in state and territory health jurisdictions in advancing that, and we are pleased that AHMAC endorsed it. We now have to report on a six monthly basis on how we are doing. Laurel McCarthy and Dr Hayman will be able to talk about small snapshots of where we believe we are trying to make a difference. However, there is absolutely no doubt that this is a challenge that will probably take at least a decade to address.

We have been active in Queensland Health but also with the curent government in trying to devlop a whole of government approach. We have a Queensland Aboriginal and Torres Strait Islander economic development strategy and a social development strategy, which again is a whole of government committee at CEO level. It is devoting a whole lot of time to looking at social infrastructure in conjunction with indigenous people about how we can advance and put on the ground sustainable and not small, one-off episodes of improvement.

Critical to all of this is our information. There is no doubt that across the health care sector in general—and particularly for indigenous people—we do not have the information and the databanks that will enable us to track, to record, to monitor and to evaluate how well we are doing. Certainly, we would recommend that you follow this in your inquiry deliberations and research. As we approach the new century, it is difficult to realise that, as we understand health is very much an integrated, whole of health service, we still cannot track people, we still do not know whether we are targeting people, and we still do not know whether what we are doing is worth while—both for the dollars and the other resources we put in.

Finally, before I turn over to the other members, I would like to talk about the funding that Queensland Health receives for Aboriginal and Torres Strait Islander health services. I am not prepared to give you details, but if you would like that I can. Suffice to say, we have 25 per cent of the indigenous population in Queensland and we receive not that amount of funding. We receive substantially less funding.

CHAIR—That is 25 per cent per cent of the national population.

Ms Taylor—Of the population in the 1996 census. We have nine full AMSs as against a total of 90, we understand. Certainly, we believe that Queensland Health has been left to pick up a large segment of delivery of clinical services. Certainly, we see our role as being to deliver hospital services and out-patient services and community based services, but we carry a very unfair load in regard to delivery of MBS and PBS remunerated services in our remote and rural areas. Certainly, I can show you a graph which shows you that in our remote and rural areas Queensland Health picks up all the services in lieu of any sort of private market.

I would like to leave you at the end of our presentation with a number of messages. The first is our bona fides in Queensland Health—and working collaboratively with other departments—in trying to address this in a proactive and very much community involved way. I also want to raise again with you our impressions of the challenges that we face, as you well know and the submissions certainly testify to. Once again, they testify to the challenges that we have all known about: the need for equitable funding and the expertise in Queensland Health to take up these challenges at clinicians and also at policy level. In that regard, I find it amazing that Queensland Health clinicians were very much involved in tackling the Rwanda crisis; yet we still have not seemed to be able, because of a whole range of factors, to address in a sustained way some of the issues that face indigenous people in regard to health status.

CHAIR—Thank you. Do you propose to speak one by one?

Ms Taylor—I would like to first turn over to Dr Claire Runciman to talk about the joint activities that we are undertaking with the Commonwealth government, our work force, cultural awareness art program and other matters that you might want to touch on.

Dr Runciman—As Geri said, after the health policy was endorsed by both parties in Queensland, the health ministers endorsed targets which actually provided an additional dimension to the policy by giving us some time frames and identifying very specific conditions that we were attempting to address. That really has left us with the challenge of setting up a model of minimunion movement essential services which can address those specific targets.

Some of the elements of that we which we have addressed over the last year and which we are continuing to address are, firstly, trying to improve access to mainstream services and trying to improve the cultural appropriateness of those services. One of the things which we can table today is a set of minimunion movement essential standards for cross-cultural awareness training within Queensland Health, which is an attempt to improve accessibility of the services to indigenous people, and I guess Noel can talk a bit more about that later.

But in addition to focusing on accessibility of existing services, we also need to

develop sustainable and comprehensive services, particularly in areas of prevention and promotion for the key target conditions. Those of course are nutrition, smoking, alcohol, immunisation, exercise and mental health programs which address the cardio-vascular disease, respiratory, diabetes and injuries targets. We also need to expand treatment services, particularly primary health care services in remote and rural settings.

We do have some success in some of these areas which we can point to, but to achieve it across the board, as Geri indicated, we need increased funding. The Commonwealth allocations and expenditure project has now finished and their results are available. They show that the amount of dollars spent on indigenous health is about 10 per cent greater than on non-indigenous people's health. Given that the cost of providing services to indigenous people is higher in rural and remote areas, that indigenous people are 300 per cent sicker and that the actual services that they use are more expensive services, this would indicate that there is simply not enough funding overall to develop those programs and to address those targets.

The work that we have been doing with the Commonwealth in the joint planning activities, with both ATSIC and the Department of Health and Family Services, has really been looking at how we can use the existing resources better; how we can avoid and reduce duplication of services; how we can move focus to achieve more allocative efficiency. But I have to say that what we can achieve in that area is fairly limited, given that the amount of duplication is not actually that great. The number of indigenous people who have a choice about whether they go to a community-controlled service or mainstream services is not that many—particularly when the lack of transport in many instances is a real impediment, as is the cultural appropriateness of the services.

The other area in which we are doing a considerable amount of work across government is with the other government agencies. For example, the government has been addressing water quality in the Torres Straits and has put considerable work into upgrading the water supply there. In the first stage of that program, seven of the islands' communities in the Torres Straits had their water supply upgraded and, in stage 2, the remaining eight will be upgraded. Stage 2 is a $14.5 million combined federal and state program.

Moving on from upgrading of the water supply systems in the Torres Straits, a series of community infrastructure planning projects have been undertaken. Of the first four, two communities in the Torres Strait—Hammond Island and Boigu—and two on the mainland—Woorabinda and Kowanyama—have been identified for planning and infrastructure development. Of course, the extension of that program to other communities will depend on further funding becoming available.

The other two areas I just wanted to touch on briefly were work force development and information systems. Geri has spoken about the need for improved information systems. In terms of work force development, again, there are a number of initiatives which are being undertaken and the Commonwealth has been providing considerable

leadership in that area. But in order to develop a sustained program for training significant numbers of both indigenous and non-indigenous primary health care workers—which is what we require to really expand a comprehensive range of services throughout all the settings in Queensland—we really need a number of good practice programs where we can actually demonstrate to the people we are trying to train how to run a program and what programs work comprehensively in a number of different settings. Dr Ring might want to talk a little further about that later.

In conclusion, I would say that we have moved quite a long way in terms of pilot programs, in terms of making progress, in terms of looking at what might work in certain settings and in terms of identifying what the minimum essential services are that we need to put in place to address the targets. We need to move a lot further to actually have comprehensive and sustainable programs on the ground and that is our real challenge at the moment.

CHAIR—This is good information, but members would like to ask questions. We do particularly want to hear from Dr Hayman. Is it the intention for everybody to make a contribution before we get to questions?

Ms Taylor—That was our intention, but we are in the hands of the committee. I certainly would like Dr Hayman and Laurel to talk about particular projects they have been involved with, and also Debra Blumel to talk about some of the projects that we have. We could not get Philip Mills down from the Torres Strait, but we have done some substantial work.

CHAIR—We are going up to the Torres Strait. It might be worthwhile to lead us in the right direction as to what we should be looking at there. I ask you to be as brief as you need to be, but not that brief, because I know members will have questions and they will chastise me later if they do not get an opportunity to ask them. Dr Hayman, we are very interested in the submission that we have read on your work. It is very encouraging—some tremendous results have been recorded there. We want to know how you achieved that, because you could have some clues for the rest of the nation.

Dr Hayman—As an Aboriginal doctor, I see first-hand the problems Aboriginal people have in accessing mainstream health services. I am in a unique position where I actually work for the government and I also work for community control. We tie in there very well because when I first came to my district, community was there and government was there and there was no interaction. That has changed around in the last couple of years that I have been working there.

Regarding improving access to mainstream health services, when I went to Inala, only a dozen Aboriginal people used a great big mainstream health service—the government community health run service. It was easy. I ran focus groups and asked Aboriginal people why they did not go there and, if we changed things, what would make them go there. I put a proposal in and got money to put in an intervention, as you see in

that document. As I said, it was quite simple, you just go and talk to people. It had to do with community consultation. It worked so well because the community wanted it. It was not what I wanted; it was what the community wanted.

There were things that they identified—for example, that there was no black face in the centre. So I put in a submission to get funding for an indigenous nurse. I first started in that district by myself, doing everything for indigenous people by myself. Then I got funding to have a nurse, so there was myself and a nurse. In the first year of intervention we went from a dozen people using that centre to nearly 900 consultations, in the second year we had 1,600, and this year we will have about 2,400. Another good thing is that I work in what they call university general practice—there are university doctors there. I forgot to tell you that I work for a day for the university too. I am involved in teaching in the new graduate medical course in indigenous health issues.

Mr ALLAN MORRIS—You are training?

Dr Hayman—Yes, for the new GMC graduate medical course.

Mr ALLAN MORRIS—Who trained you?

Dr Hayman—I went through the University of Queensland. I was one of the first Aboriginal people to do medicine in Queensland, so this is my seventh year out. I am also involved with the university in teaching, not only in the GMC but in the faculty in a bachelor of applied science in indigenous primary health care—I lecture indigenous students in diabetes or whatever. So I am involved a lot in teaching too. We use that centre to bring Aboriginal students in to see first-hand. and also it is good for them to have contact with Aboriginal people too.

Getting back to the centre itself, as I said, different points came out with my focus groups. I not only asked about the bad things, but I asked the people who did go there why they went there so I got a good idea of how people thought about the centre. From that, I put an intervention in and, as you see, the results are quite outstanding in such a short time. I do only two days a week there, and the good that is happening is that if I am not there people will see other doctors now. To me it is very important that they are using other services if I am not there.

One of the other things was that there was no black face there and also, when they came in, it was sterile, bland and there was nothing they identified with. So I have a couple of patients who are very good artists, so I got them to do some artwork that we put in the centre. So they feel a bit of ownership that so-and-so has paintings up there. That has helped a lot too, and people come in and compliment us about the art and so forth.

The other thing which Claire talked about was cultural awareness. It came out very strongly that staff there did not know much about culture, so I did some talks. We have done one each year about culture, and that has gone down very well with staff, too. They

said they have learnt a lot from the talks that we gave. So we have addressed those issues.

Also, I tried to get some collaboration with the community control to see if they would do a clinic in the centre. That did not work because of certain problems, but not to worry. We have addressed all these issues that they brought up. As I said, that is why it has worked so well: it was their ideas.

With the linkage of community control I actually do a day Yulu-burri-ba, which is over Stradbroke Island. I go over on Wednesday and do a clinic, but it has been really good now that the HIC has allowed us to bulk-bill. Even though I am a government medical officer, we have been bulk-billing up at the Cape now and putting more doctors back in remote communities, with the flying doctors and so forth. But because Stradbroke is isolated, they are allowing me to do that. With the money I am generating, we are actually going to get specialists over there now, where before they had no contact with physicians and consultants. So we are going to use that money to bring a specialist over to the island, probably once a month and probably a general physician to start off with.

We are also tying in other good things. Smoking to me is a big problem but we do very little about it. I was able to get $15,000 out of my district to send two health workers to a cessation program in Melbourne. They are both from community control and they will actually do cessation workshops for Aboriginal people to quit smoking. But we do not have anything ongoing.

I would like to have money to have labour there. I have got heaps of good ideas, but I can never get money to do it because the dollar is short. But if I had access to money, I am sure I could do a lot of good things in indigenous health. Because that program got so busy out at Inala—there was only a nurse and me—we needed extra help and we could not get any because there was no funding. Now have some money for health work and now we have a nutritionist, too. I have done baseline data to see how well the nutritionist goes. She will be there a year coming up this June, and I am going to analyse all the data about how well the nutritionist has done and aspects about diabetes. We did a quick survey audit of diabetic charts, and we have done very well with controlling Aboriginal diabetics too. We have measured their control when we first meet them, and we have measure it down the track at three, six and 12 months. We have found that we have improved their control dramatically in that time.

As I said, there is a lot of good things I would like to do but it is always the money that is the problem—just like Geri was saying. I can see that if we had more funding we could do things. I was over in North America looking at an Indian health service that has a specific diabetes program. Reports back on that are that it is doing very well, and I would like to see similar things done. I am trying to get a pilot done in Brisbane using the ideas of this program to see if that will improve diabetic control because, as you know, the deaths from diabetes in indigenous people are skyrocketing.

Ms ELLIS—Where is Inala?

Dr Hayman—Just outside Brisbane.

Ms ELLIS—So it is a suburban area.

Dr Hayman—Yes. Because I was able to bulk-bill at Stradbroke Island, as it is community controlled it was thought that I might be able to do it at Inala, but I am not able to do that yet. But I see that as a good way of generating funds—I can actually use it to employ staff, health workers and so forth—but I believe there is no direction yet as to whether that is allowable. It is a government community health centre. All the people I see are Aboriginal and it would benefit them greatly. A lot of people we see do not even have Medicare cards, and this is in Brisbane. My nursing staff are trying to organise Medicare cards as part of their duties. We have very little access to administration people to help us, and there would be good need for that too.

CHAIR—The indicators you have on access show dramatic—thousands of per cent—increase in attendance.

Dr Hayman—Yes. These are consultations.

CHAIR—There is a step down the track when you will get health outcomes. It is not possible to measure that yet, is it?

Dr Hayman—I am actually measuring that now with this diabetic control because we audit our charts. In my next yearly report I hope to have some health outcomes there that will show dramatic improvement in diabetic control. A health outcome can be that you make sure that all your patients have flu vaccines and pneumococcal vaccines and those types of things. We can show that we have different types of outcomes, but because of the size of the population it is very hard to get mortality and morbidity data. The things we look at are things like controlling diabetes and so forth but, antidotally, we do not have as many patients going to hospital.

We surveyed our program with our clients, and one of the reasons why they came was because I was Aboriginal, so there is bigger thing there about trying to encourage Aboriginal people to do medicine and stay in indigenous health. You will find that a lot more Aboriginal people will actually go to the doctor then—and one of their comments was that I was Aboriginal, I understand them and I know their ways.

Ms Taylor—We would like to table another example of where Queensland Health staff are making some improvements in diabetes at Cherbourg. With some funding from Queensland Health and some work by local indigenous clinical people, we can make some short-term gains. The point I would like to reiterate is that this will take long-term funding above and beyond the way that normal governments allocate funding.

I would like to now call on Laurel McCarthy, who was previously director of nursing at Yarrabah hospital and has now taken on an expanded role. Laurel can talk

informally—she only came back from the country yesterday so she has not prepared anything—about her antenatal project and anything else that she might want to talk about where she has made some gains, but the antenatal project and the birth weight babies is an excellent one.

Ms McCarthy—As Geri said, I am based permanently in Yarrabah as the director of nursing, and I am only in the current position as coordinator for 12 months on secondment. When I first went to Yarrabah, we were having 70 to 90 births a year, with a population which the census says is less than 2,000. However, we have a done a house to house survey with the council and there are some 2,500 people in Yarrabah. With a floating population, that fluctuates between 50 and 100 at any time of the year.

We were having 70 to 90 births a year, which is one of the largest birth numbers in the deed of grant and trust communities in Far North Queensland, north of Cairns. An antenatal clinic was established, but there were probably about seven ladies attending antenatal care. Birth weights were 1,500 grams, sometimes lower. Outcomes were premature delivery. As Noel said, it was just a simple matter of communicating with the community as to why they were not accessing the hospital antenatal clinic. The attitude was that ladies were not sick, so we moved the antenatal clinic down to the community health centre in town.

I ran the antenatal clinic for the first couple of years and trained up an enrolled nurse and a couple of health workers as antenatal assistants. Today, before I left, we had a 98 per cent attendance rate. Birth weights have gone up quite considerably. The majority of pregnancies are full term, although there is some doubt about that. There is some speculation that Aboriginal women do not go 40 weeks to term. Some obstetricians are saying that the term for Aboriginal women may well be 38 weeks, but the babies are of good height.

I give out all antenatal drugs freely so that they do not have to pay for it. Although anaemia is still an issue, it is certainly a lot better than what it was seven years ago. There are a number of drugs that I grouped together because people were not accessing medications. They would go and see a doctor and get a prescription but were not getting the prescriptions, paying for them. The majority of people in Yarrabah work on the community development employment program. It is like basically working for the dole. So I grouped everybody together on a concession rate, and I grouped a few medications such as those for family planning, sexually transmitted diseases and mental health because we had a high suicide rate over there. There were the antenatal drugs as well.

Rheumatic fever is quite high in Yarrabah still. Cardiac surgery is still a problem in the early twenties. There are parasitic infestations and skin lesions and other things like that. I just give those drugs out freely. We had quite a big problem with scabies and, although we have nearly 2,000 people over there, we have only 200 households because the council gets funding for only three houses a year. So we will always have an overcrowding problem, I suppose. The women took advantage of the free medications.

They took control of it and came up and treated the whole family. I encouraged the council to get the water tested on a regular basis, and we now have pretty clean water overall, even though it is bore water. So skin lesions are a lot better than what they were seven years ago.

There has not been a successful suicide for the last 18 moments because the community took control of that. Pretty much the elders said, 'This is what we are going to do,' so we did what the elders did. We had a focus of group of about 25 people, whose names were given to me at the hospital. They were available 24 hours a day. If they did not have a phone, the police went and got them. They took the person at risk and either stayed with them at the hospital or took them out in the community to calm them down. That program has worked quite well because it is run by the community.

I have just come back from a focus group up in the Atherton Tablelands, which is part of my current role. My current role extends from Kennedy, which is just north of Cardwell, up to Croydon in the gulf. I am based at Cairns. So, geographically, it is a big area. No-one in the tablelands in the Aboriginal groups or urban rural towns has had any consultations with anyone for quite some time. Their major problem is transport. They have not been included in consultations with the MBS. They are most upset about that.

One of the difficulties with making lots of improvements with Aboriginal health is the cost of food in Aboriginal communities. In the Cairns district alone, there are three deed of grant in trust communities and the cost of food in deed of grant in trust communities is three times higher—or sometimes 50 per cent higher—than it is in Brisbane. Yet the basic income is unemployment benefits and more than 20 per cent of your income is spent on food.

The basic infrastructure really needs to be addressed in the Cape communities. In all the Aboriginal communities, there are not enough houses. The water supply is being addressed, but there are not enough health workers. I believe that one of the first steps to improving Aboriginal health is training local people in the communities, but there are not enough to address the problem because there are a lot of other underlying social issues that really need addressing.

CHAIR—How many of the health workers that you have worked with are Aboriginal?

Ms McCarthy—In Yarrabah we have only three.

CHAIR—How many would there be across Queensland?

Ms McCarthy—There are 520-something.

Ms Taylor—We have just done an audit of the Aboriginal health workers. They are unevenly distributed, but there are a new national curriculum and national standard

which set out competencies. Certainly, it is the intent to try to upgrade the skills of our Aboriginal health workers. As Laurel said, they are front-line people and work with the communities. Where possible, we are funding and seeking to increase the number of Aboriginal health workers in small communities.

CHAIR—Do you define a health worker as everyone from the basic paramedic right through to a fully qualified professional nurse? Are the 500 all in that range?

Ms Taylor—No, we do not include registered nurses or enrolled nurses. Laurel can talk about it more, but Aboriginal health workers have tended to have a variety of backgrounds and, to some extent, have not been skilled and trained to the level that they could act as primary care workers in their community, with some noble exceptions. Laurel will talk about some of the outstanding ones that we have. We have enrolled nurses, registered nurses and medical practitioners working also as part of the Queensland health contingent.

Dr Ring—I want to table this report on the health status of our Aboriginal population. It talks about differences in health status within the Queensland Aboriginal and Torres Strait Islander population and contains comparisons with Queensland, the other states and other countries.

Part of the role of an epidemiologist is to look at the world literature and try to find reasons for the unique failure in Australia to make headway with this difficult issue. The literature points to three factors. Firstly, a fellow called Kunitz draws attention to the unique complexities of our federal system in trying to harness a national effort. I think there are issues there and I will return to that.

The second issue relates to the control that you have over your own life and the importance that that has on health. To give you an example, in the British civil service it is fascinating to note that doctors and lawyers immediately below the permanent head level have mortality rates for heart disease and other things twice that of the permanent head. So it is not due to differences in money. It is a fascinating concept for those in the bureaucracy to wrestle with. It gets worse the further down you go.

The issues of control are still with us but, in the life history of almost all Aboriginal people, there is experience of lack of control over major life decisions which, the evidence suggests, still exert a very significant effect on the health of Aboriginal people.

The third issue is, in the absence of a treaty, how to define the place of Aboriginal people in Australian society where, in every interest clash, the other interests are, of necessity, more numerous, more powerful and more important. These are all issues which, in intangible ways, the literature would suggest are having an effect on the health of Aboriginal people.

In terms of the Commonwealth-state issues—and Geri alluded to this question—Commonwealth expenditure allocations between the states appear to be on an historical rather than a per capita basis. I think there are some issues involved in that. In terms of the main streams of Commonwealth funding, there are three particular areas of funding that are worthwhile looking at—MBS, PBS and aged care. In each of these there are substantial reasons for believing that the people who need these things most, who have the worst health, the greatest need, receive a lot less than equity in per capita terms let alone need terms. How to use our funding schemes to advantage to break the cycle rather than perpetuate it is an issue which underlines a lot of the factors that most of the members here have described: it is simply the question of how to get enough money to do those things which are necessary and doable. In terms of any kind of health service delivery, you have to have an infrastructure to deliver the service and a trained work force to do it. We are, I think, still a long way from satisfactorily wrestling with those issues at a national level.

CHAIR—Everybody says that it needs more money. My personal view is that money is not the problem; the problem is putting the money into right programs, and it is a matter of identifying them.

Dr Ring—I think there are some issues about that. I think the Deeble report, when it becomes public, will help a great deal in understanding that issue.

CHAIR—Which one is that?

Dr Ring—The Deeble report. I do not know whether that is the correct title, but it is a report done by the National Centre for Epidemiology and Population Health at the ANU. What that says—and Claire alluded to this—is that spending on Aboriginal people in Australia is about 10 per cent higher than for the population as a whole when you take all sources of the expenditure, public and private, into account. That probably overstates the difference because it does not take account—and I think you pointed this out before—of the higher costs of service delivery in remote areas, and not all the Aboriginal spending goes on Aboriginal people. Up to 30 per cent of people attending AMSs in some parts of the country are non-Aboriginal. Extra spending on Aboriginal people is somewhere between nought and 10 per cent. That would be fine if Aboriginal people were only 10 per cent sicker, but they are, in fact, three times as sick.

The money is simply not there to treat the burden of illness that there is in the community, let alone provide those services which are necessary to break the cycle. The difference is quite substantial. I think there are real issues for us to grapple with. One of the obligations on Australia as a country is to ensure that we are doing what is necessary to provide the same level of service to Aboriginal people as we would to non-Aboriginal people who are that sick. I think there is a long way to go before we can say that we have done that.

Ms Taylor—We have already alluded to the fact that a lot of the issues are in the

primary health care area. Primary health care is predominantly MBS and PBS, and hospital service and out-patients is predominantly state jurisdiction. Quite clearly, with the lack of information and the way the funding streams are directed, we are not getting the best targeting for the needs.

CHAIR—Ms Blumel, do you want to make a comment?

Ms Blumel—I do and I will keep it very brief. Public Health Services is the section within Queensland Health which is responsible for the majority of preventive programs. What we have been talking about so far has been mainly to do with clinical services. The point that has, I think, come through is that primary health care clinical services can prevent the sorts of secondary complications to health which end up placing a lot of indigenous peoples in more expensive hospitals. But what I want to talk about is a little bit different again, that is, the scope within Queensland Health for population based preventive programs.

Underlying all the statistics Ian pointed to, we know that there are a lot of sensible things we can do about the environmental factors and the personal behaviours such as smoking, nutrition, injuries and so on which are preventable with very little to do with primary health care services. They are preventable through what we call public health strategies. Public health services are a very small part of Queensland Health, which is mainly focused on treating sick people or early intervention in illness. With about three per cent of the budget, we have a pretty big task.

What I have done is a quick stocktake, and I will table this for you, of the specific projects that public health services are running which are dedicated to improving Aboriginal health. The report also makes the point that a lot of our mainstream population based programs as a matter of course target Aboriginal people because of the huge additional problems. For example, someone said that food out west is 300 per cent dearer than food in Brisbane. *A report on the food supply to the indigenous people of Cape York health district* really talks about the problems with supplying fresh, nutritious, affordable food in far-flung places. It points to huge disparities in cost. You will obviously talk to those people in a lot more detail when you go up there.

Meriba Zageth for diabetes—our work for diabetes was a joint initiative of the Torres Strait council working with other organisations, one of which is Queensland Health, which is our plan for diabetes. The main strategies in all of those are about preventing disease and promoting wellness in communities on the basis of the environmental and behavioural things that can be done to diminish those sorts of risk factors.

CHAIR—They are longer term investments but at the same time there is still an acute need by people who are not being collected in that net.

Ms Blumel—There is a popular misconception that public health is all about long term. Certainly when it relates to a long history of poor food through childhood, exposure

to cigarette smoking and so on, those sorts of things are chronic and they do have health implications further down the track. But there are also a lot of things we can do that can have immediate health effects this year. With pneumovax and fluvax, we get an immediate diminishing of people who may die or need hospital admissions this year. With injuries, it is very similar. With sexual health, it is not a 20-year problem; it is short term.

With injury, the sorts of things that often underlie injury are to do with not adopting a harm minimisation approach with alcohol abuse. Young indigenous men plus alcohol can often be very disruptive to communities and can lead to family violence. There are child protection issues in there as well. Those are the sorts of things that are very immediate. It is not just a long-term health issue to do with getting cancer at 60.

Ms ELLIS—Dr Hayman, are you aware of the numbers of indigenous people in medical training at the moment, say, in Queensland?

Dr Hayman—Australia wide there is probably about 28 that have graduated. Throughout Australia at the moment, I think you would pull up around about 70.

Mr ALLAN MORRIS—But 50 in medical faculties?

Dr Hayman—Yes, but with this new incoming intake I think it has gone up a little. It was last year that it was 50, but there is a new intake this year.

Ms ELLIS—For the sake of the record, what is the indigenous population in Queensland? Do you have a break-up between Brisbane and the rest, remote as against urban?

Dr Runciman—There are about 30 per cent in urban, 25 per cent on the deed of grant in trust communities in remote and rural areas, and the remainder are in provincial and rural settings.

Ms ELLIS—What is the overall figure?

Dr Runciman—I believe the overall figure is about 90,000 but, as you know, there is always dispute around that.

Ms ELLIS—I understand that.

Dr Runciman—And the Torres Strait is about 10 per cent of that.

Ms ELLIS—To show my ignorance, can someone please tell me what a deed of grant in trust community is. What is a deed of grant in trust community?

Dr Runciman—A deed of grant in trust community was established, I believe, under the National Party government a long time ago. They were really when the

government took over administration from the missions and—

Dr NELSON—In 1897.

Ms ELLIS—In 1897?

Dr NELSON—Yes, after the passage of the Aboriginal Protection and Restriction of the Sale of Opium Act 1987.

Dr Runciman—So they are a protector of Aboriginal people.

Ms ELLIS—So how many of them are there?

Dr Runciman—There are 15 Torres Strait Island DOGIT communities and about 13 mainland Aboriginal communities.

Ms ELLIS—I have just one more quick question, if I can play the devil's advocate for a second. I notice on page 3 of the main part of your submission that you talk about these communities and you mention the lack of adequate water supply, the lack of water quality and reticulation, the inadequacy of sewerage and waste disposal systems on these particular communities, let alone any other communities—because I gather there are plenty of other communities not in the same category—and the estimation in that part of the submission that you have put in front of us is that you need about $500 million alone in dollar terms to correct the inadequacies on those community areas. I take Ms Blumel's point very seriously about the need to get out there and do work now, but I really seriously question how we can put long-term health practices into place when we have a basic problem of water supply, water quality, sewerage and other transport infrastructure—the whole thing. Can someone give me a view as to how we are tackling that in a whole of government process in trying to get long-term health benefits in the preventative fashion before we start talking about the immediacy of other issues?

Dr Runciman—The Queensland government had a program of doing total management plans for each of the communities, which have been done. They have included Department of Main Roads, Natural Resources, Local Government and planning staff. They have constructed the sort of hard infrastructure plan for those communities and, as money has become available, there is a sort of a program of addressing the main issues. One of the longer term issues has been the issue of maintenance—that, in many cases, the initial infrastructure has been provided but the budget for maintenance does not go along with it. So some of these things have in fact been done before unfortunately—and need to be done again because the maintenance budget did not accompany the initial budget.

Ms ELLIS—Can I just ask the department of health in Queensland generally then: how important do you rate this sort of work, where we are talking about the health of our indigenous population?

Ms Taylor—Obviously, it is quite important, otherwise we would not have put it in our submission. Through the social development strategy and the CEOs committee—and they have a subcommittee on infrastructure—at bureaucratic level there is a concentration of trying to ensure that, collectively, we get resources to address that. The ticket on it is $500 million. That is a huge ask, as Claire has said. Then there is the maintenance of it in obviously very remote and rural areas and areas where it is very difficult to get any sort of ongoing services. It has been identified. We have done the plan. It is one of those things we just have to try to start tackling systematically as different communities are being identified.

Ms ELLIS—Dr Hayman, can you give us your views on how important you believe extraneous affairs are in relation to health—for instance, unemployment, lack of occupation, lack of direction within an Aboriginal community—and the impact that sort of situation has on the health and wellbeing of the community at large?

Dr Hayman—It is very important. I did a survey on Stradbroke Island and there was around 40 per cent unemployment. Most of the Queensland statistics come from DOGIT communities. We have only had identifiers on death certificates in the past two years. In that survey that I did it spelt out that people in urban communities still have significant health problems—diabetes, heart disease and so forth. Smoking, as I said, is a big problem too. When 60 per cent or more of a population is smoking you get the respiratory problems and everything goes with it. When you are unemployed what do you do? Sit around, smoke and sometimes drink.

CHAIR—Is that related to what Dr Ring was trying to say about being in control?

Dr Ring—That is right. All the things that have been pointed are all classic determinants of health. The health status report based on information from the national Aboriginal and Torres Strait Islander survey deals with those issues of unemployment and protection against the elements—housing, water supply, sanitation. These are all fundamental determinants of health and related in a sense to those sorts of control issues. There is a real challenge in terms of how to provide local government type functions when there is not a ratepayer base to support that and how to make the levels of government work for you rather than perpetuating a system which we are all too familiar with.

Dr Hayman—Education goes with it, too. To me, a lot more money should be spent on education. If you look at figures of Aboriginal people going to high school, the figures completing senior are very low. Not many actually go and do a graduate degree. We should be looking at spending a lot more money on education too. Once you have a good education you get a good job, you get good money and health falls into line. With my children I saw education as very important. Whereas sometimes for a lot of Aboriginal people it is not their important issue.

Ms Taylor—Can I reiterate that? Previously Mr Morris asked how many medical graduates. Noel, as he alluded to, went overseas last year with the Director-General. I in

my role and the manager of the Aboriginal health unit have had conversations with the federal Department of Health and Family Services. We see that we really need to be in a partnership to dramatically increase over a 10-year period the number of clinicians—doctors, nurses, dentists, allied health professionals—as well as upgrading our Aboriginal health workers to be able to achieve in communities and with different groups of indigenous communities the gains that needed to be made. Certainly in talking to Afro-American colleagues that has been one of their successes they have had in actually educating a cadre of health professionals who can take their place with non-indigenous health professionals to meet the needs of their communities. It is an overwhelming need and it is something that is long overdue in Australia.

Dr Hayman—The University of North Dakota has a very good program to get indigenous people into the medical faculty. As a matter of fact, their federal government allocates seven extra places. The year I was over there about 16 per cent of their first year students were indigenous. They have also shown that indigenous people who come from remote communities are more likely to go back and practice in remote communities.

Ms ELLIS—Can I put a footnote to that? The Borroloola 'Dying Shame' documentary that was on SBS recently showed two things that Dr Hayman and the chair have referred to. One of them was the appropriate targeting of money. The local indigenous community actually had a program of trying to deal with those who had been drinking heavily at night by going out and picking them all up but the funding had been withdrawn for that. So their own initiative was being curtailed somewhat, and that is bad targeting. The other one was—and you mentioned it before, Dr Hayman—which clinic will they walk into and which will they not? In the same documentary I think there was a clinic they would happily walk into and there was a government built beautiful, shining, pristine, white glistening building that nobody went to. It is evident that there is plenty of evidence to suggest that a lot more consultation with the communities themselves needs to take place so we understand where we are putting the money and why. You obviously agree with that.

Dr Ring—I think you have to see Australia's record in this as a national disgrace. You have seen the unique contribution that people like Laurel and Noel are able to make which I do not believe white staff can really do in the same way. We have at this stage 20 to 30 Aboriginal doctors. Our work force strategy is basically one and two-year trained health workers plus white doctors and nurses thrown into the deep end often with very little preparation.

As I say, we have 20 to 30 Aboriginal doctors. The nurses, who used to be the core of the work force, are going backwards because they find it more difficult to get into graduate programs and the old hospital based programs. We have, I understand, one dentist—I still have not found out who that is—and hardly any allied health workers. By contrast, the Australian administration was churning out doctors in PNG from the early 1950s. The oldest of those people have now died of old age. The record of the Australian government in Australia stands in stark contrast to that and the experience in Canada, US

and New Zealand.

A national training strategy is an essential part—this is not new knowledge—of the process of coming to grips with these issues and the questions of education. The World Bank has alluded to the essential importance of education in health. Our retention rates in schools are certainly not going forward but whether they are actually going backwards is a moot point. Queensland has apparently a comparatively good record, but I think that is more a testimony to the difficulties in other parts than saying there is any particular cause for satisfaction for how well we are doing on this core issue here.

CHAIR—If Queensland is doing better than others we want to find out why so we can highlight it.

Dr Ring—We are speaking from a health point of view. Recently in the Northern Territory they are grappling with issues of retention in high schools. We are concerned about the situation here. Again, it is a national issue.

CHAIR—The Northern Territory still has not signed any agreement on the matter, so they have not made much progress.

Mrs DE-ANNE KELLY—I have some questions for Dr Hayman and also Ms Taylor. Dr Hayman, congratulations on the results you are achieving; it is superb. If it is so difficult, what brought you to medicine personally?

Dr Hayman—I was an assistant quality control manager in a food factory Edgells in Manly. There was an article in the *Sunday Sun* about no Aboriginal people have done medicine at the University of Queensland. You always see in the papers how bad health of Aboriginal people was. I thought I might be able to do something. I had a past degree. With that, the dean let me in and here I am.

Mrs DE-ANNE KELLY—The point has been made that Aboriginal people rarely go into the professions. Do we need a medical school in North Queensland that has—it is a very loaded question—a different approach to enrolments and entry levels and specific places for Aboriginal students?

Dr Hayman—It would be a very good place to have one for indigenous people because that is where most of the population is. They would be more likely and more feel at home going to university up there rather than coming all the way down to Brisbane.

What was unique in America was that they actually targeted kids at the reservations at a very young age—at elementary school, which is our primary school—and they nurtured those kids and encouraged them to do science based subjects. Once they started growing up, they took them to the university and showed them a bit of university life—how to fit in and so forth. Some of them did their first years at a community college at the reservation and then, once they did that, they came to the university to do medicine.

If we had a similar program within a university, where people went out and spoke to all the kids in the communities about medicine as a career or any health profession, like Geri was saying—it could be nutrition, podiatry, physio or whatever—and if they promoted these types of careers in our DOGIT communities in particular but in any place where they had high indigenous population and if they had it affiliated with the uni, I think you would have a better chance of attracting Aboriginal people to do medicine and other para-health professions. So I think we need a specific program to go out and target those kids. It has worked very well. As I said, they got the Inmed program—Indians into medicine—and that is what they do. They have graduated at the University of North Dakota. There must have had about 100 graduates at present.

Mrs DE-ANNE KELLY—That is a very sound suggestion. Ms Taylor, you mentioned the disproportional funding into Queensland from the Commonwealth. I also note—and I congratulate your department on the fact that you care for them—that, certainly in the north, you also have 6,000 South Sea Islanders whom the Commonwealth does not recognise them as indigenous even though they have the same disadvantage. I know that because a lot of them live in our area. So you really have an extra 6,000 people over and above the 19,000. You really have 25,000 people that Queensland cares for through its health programs so you are even more disadvantaged than the figures show. Why is there such a problem with funding? Who is the difficulty? Is it the federal minister? Is it the view of the other states?

Ms Taylor—We are straying into areas that perhaps the minister or the Director-General might need to comment on. From my perspective, as part of sins in a previous life, I also am the responsible officer to the Director-General for the negotiation of the new Australian health care agreement. Certainly, for a number of historical reasons, Queensland does not seem to have got its per capita funding on hospital services, on specific purpose payments—and that includes a number of public health payments in regard to aged care. For the aged care residential care, the Queensland industry does not receive the same level of funding and certainly not for the indigenous health that I have already alluded to. So on many fronts, for a number of reasons that probably go back in time and to various decisions taken in the past, Queensland does not receive its per capita share.

You have raised the issue of South Sea Islands population, and indeed we also have Papua New Guineans. And certainly if you go to the Torres Strait you will be able to talk to Philip Mills and the regional council about that. We also have Papua New Guineans because of the land bridge coming across, and that is an extra load Queensland carries.

We have been in active negotiations with the federal Department of Health and Family Services for better funding in specific projects to acknowledge of some of the difficulties we have. As you would be aware, these things tend to be long. We have some breakthroughs in some small areas, but overall we look increasingly to times such as the Premiers Conference where, across the nation, we can argue Queensland's case for

equitable share of funding. I have probably given you a fairly bureaucratic and considered answer.

From Queensland's perspective, we are on the public record as saying we do not believe we get fair share and something needs to be done. Over the life of, for example, the previous Medicare agreement, we can actually demonstrate that the Queensland government, particularly in the last couple of years, had put in extra funds, and certainly Noel has indicated that he has got extra funds.

There is support for whole of government. The issues are there. Wherever we can we try to get some funding both in health and whole of government by working collectively. The youth suicide project is one where there is a whole of government basket being developed to promote a whole of government consideration to help reduce suicide.

Mrs DE-ANNE KELLY—If you had to rank the steps that need to be taken to improve Aboriginal, Torres Strait Islander, South Sea Islander and Papua New Guinean health in this country, how would you rank them and what needs to be done?

Ms Taylor—I am going to let Ian talk about this because he will talk about the four major health issues. There are issues of infrastructure, there are issues of funding, but there are issues around the health of indigenous people.

Dr Ring—That is right. You can talk about this in two different senses and there are three fundamentals. Firstly, we have to get the infrastructure right—that is, housing, water, sanitation, land, education and so forth. Secondly, there has to be an infrastructure which allows the effective delivery of health services that are targeted at the main issues. Thirdly, there has to be a trained work force. No-one is saying this is easy, but there is no difficulty about saying, 'What are the things that need to be done?' because there is a world of experience literally all around the Asia-Pacific region, let alone indigenous populations in similar countries. They are the three fundamentals.

In terms of the specific health issues, four issues account for around 60 to 70 per cent of the extra deaths—that is, cardiovascular, respiratory, injury and diabetes. That is true pretty well all around the Australian indigenous population. The implication of that is that Aboriginal people will go on having high death rates until there is an effective approach to those issues. It means that they are priority issues. You do not need to ask yourself, 'Are these big issues in any community?' They are big issues in all Aboriginal communities and, for that matter, the population as a whole—and, for that matter, the world as a whole. We need to be good at tackling these issues. There is reasonable experience from the indigenous populations of North America and New Zealand that you can achieve very sizeable improvements in cardiovascular, respiratory and injury. That has happened in Canada, the US and New Zealand. Diabetes has proved somewhat more intractable, but those other three are quite doable propositions.

CHAIR—We did not get a score.

Dr Ring—I do not think there is a one, two, three. I do not think you can disentangle these things more than that.

Ms Taylor—Quite obviously this is the line of inquiry that you are taking. We have alluded to the issue of the separation of funding, and I have alluded to the short-term nature of funding. Certainly in regard to mental health, for example, Queensland Health is committed to a 10-year mental health plan which we hope will have bipartisan support for a long time. With respect, I think that ongoing funding and an ongoing plan which overlies successive governments and successive funding cycles is absolutely critical, otherwise we will continue to have situations where, say, there is a clean water supply somewhere and, because there is no maintenance, it goes out. Three-year and four-year funding cycles are not enough to address this incredible challenge that we have.

Mrs DE-ANNE KELLY—What number of Papua New Guineans does Queensland care for?

Mr Taylor—That is a moving number because there is a land bridge. People come, they stay for a short period of time and then they go back. Probably, in the Torres Strait you will be able to get a much closer idea of the numbers coming in. We cannot actually put a number on them on the basis that we do not have any idea—we cannot track people. People present at our hospitals, at our post areas, at our community health services and they do not have a Medicare number so we do not know whether they are different people presenting or the same person presenting.

Mrs DE-ANNE KELLY—Is it in the hundreds or the thousands?

Ms Taylor—We believe it is in the hundreds. We have actually tracked through—particularly in Cairns and the Torres Straits, some of our posted areas—that there is a cost impost in our hospice services between $2 million and $5 million annually recurrent. That also includes humanitarian evacuations that Queensland funds from Papua New Guinea into our hospitals. It has been an ongoing discussion.

Dr Hayman—I have actually worked up in the Straits. Some people come over to Saibai Island. When they have outbreaks of dysentery, they will come over to us because they get treated better by Queensland Health than if they go up to their villages and so forth. So a lot come over when they get outbreaks of certain diseases.

Ms Taylor—We do a lot of vaccination up in the Torres Strait to try to have a barrier.

Mr ALLAN MORRIS—Ms Taylor, I understand you have been made aware of a submission by a young student called Neil Willmett. I should point out for those who are not aware that Neil left school at 15. He first came to me in September last year, and he was incredibly stressed out. He eventually failed last year. I think he spent more time writing submissions to ministers than he probably did doing his medical degree. I have

effectively, I suppose, three questions to ask of you.

Firstly, why did you decline to accept his offer to serve a year in lieu of the year he had actually received a scholarship for? Why are you asking him to pay $100 a month out of his current Abstudy payments, which means he will fail and leave? That will guarantee it. Secondly, what is the real problem with the Commonwealth and the states negotiating a sensible arrangement to integrate their support systems? In Western Australia, we spoke to their department, who were talking about a similar scheme which will have a similar effect of denying Abstudy if, in fact, it goes ahead. Thirdly, there seems to be a lack of adequate effort in those areas where you are offering scholarships and training to actually integrate those back with remote and rural and regional communities as part of either the informal health system or the formal health system, not just for medical students. I do not see any clear signs.

So there are three questions. Why was that offer of Neil's—which, by the way, was made at my suggestion—to serve that one year because he was forced to relinquish the scholarship because of Abstudy? We will be talking to him at some stage during this inquiry. I hope we recommend to the federal government, when we eventually report, some way of modifying Abstudy to allow it. Why have you turned down that offer and are actually requiring a monthly payment, which is guaranteed to destroy him? Why can't we negotiate between ourselves and the federal minister for health and the minister for education a sensible system, where you can actually put them together?

CHAIR—That is three questions.

Mr ALLAN MORRIS—I am making it very clear. It is a complicated issue. Thirdly, there should be a program to actually integrate training programs and practical work between semesters, between years to try to ensure that the connections are maintained with remote and rural areas, where they come from in many cases.

CHAIR—Do you need to take that on notice?

Ms Taylor—I was made aware of it yesterday afternoon, Mr Forrest. If you want me to devote time to this, I will and I will do it very quickly. First, Queensland Health offers a large number of scholarships for the people in remote and rural areas in a genuine effort to try to get people back there.

Second, having been made aware of this matter, which has been ongoing for some time, I would ask you to suggest that Mr Willmett actually keeps his lines of communication with Queensland Health. Certainly there is some precedent and there are some issues that we would want to have, that people who do receive some scholarship moneys from Queensland Health actually fulfil their commitment. However I would say that, wherever possible—and I have had personal experience—we try to have a meeting of what are the best needs of an individual and what are the best needs of Queensland Health and the arrangements we have entered into.

Third, I would welcome an end to this impasse of how Abstudy and scholarships at both the state and the federal level are arranged. I have already stated the importance of trying to increase dramatically the numbers of health clinicians who are available to work in Queensland, and anything that this committee could do to overcome this impasse would be welcome.

Mr ALLAN MORRIS—Can you tell us what the obstacle is and why the Commonwealth does not accept? The Commonwealth says that they are a scholarship, therefore they are of equal value, whereas yours is actually an indentured system that requires a person to work wherever you specify for however many years you specify, which is not a scholarship in the normal sense of the word. I want to know what is the obstacle in negotiating an outcome between yourselves and the Commonwealth. Can you tell us what is the sticking point with the Commonwealth? What is happening is that each person you give a scholarship to loses Abstudy automatically, despite the fact that Neil Willmett was told that he would not. The tragedy in this case is that he was told the opposite; he acted on that advice and then discovered that a mistake had been made.

CHAIR—I think, in fairness to the department, that this is a Commonwealth problem more than a state problem.

Mr ALLAN MORRIS—It starts off that way. One would have expected that the state departments would know what disqualifies people from Abstudy and what does not. So it is clearly a lack of a relationship between the Commonwealth and the state departments.

Ms Taylor—I would like to take that particular perspective on notice, Mr Morris, and provide it to you.

CHAIR—It is relevant to what this committee is trying to get at. There is an impediment.

Ms Taylor—Yes, it certainly is. So I would prefer to take it from the individual to the strategic as to how we could actually overcome this. I would say that, sometimes, departments write fairly bureaucratic type letters which, obviously, was of concern to Mr Willmett in particular, but I would certainly ask that he keep open his lines of communication.

Mr ALLAN MORRIS—Could I just read to you part of a letter from Judith Robson?

Ms Taylor—I have read the letter.

Mr ALLAN MORRIS—He was told, 'If payment in full is not received by 31 March, we will take action at $119 a month.' This is for money he was told he could get legally.

Ms Taylor—Not by Queensland Health, I might add.

Mr ALLAN MORRIS—No; by Abstudy. We will be talking to Neil; we will be talking to other medical students. I think they have all been saying there is a need to integrate the systems and a need to get better education. You have tried to, and I applaud your scheme. I am very supportive of it. After today, can you perhaps drop us a note and tell us what the sticking points are so that we can try to move on?

Ms Taylor—We would be very pleased to do that.

CHAIR—That is a good way to do it.

Mr ALLAN MORRIS—I am raising this young man's case now, normally I would not have raised it in this way, because he has only until 31 March. He came to me absolutely out of his brain. If you persist with that, he will just leave.

Ms Taylor—I ask you to ask him to contact Judith Robson, who has provided me with the information. We will try to ensure that there is due process both with regard to Queensland Health and with regard to Mr Willmett's needs being met.

CHAIR—That is for his personal benefit. But, in the broad sense, we would like to make this a case study. Here is an example of messing it right up and not achieving anything.

Ms Taylor—Yes, Mr Forrest, we will provide you with that information.

Mr ALLAN MORRIS—Would you give us some advice as to how it could work? If it is good advice, we will recommend it to the parliament.

Ms Taylor—We would certainly be delighted to do that.

Dr NELSON—I would like to ask Ms Blumel a question and then Dr Ring. First of all, will you table those reports on nutrition for us?

Ms Blumel—Yes.

Dr NELSON—Thank you. A number of Aboriginal communities throughout the country have taken control of the alcohol and petrol sniffing problems by restricting their availability, amongst other things. Have there been any communities that have actually made moves to restrict the availability of low-quality, high-fat essentially fast food in their communities in an attempt to improve the sort of food that is being consumed?

Ms Blumel—Yes. There have been some attempts in more recent times. This year we have had funding through the state government to put in place three public health nutritionists. We have allocated one to each of the public health networks.

We have three networks throughout the state and their role is to pick up on earlier analysis which has showed that, for food that lacks acceptable nutritional quality which is available, for example, through community stores or through the market, food policy needs to be developed to ensure that that food is improved. So there are a range of initiatives happening in the actual programs. We now have funding for public nutritionists to take the community development role in store policy and in education in communities to promote the need to eat better. That is often accompanied by programs like Gutbusters where, to run a program like that targeting overweight men, there is not much point doing that if they then cannot go to their local store and buy the sort of food that they need to sustain their weight improvements.

Dr NELSON—Are there specific examples of communities that have restricted if not banned the sale of certain food products in an attempt to improve the nutrition of their members?

Ms Blumel—I am not sure that a heavy regulatory approach would be anything we would support in this day and age, but influencing store policy or educating people to increase demand for other types of food would be the sorts of enabling tools we would use with indigenous communities.

Dr NELSON—Are there any communities which have said at this stage, 'We don't wish to have certain things sold'?

Ms Blumel—Not that I am aware of. If there is anything you want me to find out, I certainly could.

Ms McCarthy—Only in the schools. Through tuckshop, the parents have some control over the way food is prepared for the children, but in communities, no.

Dr NELSON—You have obviously identified the costs of healthy food and where the composite costs lie. Could some thought be given to the Commonwealth and state together providing a kind of subsidy to communities who wish to voluntarily undertake the restriction of certain food products in order to improve the availability and affordability of healthier things, for example, if they were to say, 'We will not sell this range of products in our store,' and in return there is a Commonwealth-state program that will provide a subsidy to make vegetables and nutritious food affordable? Is that something that has been considered by any communities?

Ms Blumel—I might make a couple of points. One of the things that has come out of our discussion has been that with the socioeconomic patterning of poor health, we know that one thing that helps to improve health is when people have a sense of control over their own community developments. So any approach would need to be facilitative and enabling, rather than 'If you do this, we'll do that,' with the outcomes bargained right up front. In terms of a general approach, yes, you could achieve those sorts of outcomes but I would not go in hard with that sort of strategy.

The second point is that the national priorities for health to do with cardiovascular disease, cancer and diabetes are all very much going to depend upon what the Commonwealth and the states can do together in terms of food and physical exercise. In food, it is from the paddock to the plate. It is the availability, it is whether it is nutritious and clean—not going to make people sick—and how it is prepared. People need to have fridges to keep their food in. Stores have to put the nutritious food up front and they have to gradually phase out availability of food that is bad for you. I would very much welcome a joint Commonwealth-state arrangement to get some decent solid outcomes about getting affordable food to remote areas.

Dr NELSON—Has the department given any thought to the impact of a broad based consumption tax on food pricing for Aboriginal communities and how you might deal with that?

Ms Blumel—I am not sure that our department offers advice on taxation policy.

Dr NELSON—Clearly there is a national debate about taxation reform. I would have thought that in communities that are paying a 20 per cent premium on food it might be prudent to make a submission to the Commonwealth in relation to that.

Ms McCarthy—The heads of the councils of the 15 deed of grant in trust communities in Queensland are called the Aboriginal coordinating council. They currently have submissions to the Commonwealth—they have probably put a view to the state also—to support a program whereby they want to employ local people in the individual communities to establish market gardens given the accessibility, choice and price of fruit and vegetables. I would ask the Commonwealth to look very favourably to support that initiative in every Aboriginal community in Queensland, the DOGIT ones. Do not leave out Yarrabah because Yarrabah is geographically disadvantaged. Yarrabah always misses out.

Dr NELSON—Dr Ring, I think it was in 1996 I read some work that you had published. As I recall, you said that there had been no improvement in any significant indicator for Aboriginal and Torres Strait Islander health since 1983. Is that the case? Do you feel that what we are doing at the moment is likely to provide any improvement over the next decade?

Dr Ring—The one area where Australia had made gains was an enormous reduction in infant mortality largely in the 1970s. That did continue on a little bit into the 1980s, but the rate of decline flattened considerably. The characteristic feature of indigenous health in Australia has been these enormously high adult mortality rates particularly in middle age. They have proved to be remarkably intractable.

The latest information we have shows a decline but it is non-significant at this stage. It may go on and be big enough to start to become significant, but at this stage there is no significant decline, and we are about to put together a new report on this. But

the general picture is one of continuing lack of improvement, but perhaps there may be some early non-significant signs at this stage. If it were to be continued, it may well become significant. By contrast with the enormous rapid gains made in the health of indigenous populations in comparable countries, we really have not done that yet.

Dr NELSON—There are people who say that, if we continue to provide more of the same, as worthy as it is, we will not achieve any gains and that in fact we need quite a radical approach.

Dr Ring—There are two aspects to this. As I read the Commonwealth line, they are saying that holding the line against budget cuts is a good result. That really has to be looked at. No-one can take any real credit for this national Australian issue, but I think in Queensland there has been a genuine attempt to inject genuine new money into the system. My feeling is that there are two parts to the issue. Australia now has for the first time a belated but nonetheless real national commitment to bring about measurable improvement in indigenous health. That is a first. I do not think we really have thought through what that actually means and what the things are that we would have to do to make that happen, but commitment is a first step.

I think there are two issues. Firstly, I think the present scale of activity is unlikely to make much of a difference. Certainly you can point to good things around the place, but we will only get a change with a much more systematic and comprehensive approach. Secondly, would pouring money into the same approach really do it? I have certainly indicated that I think resources are a significant issue. On the other hand, if you are the one country in the world that has gone nowhere over two decades, more of the same is unlikely to do it. I do think we need to look at new approaches.

The problem, in part, is that the service delivery patterns are determined by funding mechanisms rather than saying, 'This is the kind of service that we would like to see and these are appropriate funding mechanisms.' You can get money for a hearing thing under this and that by program, but the biggest single cause of excess deaths in Aboriginal women in Australia is diabetes. If you try to find a bucket of money to do something sensible about that, you sort of hawk your quest from donor to donor, from state government to Commonwealth government, to NGOs, and so forth. But the plain fact of the matter is that there are no identified sizeable continuing funding sources to tackle any of the big four issues that I mentioned. Having funding systems which allow the main issues to be funded and tackled is one of the things that we have to do.

I think that the scale of things is not right at the moment. There are many good things happening, but I do not think a continuation of the status quo is going to do it. We need to have a fundamental rethink about the way we do business and make a much more systematic attempt to learn the lessons that have been used so successfully in pretty well any other setting apart from Australia.

Mrs WEST—Further to those four areas, I have got cardiovascular, injury and

diabetes. Is drug and substance—

Dr Ring—Respiratory.

Mrs WEST—You have not mentioned drug and substance abuse. Could you tell us what the incidence is of drug and substance abuse in Aboriginal communities? Is it significant as a factor in mortality?

Dr Ring—I certainly would not want to say that those four issues are by any means the sole events. What I am sort of saying is that those four collectively account for about two-thirds of the total excess. There are many other issues of importance, and pretty well any issue that you care to name is much worse in Aboriginal people. Issues of mental health are extremely important, issues of infectious and parasitic diseases, and so forth. There is a whole range of other issues.

In relation to alcohol and drug taking, the general information is that the proportion of Aboriginal people who drink is somewhat less than it is for the population as a whole, but those who do drink have quite different consumption patterns characterised by binge drinking, and so forth. Smoking rates tend to be about twice as high. As far as the knowledge of the importance of smoking in relation to health is concerned—the WHO has been talking about this for decades—it is the single most important preventable issue in mortality around the world. It certainly is a much bigger issue for Aboriginal people than it is for the population as a whole, and certainly it is a big issue for the general population. It is hard to point to programs which are commensurate with the importance.

Everyone knows, blind Freddy knows, that alcohol is a big problem. But what you tend to find is that people say, 'Alcohol's a problem. I'll appoint another Aboriginal health worker and call them an Aboriginal alcohol health worker, and we'll kid ourselves that we have done something.' If issues are important we need to make a sensible investment which is in some way geared to the size of the problem and evidence about what works and what does not work. We have not really done this in key basic issues. All that lies in front of us—incredible as it may seem.

Mrs WEST—I am familiar with some of the Queensland health institutions that assist in drug and alcohol assessment and rehabilitation. But are they assessed using achievable outcomes and significant results for improving their standard of care? Is it worthwhile considering changing the philosophy of what currently exists.

Dr Ring—Absolutely.

Mrs WEST—I am aware of certain initiatives that cannot get a look-in because of current funding. The excuse is always, 'Well, who do you drop off a funding round?' If you take money out of one group to give it to another group that has a different attitude—for example, harm minimisation as opposed to abstinence—who loses out? Are these some of the things you are grappling with in assessing the outcomes of your programs?

Dr Ring—You tend to have people with ideas and no money, and sometimes you have people with money and no ideas, but we need to be in the business of building success stories. My personal view is that the particular ideology you have about alcohol does not matter. The key thing is: does it work? Again, there is some interesting stuff from the Canadian Indians. We need to try out a couple of different sorts of models and resource them on an adequate scale. We need to assemble expertise from all around the country and beyond on what works and what does not work, and combine that with community people to make sure that what is proposed is likely to be viable in a community setting. We need to try out some models. Making a sensible effort on things like alcohol, nutrition and smoking may be decades overdue, but it still has to be done. It is important.

Ms Taylor—I will ask Debra Blumel to make a brief comment, because drug and alcohol services are managed through our public health unit.

Ms Blumel—Let me say, firstly, that the problem of alcohol, tobacco and other drugs is that the policy lead is provided within public health services but the services are provided through the 39 or so districts. There seem to be two general themes: through the districts there is a focus on treatment. It is very much a treatment approach. Ernest Hunter is doing a longitudinal study up in North Queensland—we are working collaboratively with him—which is looking at indigenous communities and substance abuse and trying to look at a best practice model for what works and what does not work. The great bulk of alcohol, tobacco and other drug resources are put into the treatment end.

With a very small bucket of money which came from the Commonwealth—the amount was $80,000—a project is being conducted at the moment to look at population measures to enhance community control and develop community-based prevention programs. But the approach is not abstinence; it is harm minimisation, which seems to be more effective. With that money, reference groups are being set up. At this stage, they have been set up in south-west and central, so there is nothing really above Rockhampton and Brisbane north and south.

There is another specialist group in Brisbane which is focusing on Torres Strait Islanders who are living in Brisbane. There is another one looking at IV drug users, again in Brisbane, but they are all about indigenous communities. They are big reference groups of 40-odd people to a group. Someone made the point before that it is about targeting. It is; it is about linking Commonwealth-state resources, elders and relevant organisations together to get communities to look at what their needs are and what needs to happen. Even though that is longer term, it seems to be what is required to get the sustainability of programs. But $80,000 is a drop when it comes to a population based program. So, yes, the great majority of resources are being spent on treatment and minimising secondary blow-outs in health.

Dr Ring—An interesting report has just been produced. It is a joint report of the Australian Institute of Health and Welfare and Queensland Health. You should ask the

people in Cairns about it if you are going there, because it is a fascinating piece of work. It looks at what happens in these DOGIT communities. The principal source of revenue in many of the communities comes from a liquor licence. That is a major structural issue for us to deal with, but it looked at the consequences of moving the licence outside the community. It seemed to halve many of the alcohol related consequences. What the long-term effects will be and what sly grogging will do in the long term remains to be seen but, certainly, the short-term results at least are encouraging. There are many aspects, of course.

CHAIR—I think we had better pull it up there. The fact that we have gone well over our allocation indicates the value that this exchange has had. We very much appreciate your time and effort. We are aware of the whole of government strategy as a result of the inquiry we were conducting on competitive tendering here yesterday, but those tabled reports will be useful.

Just in respect of that, I was a little disappointed yesterday not to have representation from the department of health here in Queensland on our competitive tendering, because an issue came up in relation to competitive tendering with respect to sexual assault. We made a request that the Department of the Premier and Cabinet follow that through with us. That is something you will find back at your office when you get there.

Ms Taylor—No doubt.

Mr ALLAN MORRIS—Can I please add for Ms Taylor that that question about synchronising between you and the Commonwealth was for Aboriginal students but also possibly for students from remote communities who are from a non-Aboriginal background. It may well be part of the question for rural and remote health workers, not only Aboriginal health students.

CHAIR—I will wrap it up there. We may well have an occasion to talk to you some more, I think, as we find our way around the inquiry.

Ms Taylor—We would be delighted to do so, and thank you very much for your time and attention at the inquiry.

Proceedings suspended from 10.56 a.m. to 11.05 a.m.

DAVISON, Dr Rodney Paul, Secretary, Queensland Regional Committee, Australian Faculty of Public Health Medicine, , c/- Secretary, Queensland Regional Committee, AFPHM, PO Box 406, Queensland 4032

RILEY, Professor Ian Douglas, Chair, Queensland Regional Committee, Australian Faculty of Public Health Medicine, c/- Secretary, Queensland Regional Committee, AFPHM, PO Box 406, Queensland 4032

CHAIR—Welcome, Professor Riley and Dr Davison, representatives of the Queensland Regional Committee of the Australian Faculty of Public Health Medicine. Before we proceed, I need to point out that, whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the proceedings of the House of Representatives itself. Any deliberate misleading of the committee may therefore be regarded as a contempt of the parliament. I would also advise that parliamentary privilege applies and protects witnesses in giving frank and fearless evidence in assisting us with this inquiry. The committee has already authorised your submission's publication in volumes of submissions in connection with the inquiry. You may wish to briefly speak to your submission to us before members ask questions.

Dr Davison—In brief, we felt it was important that as a regional faculty of public health we did put in a submission. We felt, as one of your previous witnesses mentioned, that there had been a stagnation in progress over the last two decades, that it was a national issue and that there were some approaches that have yet to be implemented that we could suggest and we could offer some expertise in that. If you like, I could summarise the submission but I presume you have all had a look at it.

CHAIR—Yes. The committee has been to Hobart, we have been to Adelaide, we have been to Perth, we are now in Queensland, and everywhere we go people say, 'More money, more money.' This often makes everyone feel better if they are given more money, but it does not necessarily mean you get a better result. Obviously, the key is in looking for programs and targeting programs that deliver a result rather than 20 years of what we have had. I think members of the committee—and I am certainly on the record—as agreeing with previous witnesses that it is a national disgrace and there is a real resolve with this committee to try to break through whatever the impediments are.

It is very useful to have people with your background come along and talk to us. There has to be a different answer than just throwing more money at it. The answer we have to have is, 'Let us target what money we have and, if there is a case for more, let it be to this style of programs because they are delivering.' Is that a reasonable summary of where we are at? Probably what we are looking from you is your advice as to recommendations we may be able to make to capitalise on what we think is now a bipartisan resolve to make some progress on them.

Dr Davison—From our point of view, I think what you have said is excellent. The first thing is that we need a bipartisan result; we do not need it to be a political ball game forever. Coming up to the year 2000, we need to make an acknowledgment as a nation about the situation and also about the factors that resulted in the current situation. We have listed those for you, and there are probably others we have not listed there.

This needs to be out in the public arena. People such as you are aware of this, people who have been involved in Aboriginal health are aware of it, and people who have had close contact with the consequences are aware of it but the bulk of the population is not aware of the situation and of the factors that have caused it. So we need to do this nationally. Our leaders need to show leadership, in our view.

Secondly, we need to look at not only health interventions but parallel interventions in education, in employment and in housing, and we need to make the community aware that there are major efforts needed in those areas to supplement the health areas.

The third thing we need is a partnership between the Aboriginal and Torres Strait Islander community leadership and the public health professionals, such as Ian Ring, and clinical experts. To take this matter forward, in our view, we really need a national integrated indigenous health service, such as existed in the United States. We need that service, not so much to be a service delivery agency, but to be a standard-setting agency and to be an agency that can monitor trends and fund projects, such as those which other witnesses have been suggesting—projects of national significance that can be evaluated to prove whether or not they are successful. The projects can then be made available to other groups, which may have to modify them for their areas. These projects could deal, for example, with respiratory disease or diabetes or whatever.

But we also need national standards for health service delivery throughout the nation so that communities do not miss out because of politics. Whether it is state governments, community-controlled services or others who bid to provide those services, they should be of a standard that we can be proud of.

CHAIR—Your submission was quite sobering in its history and presentation and that will be part of the record. My feeling about making the general populace more aware is that it is going to be counterproductive if you make Aboriginal people feel even worse about themselves. As chairman, I have had a couple of radio interviews on the matter where everyone wants to zero in on these terrible outcomes. What we are discovering, as we have been around, is that there are some really good, positive and committed Aboriginal people out there. So my view of your submission was that perhaps you felt you needed to shock us, but you really do not as we are well aware of that. We want to know where we go from here. We have heard—

Dr Davison—Mr Chairman, I was not saying that we need to shock with the outcomes. We need to bring people's attention to the causes of those outcomes because the greater population does not understand them.

CHAIR—Yes, I think you are right. I am exploring how to promote that debate in the broad, rather than focusing on a negative, because it might make matters worse. I would like to see the statement, 'Yes, we have not had a good history, but here are some good results'. We should try to be focused on the positive. So we need you to steer us towards some of those good models and good results, not because we want to ignore the bad results—in fact the committee is going out to do its own field inspections and we know what we are going to come across but we are going to do that—but because we also want to look at some good models.

Dr Davison—That is basically what we are saying. There are good models but they need to be evaluated and tested, because a lot of the good models appear good; but they do not have sustainability, or they do not have adequate proof of their outcomes. But there are some very good models around the place; many of them are indigenous-controlled models. For example, Dr Nelson mentioned dealing with alcoholism: in the Northern Territory approaches to this there are excellent models. Back in the seventies, there were good models of how to deal with particular issues: intervention models for children's health issues, which could be developed for some of the adult health issues that Ian was talking about before; screening and developing targeted, evidence-based campaigns to deal with respiratory illness for example, or smoking.

CHAIR—Are there any of those that you could steer us towards?

Dr Davison—There are some. My direct involvement ceased four or five years ago, but there are some around the country. Yarrabah—where Laurel McCarthy is from—had some good models of community interventions: for example, rheumatic fever interventions, which is a small issue but it is a very important issue in that community; and some issues of intervention in relation to alcoholism.

CHAIR—Have you made our secretary aware of some of those? Some of them we would like to fit into an inspection. We are deciding on some. We cannot see them all, obviously.

Dr Davison—I could do that.

CHAIR—If you think there are some that we should be having a close look at, then advise the secretariat.

Mr ALLAN MORRIS—I want to ask about distant learning. The complication I am asking you as professionals and people experienced in the field, not necessarily as professional educators of Aboriginal health workers. We find that people from remote areas, which is much of the problem, often tend to end their high school years in many cases away from home and certainly university years away from home. By the time they have completed their courses, whether it be radiology or medicine, they have become citified, if you like. That is a problem across the country. Can we look at ways of educating and training people so that part of the training is actually pushed closer to their

childhood base, so they that they retain their relationships and connections with their towns, villages or community or whatever it might be without any loss of standards? Obviously, the problem is that we do not want second class doctors or second class health workers.

Prof. Riley—I am also Director of the Australian Centre for International Tropical Health and Nutrition. We have a indigenous health program and we commenced a batchelor of applied health science for indigenous primary health care workers in 1993. We have had our first two years of graduates. We have focused on providing basic professional education across clinical, public health, community development, preventive, environmental. We have had retention rates in that course in excess of 90 per cent. We have seen our graduates stream into what we would regard as appropriate health services.

We think there are two issues with health workers. One is the development of the interface worker. The other is a more general requirement that we increase the number of educated indigenous people within the health sector generally as quickly as possible. If you look at the total graduates across the board, they are very few indeed in this state. We are funded from a Commonwealth department of health program, which means that that program is up for review this year.

At the end of last year we had a grant from DEETYA to extend our training to northern Queensland. Essentially what happened was that DEETYA asked to increase the number of indigenous people in universities in the tertiary sector. Our response was that the pool of graduates was so small that you could not drive directly towards that. Essentially what we planned to do was take the course, put it in Cairns and try to offer people more equity of access, given all the problems of distance, social education and that sort of thing. We are still experimenting trying to find the right models for that because we are expecting to start that in second semester this year.

It is clear you need a mixture of mechanisms that would include block release. It includes distance learning. It includes travel by tutors. As I said, we have experienced 90-95 per cent retention rates, but this is costly. It is costly in terms of the cost per undergraduate in Australia because the usual formula assume classes of a couple of hundred people. The cost to the department is on that basis. We have a very intensive relationship with the students and we think it is cost-effective, but it would cost roughly three times as much to graduate one of our students.

Educational programs are medium to long-term things. Again, it is not simply the sum of money; it is a question of the assurance that you will be able to continue. We have DEETYA funding for three years. I would say that it took at least five to bed down a new program of that nature—to develop it, find the area, rectify it, start to see new graduates come out, start to see their performance. You are talking five to 10-year time scales. So we have no certainty of funding and we spend a lot of time trying to cadge, if that is the right word, money from government departments. At the same time we find that the Abstudy regulations and the incorporation into the youth allowance are working against us.

So when the money is taken away from block release or there are restrictions placed, like 200 kilometre radius of Brisbane, that just wipes it out.

Mr ALLAN MORRIS—I am grateful for Professor Riley's comments. I was not aware he had such a pertinent information base. I do not think we have time today to actually probe that. Given education and training is going to become one of the major areas of inquiry without doubt, if you could perhaps offer us any more information about the things you are talking about and want to expand on it or material that maybe appropriate, then we would be grateful for it. That is the first part.

The second part I wanted to tease out a fraction more is that getting them educated is one thing but getting them to go back and work in those remote areas is another thing. There is a cultural impediment there. There is a financial impediment as well. We do programs for people from overseas as an aid program. We train people from all over the world in public health. We can do it for the rest of the world but we cannot seem to do it for our own people very well.

Prof. Riley—My principal area is international and not indigenous in fact. Firstly, I think in the health professions you rely finally on motivation and idealism. I think you have to rely on those things. I think we have developed a type of course which is aimed at a certain group of people and that training is of itself orientated to the community. When we set this up and dealt with reference groups at the beginning, people said we send people to universities, they graduate and they are different people. If you spend three years considering the problems of indigenous health, if you try to look at those with both indigenous and western eyes, then you produce a certain sort of person. Then finally you are relying on the integrity of that person. We have two years of output and it is early days.

Secondly, if you go through that process and you send your graduates back and the recipients of the education, the users, behave as though nothing has happened and in the words of one of my graduates 'treated me as though I was just a little black fella and put me in the corner again', then those things will fail. So there has to be education of the user.

I think you then have to look at the mainstream courses. Radiology I do not have strong feelings about. Nursing I have extremely strong feelings about. I think there is a whole process of education of the nursing faculties which needs to go on. We are currently working with QUT on this. I think the professional staff have to be involved in community issues. For me the key faculties are nursing and environmental health. I think they have to consider their courses. One aspect of courses is that people choose problems in terms of their importance over the general practitioner. So how many Aboriginal patients do you see in a month, therefore, that is the amount of the course we will put in. I think Aboriginal issues are much more important per se and need to be brought up in course because it is an Australian concern.

I think that there has to be some provision for those indigenous students within the larger courses so they retain their feeling of their own community and they have contact with other indigenous people working in the same areas. Then I think through that one should be seeing something of a change in attitude of those professions generally. We just heard about Australia as a whole, but Australia as a whole is in 'blame the victim' mode. If you talk to, say, nurses in Royal Brisbane, they will say, 'We went to school with them and we are doing all right. Why can't they?' It shows a very deep misunderstanding of what cultural destruction means. I think we have to address those things educationally for a start.

Dr NELSON—Could you elaborate on the National Indigenous Health Service: how you would envisage it being structured and funded, how it would operate and how it would differentiate from what some in contemporary society would describe as 'mainstream services'?

Prof. Riley—I will turn that back to Rod. I do have a comment, but that is more Rod's area than mine.

Dr Davison—The way we envisage it, it would be a national service that would bring the whole thing together. It would not duplicate in any way, and it would allow indigenous people at a national level, together with professional people with some acceptance by the indigenous people and knowledge of the area, to work together to develop a service. Over time, that may mean a shift of funds from states to that service so that it could provide a funder-provider arrangement with contracts for the states to provide services at certain levels—primary, secondary and tertiary levels—or it may mean that indigenous health services would provide primary and, in some cases, secondary health services in some areas, and the tertiary services would be provided by the state services.

The actual organisational arrangements are only a small part of it, but they are an essential part of it because they give power to the group that understands the issues and they bring the whole service together across the nation. The advantages of that are that we can then start to do what the national Aboriginal health strategy tried to do, which was get some base-line statistical evaluation of programs as they were implemented, to watch trends and to try to influence trends. Basically, we have still got to keep providing the needs based services: people come in with a need and that has to be met. That is what we have been concentrating even more on in the last two decades. We have been putting more of our funding into that and less into preventive services—which is fine, because that is what the indigenous community felt was essential.

However, we are not going to go forward and make a dent in those horrible outcome indicators unless we do something in addition to that. We are proposing, in addition to that, that that service would then commission large-scale intervention projects on the major causes of death and morbidity, for example, respiratory disease or diabetes. Those large-scale intervention projects might be across a state or across different communities or in one community there might be an intensive project, but that would be

evaluated very carefully and scientifically. It also would involve community control right through the planning, implementation and evaluation stage, so there would be ownership by both the professional community and the indigenous community.

If those interventions are successful—our new chairman wants to see successful interventions—all the ones we can demonstrate at the moment, apart from the ones in the 1970s, are small-scale local ones. The reason is that we have not got an integrated service; we have got a piecemeal service. There are great gaps in that service—gaps for political reasons, economic reasons and various other reasons; you probably have seen them more than any of us—through the country. What we are talking about is getting the whole country together. It may not actually end up costing more money—it may do, but it may not. What it may do is target that money more successfully.

Dr NELSON—There is one other thing which is relevant but possibly tangential to this. If a medical graduate wants to train to be a physician and, for example, goes to Royal Brisbane or somewhere like that, in the course of his or her training is any incentive at all provided by the college to spend some time in rural if not remote Australia servicing both Aboriginal and non-Aboriginal populations? Are there any cultural drivers in the college itself that, possibly in the advanced training years, place a priority on servicing, even for six months, remote Queensland, for example?

Prof. Riley—As you are probably aware, within the College of Physicians per se, as far as I am aware, no. The Faculty of Public Health Medicine has been involved in the development of the rural training units in both Broken Hill and now Mount Isa. I think there is no specific incentive of which I am aware for trainees, but I think the existence of those things is a move in the right direction.

Dr NELSON—If the college were to provide powerful incentives—for example, positive discrimination in favour of advanced training positions to trainees who were prepared to spend three or six months working in a rural setting, perhaps even a remote one—do you feel that that would assist the provision of services, if not education of other health workers, to Aboriginal people?

Prof. Riley—Providing you fund the positions and you structure the training. It is no good sending highly skilled people out to get their hands dirty; you have to have a clear purpose.

Dr NELSON—If it is desirable, is there a point during the on average six years of postgraduate training at which it would be best to send such trainees? For example, should it be earlier? There seems to be a need. There is a cultural problem in the profession. There is a work force problem in rural and remote areas. There is a need for physicians—indeed all specialists—to be exposed at some time in their careers to the real problems in rural and remote Australia. There is also I would suggest a benefit in terms of the education that can be provided to Aboriginal health workers and support for nurses and GPs.

Prof. Riley—Firstly, I think you should speak to Dr Paul Torzillo on these issues, as you quite possibly have. Secondly, we are shifting between physician training and public health training which are different things.

Dr NELSON—I understand.

Prof. Riley—The college has been closely associated with the training of registrars in Port Moresby and Papua New Guinea generally. I believe that is of general value to the profession in Australia. In major hospitals in more remote areas like Broken Hill I think that is a worthwhile exercise. To my mind the problem is the gap between what a general physician or a specialist physician trains in and the sorts of problems that are seen in indigenous communities. The problem for the trainee is the size of that gap.

This is a slightly different issue, but I think if specialist services are to be involved in the problems of communities—and we are involved in that at the moment with a group looking at paediatric infectious disease—then we have to give a great deal of thought of how to lift up the special diagnostic abilities and skills of the specialist unit and put that at the peripheral area. Say in the area of paediatric respiratory disease many of the techniques are appropriate to cystic fibrosis and can be picked up and put there. I think that then has to be linked to databases. That has to be linked to very careful evaluation and one has to look at the outcomes in a very systematic way.

Dr Davison—The paediatrics people put some paediatric registrars out in Mount Isa over the last six or eight years. They have now got a paediatrician full time out there. There were some difficulties and the difficulties were that there was no supervisor out there so they had to put someone at the end of their training initially so they could provide a consultant service as well as get some final training. Now that there is a full-time paediatrician there, they can send people at a more junior level out there. It is an excellent training ground as well as an excellent service that can be provided. So I think you need to be aware of their training.

The second thing is the faculty programs need to be such that having spent some time in a remote area does not disadvantage the career of the person. They need to build in that it is an acceptable part of their training and that they will not miss out on jobs when they come back, otherwise you will not get the best people doing it.

CHAIR—You are on a merry-go-round with that one.

Dr Davison—It is doable, though.

Mrs DE-ANNE KELLY—On page 2 you have a long list of dot points of events. You ask the nation as a whole to formally acknowledge and endeavour to remediate the destructive effects on the health of the indigenous community for those events. I want to put it on the record—and this is not place to discuss those—that that shows a fair lack of understanding of tribal law. I would like to leave that there. While some of those things

may be valid, I think you have misunderstood the reason why some of them occurred. Some of them show a lamentable lack of understanding of tribal law, and I would like that on the record.

When we went to Western Australia, the chairman of one of the medical services over there was talking about how successful they had been because they had devolved the approach to handling indigenous health right down to the communities, medical services and so on. Why are you suggesting that we go the opposite way to a national indigenous health service, which seems to me to be the very antithesis of the what the Aboriginal communities and leaders are asking for? The argument they gave to us is that every tribe and every region has cultural sensitivities and quite marked differences in the way in which they approach every aspect of their lives—not just health.

Dr Davison—I would be interested to hear the reason for your first statement.

Mrs DE-ANNE KELLY—As I said, I do not think this is the place to discuss that, however, as you put it in your submission I thought I was at least entitled to make one quick general comment on it.

Dr Davison—It is difficult to accept it without understanding the reasons.

Mrs DE-ANNE KELLY—It was difficult to accept your dot points without more supporting data, but I think we will leave it at that because this is not the venue to discuss that.

Dr Davison—We offered to provide additional data. In relation to your question, they are not incompatible. What we are suggesting is exactly what you have suggested, and that is that the local culturally sensitive health services are what we need to support, but we need to support them with a national indigenous controlled health service that will ensure their continued existence, but will also support them with knowledge from other areas and support them with backup that they cannot do at a local level.

Having worked in several of those services, I know that they are constantly under pressure to meet the needs of the community. If they have to stand back and look at a preventive program or an evaluation, it is beyond their capacity. We are proposing to assist and support that in a national way that really makes a national commitment to it, instead of just saying, okay, we have satisfied this group, we have given them a little bit of funding, so lets continue that. We are not improving things.

Mrs DE-ANNE KELLY—I think that we all agree that we are not improving things—that is why we are here. I am still concerned that that is very much going against what we have been hearing from Aboriginal leaders themselves.

CHAIR—We have been hearing pretty much a bottom-up approach—give us control of our own destiny.

Mrs DE-ANNE KELLY—They are saying, 'Don't give us a white man's solution. Let us do it.'

Prof. Riley—Listening to the conversation with Dr Ring before we came in, it seems to me that one of the most obvious things about Aboriginal health in Australia is the fragmentation and the demand for specific community interactions. That is obviously totally correct. The problem with that is that it places extraordinary demands on communities in terms of resources. One has the feeling that people are solving the same problems over and over again. If you turn to something like smoking and you wanted to draw a map of communities around Australia, you would dot it with people who were doing good jobs and people who were doing nothing.

It would seem to me at least that what you need is an understanding of how a smoking strategy is developed, how materials and approaches are made available to communities for adaptation for local use and how that community feeds back into the strategy so that those processes are understood and so that those materials are updated. Some years ago, our people looked at the availability of health promotion materials across a number of areas in Queensland and it was very patchy. People grabbed for materials which could be quite inappropriate for their communities. What they really needed was the ability to pick up on generic materials and adapt them to their own circumstances; they did not need to invent anti-smoking campaigns from square one. I am sure you could apply that across dozens of areas.

When it comes to local services—and I am in fact working with the Papua New Guinea health department on this at the moment—I think you do need standards for services. The central authority or the central agency needs to say what the minimum standard is for peripheral services. They may be structured in terms of resources, in terms of outcomes, or whatever, but there needs to be that two-way process. You cannot devolve the lot.

Mrs DE-ANNE KELLY—Bearing in mind that you represent one of the specialist medical colleges, one of the difficulties we have in Queensland is lack of doctors in rural and remote areas. That, of course, overflows into the lack of doctors in indigenous communities as well. As you would know, we import 350 doctors into Queensland every year just to keep the general medical services going. In the area I come from, there is a doctor who has been trying to attract somebody to help him for 16 years. That is just with GPs; it is even worse with specialists. If you are not part of the solution, I have to say you are part of the problem—seriously. What are you doing to ensure, in rural and remote areas and in indigenous communities, that we get not only more GPs but also more specialists because it is just not happening?

Prof. Riley—We should make it plain that we represent public health medicine. Our efforts really have been directed towards issues like the development of the remote area training units and we are not directly involved in the allocation of staff to peripheral areas. Rod would probably know more. We have very little flexibility.

Dr Davison—Getting doctors into rural areas is a workshop in itself, but there are successful approaches that communities can look at. There has been a successful approach in Port Augusta in South Australia to get paediatricians. That involved asking the paediatric trainees what it was that would encourage them to go there. These are the sorts of things we were talking about before. They actually did not want a major increase in money to go there. They wanted some incentive and they wanted it fitted into their training program with no disadvantage to their long-term training. They did want access to ongoing postgraduate sessions and they did want access to relief. Things like that dare what the rural doctors group has been working through. Relief is one of their biggest problems—getting away for one month a year—and they have come up with a few suggestions in recent years for relief services.

We need to build in something more structural, like a career structure. If we are looking at government doctors in remote areas, we need to make it worth their while to stay there but we also need to recognise that they cannot stay there forever and that, having stayed there, their whole career is not disadvantaged because of that. We need to have some form of career structure for them. If necessary, we need to negotiate with the specialist and the general practitioner colleges to make sure that training places are available when they come back to the metropolitan areas. We do need a bigger approach in order to coordinate things.

I myself have worked in a remote area for two years. A lot of my best medical colleagues are still in remote areas, but they do become a bit eccentric after a while and they admit themselves. To stay there you have to be a certain type of person. We do not just need those kinds of people; we also need people who are prepared to make a three-year, five-year commitment and have their careers go on from there. There are ways of approaching that.

Mr ALLAN MORRIS—It is lucky you have parliamentary privilege here this morning.

Dr Davison—I say more than that to them.

Mr JENKINS—I return to page 2 of the submission and to the prerequisites—therefore, I return to the dot points in paragraph 1. I also note that in paragraph 2 you talk about the need for parallel improvements that, inter alia, go to dealing with self-esteem and recognising all the issues which impact on the dignity of people. At the moment there is an ongoing process of reconciliation that others who have appeared before us have put the view is important or could have important consequences on indigenous health or indigenous wellness. Others have put to us that, through putting in place appropriate programs for indigenous health, indigenous education, we could go a long way to creating this reconciliation. Hopefully I have not led too much in the question, but I would like your comments about the importance of the process of reconciliation to what this inquiry is about.

Prof. Riley—I do not pretend to be an expert. Clearly, it is two-way. From what I hear, a lot of people are asking not that history be reversed but that history be recognised. I think the roots of ill health do relate to cultural destruction. It is culture that gives meaning to life, and when a culture is destroyed that meaning is taken away. Non-indigenous people set out to solve problems, and I personally think that the only way forward is to create the circumstances in which indigenous people can solve their own problems, and I think our job is to facilitate that. Everything I have said would be in that context.

Things like education are of fundamental importance because, in order to solve their own problems, it is very important for indigenous people to see the world with our eyes. Without education, that is almost impossible. Our culture is a very open culture in many ways but, if a person is not educated, I do not think they can penetrate it, nor can they use our systems. I think that employment is so screamingly obvious that people ignore it. I personally do not see how you can get past many barriers without employment and something to do which itself has meaning.

I do not think that that should stop the development of health services and health interventions. I agree completely that those health interventions should have a community base, but what I perceive as the weakness of that system I have outlined does not have sufficient resource to continue to reinvent the health wheel. Does that answer your question?

Mr JENKINS—I was seeking your personal view and, to that extent, I thank you very much.

Dr Davison—Our faculty at its latest meeting decided to write to the press indicating that we saw the current discussion on reconciliation and on native title as essentially linked to improvements in health.

Mrs WEST—I know you might not have been around 20 years ago in Aboriginal health but, in your estimation, how much progress has been made over that time, or even in your time, in improving Aboriginal health outcomes?

Dr Davison—I was on Palm Island in 1975. There has been a lot of progress. As Ian Ring said, the progress was, predominantly, that outcomes improved up to the late 1970s and then plateaued. The progress since then has been in the level of delivery of service, particularly community controlled service. That has improved with both the traditional community controlled health services and the state government services with largely indigenous control in remote areas. The levels of both those services have improved in the last 20 years, particularly in Queensland. I am not as aware of the other states.

Unfortunately, there has not been a parallel improvement in outcomes. That is where I think we are in our history now, and we have to build on the good things we have

achieved, not lose those good things, and add value to them.

Mr ALLAN MORRIS—I would like to put a medical question on notice to the doctors. In Western Australia, we were advised by some people from the Aboriginal medical service that the diabetes problem was perhaps being addressed by bush tucker and that it was a dietary issue. They found that when people went back to eating bush tucker, to the normal Aboriginal diet, their diabetes either diminished or, in some cases, disappeared. Would it be possible to get some medical advice? Are you aware of whether that is substantiated? Are there any comments available?

Prof. Riley—Yes. There is some evidence.

Mr ALLAN MORRIS—Thank you.

CHAIR—Thank you, Professor Riley and Dr Davison for your time and effort and your preparedness to have ongoing dialogue with us in relation to that question on notice. We will take on board your suggestion about a national service and digest it with the other information we are hearing.

[11.53 a.m.]

DOWD, Dr Lynette Toni, Consultant Researcher, Centre for Research in Aboriginal and Multicultural Studies, University of New England, Armidale, New South Wales 2351

ECKERMANN, Prof. Anne-Katrin, Director, Centre for Research in Aboriginal and Multicultural Studies, University of New England, Armidale, New South Wales 2351

Prof. Eckermann—I am an anthropologist and I have worked in Aboriginal communities in Queensland, New South Wales and the Northern Territory for the last 30 years.

Dr Dowd—My background is in remote area nursing. I have been working in the area of Aboriginal health since the early 1970s. I am currently working on the national remote area nurse competencies project to develop minimum standards of practice in remote areas.

CHAIR—I wish to point out that, whilst this committee does not formally swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives itself. Therefore, any deliberate misleading of the committee would be regarded as a contempt of the parliament. I need also to advise you that parliamentary privilege applies to evidence given to this committee, which gives you protection and allows you to be frank and fearless in the evidence you give to us today. The committee has received your submission, and it is currently circulating as part of the published volumes of the inquiry. Do you wish to make an opening statement?

Prof. Eckermann—My submission was relatively short, and I am glad it was because it seems to me that you are getting quite diverse information and definitions of what primary health care is all about and how you might incorporate the principles of primary health care into any strategies that the government might develop in the future. I think it is important to note that Commonwealth and state governments have committed themselves to primary health care as an approach to health care generally for all Australians. Particularly in Queensland and New South Wales, the state policies say, in terms of Aboriginal health, that they are fully committed to this principle.

So I think you really need to get clear in your head what you mean by primary health care. It is not primary care; it is not the first point of call. The World Health Organisation is very clear in its definition of primary health care. It is not simply the absence of disease, but the whole wellbeing of the individual and the community in which that individual lives—the social, emotional, physical, psychological wellbeing of the individual in that community. That is what we are striving for. It is no good saying, 'Yes, we have wonderful committees which are going to coordinate economic strategies, social strategies and health strategies at the CEO level.' What we are really looking at is

community development. That means that we do not develop separate programs, but we develop community provision which address health as well as education, as well as housing, as well as employment.

It is very important, for example, to look at substance abuse but, as long as you have 90 per cent unemployment in some communities, no matter how wonderful your programs are, it is not going to work. It is great to say that we are going to have a healthy nutritious lifestyle but, if 10 years after the national Aboriginal health strategy we are finally getting some clean water in the Torres Strait, than something is wrong. Why has it taken so long? We have known about it.

With respect to the DOGIT communities you asked about, deeds of grant in trust were created in 1983-84. They had problems before that in terms of housing, in terms of employment, in terms of child abuse, in terms of alcohol abuse, in terms of problems with the law, in terms of suicides. And we still have not done anything about it, because we keep focusing on programs. Am I talking too much?

CHAIR—No.

Prof. Eckermann—You asked for examples of initiatives.

CHAIR—You are entitled to 20 minutes, because I know my colleagues like to get to questions and later on they nag me because they did not have an opportunity.

Prof. Eckermann—You asked about community initiatives. I will give you three examples. One is Julilakari, which is in Tennant Creek. It is a program run by the elders to monitor the streets of Tennant Creek for people who are either sick, using alcohol or fighting. They are picked up at night. I am sure you have heard about the project. It includes tribal law. It includes responsibilities of people for their own people and their own country. It solves of lot of problems of conflict with public authorities.

Another one is the primary school in Armidale called Minimbah Aboriginal Preschool. It is now a full school, going up to grade 3. Minimbah caters for the total child and the child in that total family in the community, so it is not just giving Aboriginalised curricula. It is not just having Aboriginal teachers. It is also looking at the kids' ears, it is talking to parents about nutritional programs, it is encouraging people to get training to become involved in the school as child-care workers and so on. It is a total program.

The third example is Nalangu Aboriginal Corporation in Mitchell in south-west Queensland, where people are collecting and recording their own ethnography and their own ethno history. They have two purposes in mind: one is using this material for their native title claims; the other is collaborating with the school to develop regionally appropriate Aboriginal studies programs for all kids.

There is a spin-off for employment there. There is spin-off in terms of integrity

and pride in self. There is a spin-off in terms of positive interactions between the Aboriginal and non-Aboriginal community—all kinds of spin-offs. That is primary health care because people take control. I think it was Dr Ring who said that one of the things which really is important, one of the reasons why we really are not making any headway, is because we do not have control over our lives, we do not have control over our health. That is where Aboriginal and Torres Strait Islander people are constantly missing out on—that level of control of making decisions. Dr Dowd has done a lot of work on health programs and stuff like that.

Some of the things that are in the material that I sent you concerned the level of change that we are involved in and we are progressively doing the same. You are talking about doing more of the same. That is first order change. That is when we keep pouring funds and energy into something to try and make these people better. It does not work. People have to make themselves better. People have to decide, 'I would like to stop smoking', not 'I will stop smoking because. . . ' or 'I will stop eating Kentucky Fried Chicken because you will give me a subsidy for the council of my community or for a road project or something.'

People have to take control of themselves and that can only be done through a community development model in which all aspects of health service are included but start with things like the Aboriginal health worker. Laurel McCarthy said it very clearly: 'It is so important that we do not see them as aides to nurses, and nurses as aides to doctors, but that we see that whole team approach as important.' I will shut up now.

CHAIR—I was just wondering about, in a cultural context, your comment that people need to decide for themselves to live a healthy lifestyle. We have heard so much about the cultural relevance of things. But the fact is that you can choose not to live a healthy lifestyle; I got your point about the Kentucky Fried Chicken. I know what you are saying there. But sometimes people have to be enticed, or in some way you have to have a carrot there it seems, to get them to the first point of committing themselves.

Prof. Eckermann—Involvement is the most important thing.

CHAIR—I have seen people try to give up cigarettes. They know it is not healthy and they want to and they want to and they want to, but they cannot.

Prof. Eckermann—So we chew Nicorettes.

Dr NELSON—But the problem at the moment is that people are dying because we do not have the political will to do something about the fact that nutritious food is five times more expensive to eat than fast food in a community.

Prof. Eckermann—Absolutely.

Dr NELSON—I agree with you that it is not a question of coercion because that

will fail, but every day governments of all persuasions provide incentives and disincentives to affect human behaviour. If some kind of incentive is delivered to a community which voluntarily then chooses an option, surely that is something that we ought to consider, because as long as we just keep doing what we are, people are going to keep dying.

Prof. Eckermann—People are dying at the moment, and have been dying for the last 15 years and 20 years and 30 years, because of inactivity. If we take a different approach, let us think that through too. Dr Dowd, there is a program in the Northern Territory that you were involved in in the late 1970s.

Dr Dowd—It is a long time ago now. In relation to a couple of comments: a lot of our energy through our mainstream system is, with good intent, put into defining problems and prioritising. The reality is, in my experience, that so very often—this is not just rhetoric, it is still happening—that people themselves are not part of defining the problems. So we have missed out a lot in our systems in being able to identify strategies, assets, resources, and not just money—of course, we know there is little of it—but positive vital things do exist in communities that would influence our way of defining problems even. That is a very general statement, but I think so often people are left out of defining the problems, and it is for all good reasons. There is not any negative motivation behind that.

Di Roberts is the Aboriginal director at Minimbah. The Minimbah school exemplifies turning that whole process around. So often in mainstream, particularly in positions where people have quite a lot of clout in terms of decision making and developing policy, they are not privy to the kinds of processes that, at a local level, people might feel comfortable to be involved in. That is one aspect. The program that Anne is referring to, which was a long time ago, was called tucker today. It was based in a little town in the territory called Elliott. That involved negotiating with the management people at the shop working very closely through the Aboriginal health workers and also negotiating with the education department.

So there was an on the ground, fairly concrete collaborative effort, as small scale as it was, to implement a lot of the things that the nutrition people were mentioning here to improve nutrition. That was part of the overall goal, but the actual participation of people in the process setting the way it would be achieved was very important. We moved away from some of the traditional western models of the five food categories and adopted ideas from Milingimbi where people had talked about three major food groups instead of our traditional five—the dillybag foods, digging foods and spear foods. Through the health workers and through the women in the community, particularly some of the elders, that was culturally relevant. It was just a matter of being guided by them and letting people lead the way on how it should be done.

That was effective over two or three years and changed around. We monitored—again, it was small scale—the buying habits of people and the amount of budget that was

going on what had previously been spent on meat, sugar and damper. There was quite a change over a two-year period. That also influenced what was made available through the school tuckshop. So there are examples out there. That is one from some time ago. I understand that a few years ago Lockhart River picked up a similar sort of model. They made radical changes to the foods that were being made available through their store, but the expense factor that people have highlighted is still very real.

Prof. Eckermann—It is not quite as bad but it is also not all that good in western Queensland. I remember doing my PhD out there and the Institute for Aboriginal Studies gave me a supplement in my scholarship because it cost so much to buy an apple or an orange.

Mrs WEST—In your estimation after years of study, is there a cultural aversion by Aboriginal people to traditional white medical treatment?

Prof. Eckermann—This is my opinion, and you can ask Dr Dowd that afterwards because she has a different opinion. In my opinion, sickness becomes a way of life and you expect not to be feeling too good most of the time. So you do not seek medical help as often perhaps as a middle-class person like I would because not feeling too good is normal and there is a white doctor and you are not quite sure about him. Even if you are sure about him, you really do not want to waste his time because you know you are not that sick. So people tend to go often when they are really in crisis or very ill. Then it is difficult to do things quickly and well.

It is very difficult for the health professionals who see people who have let it go and have not sought help for things like very high blood pressure or people who have diabetes or advice about diabetes or people who have had a chronic stomach ulcer and have not done anything about it. I think that it is not so much a reluctance to ever seek help; it is a patterned way of interacting in many instances, not all, which makes you wait too long. So then the experience is not so good because you have been very ill. Then the next time you go you prolong it a little longer because you do not really want to do it again. That is my experience.

Dr Dowd—I do not think there is a cultural aversion—not in my experience. I think it depends on what Aboriginal people's experience has been. As a remote area nurse, as a white nurse going bush, for quite a long period I was 'the white nurse'. That brought all sorts of baggage: the authority thing, the power base. It was 'the nurse' that the person coming in was interacting with. It took time to develop a rapport and for people to get to know you as a person. I think that is very important too. Often we highlight that and people say, 'Oh, that's all abstract interpersonal stuff. Let's get on and achieve the task.' But, if the time is not taken to build the rapport and develop the trust, then no matter how much energy and resource is put into achieving whatever we are aiming for it is not going to happen or, if it does happen, it is not going to happen well.

That is certainly where remote area nurses, many doctors in many situations and, I

guess, many non-Aboriginal professionals are at a real disadvantage. In my small group, for example—remote area nursing—there is a syndrome we describe as 'Mary Poppins', because nurses pop in and out of communities. The turnover rate is horrific—absolutely horrific. You often will encounter antagonism, racism, prejudice—whatever—from Aboriginal people, as they do from us, but it is not because of a cultural aversion. I think it is the reality of their experience with white people in authority. For many, just as is true for many white people, there has not been an opportunity for people to develop solid rapport and to establish relationships so that they know one another as people.

Prof. Eckermann—I will give you a good example. Toni said that we concentrate too often on the problems. In December, I facilitated a summit on suicide in the Cape York for the Cape York Health Council and the Torres Strait Alliance. An example was given of children who had become so blase about suicide that they almost saw it as a game. Five little petrol sniffers actually made up this game. They sniffed petrol and they all put a rope around their necks. They worked it out that, at the count of 'one', they would all stand up; at 'two', they would all climb on the table; at 'three', they would all put the nooses around their necks; and, at 'four', they would jump off the table. It is an horrific thought that this could happen. It did not happen, thank God, because the grandmothers intervened—they were alerted.

That started them talking and thinking about the strengths in their communities to start to deal with a number of the problems that they are facing. They said, 'Yes, we can do this. Yes, we can do that.' They started to talk it through. It seems to me that is where primary health care, community development, starts: with the strengths in people and in their communities. If they are given the opportunities to articulate those, they will then start articulating their needs as well.

What do we need to make this happen? It is very important. I am not saying that money should not be given to people, and so on. But, if we concentrate only on programs, the programs will vary from one place to another. There is no doubt about that. What will work, for example, because of a smoking campaign in the Lockhart River is unlikely to work in a place like Inala because the physical, social, political environment is so different. Once they start identifying strengths, they also start to empower themselves to take control of the process of change. We may see something different from just first order change, which is what has happened so far. We may see second and third order change. We may see true community development.

Mrs DE-ANNE KELLY—It is a very interesting submission—there is a lot to think about. Thank you. You talk about involving indigenous people in communities in planning, decision making, service delivery, and so on. You obviously have a very good understanding of the cultural basis of Aboriginal society. Do the structures that have been set up in ATSIC, the way in which we administer government and every other facet of our lives, and the fact that Aboriginal, Torres Strait, South Sea and Papuan people have all been forced to fit into our administrative structure go against the cultural line of command in their society? That has been put to me—I just do not know whether it is true or not.

Obviously you are somebody who probably would be well placed to know. Do they have a different idea of authority, the lines of authority and ownership?

Dr Dowd—I think there is such incredible diversity that often we do not appreciate amongst the many different Aboriginal groups out there. In organisations that I have worked alongside of or in partnership situations sometimes the decision makers in the system are working in a system similar to ours and they have internalised some of the values related to our system. In other organisations it is totally different. It is not as simple as saying yea or nay. It just varies. Again, it comes back to the process of negotiating. What are the appropriate ways of doing this or that?

One of the big downfalls I have seen particularly in recent times is where there has been very genuine effort and there has been a lot of funding put into establishing partnership between mainstream and community control services. I will give you a couple of basic examples of where it has fallen down. They are so commonsense you wonder why it got to where it happened. Submissions have been put in for a $250,000 plus for initiatives based on a partnership but without one of the partners being involved in the submission. That has been done on a premise that we do not want to set up a situation where the funding does not come through and we disappoint people and they fail yet again.

But when you speak to the Aboriginal people in the organisation they wanted to be in at step one and I guess wanted to be given the opportunity to be actually involved in the whole process. It was not a concern to them that the funding might not come through, because that has been our experience many a time. That was a very early step where it was overlooked. Then two years down the track you had to work backwards to try to work out what is the partnership we are talking about. So the actual process and along with that the structures vary immensely and it is not easy. It takes time and, unfortunately, a lot more time is wasted than used wisely.

Prof. Eckermann—I think most groups that I know of can live with the existing decision making structures with the board, the CEO and all of that. They may not actually use those structures to make decisions internally. They may use the structures to deal with government or funding bodies. In the past and still in the present I think it should be noted that the way things have been set up has facilitated a very strong cultural belief or practice. That is to support your own family because they are the only ones you can really rely on, your own kin group. I have numerous examples of government organisations exploiting that in the sense of divide and rule, making sure that 'Yes, we will support you but . . . ' That happens. I am not saying it is policy but I think it is certainly in practice carried out.

I think more and more people are becoming aware that that is a weakness that can be exploited by systems. The three examples I gave you of positive things happening in Australia all take account of the diversity of their communities and ensure that that diversity is represented in the organisations. That is a step that is being taken more and

more as people think through this whole process of running their own organisations and becoming involved in them.

We are currently piloting a health management CEO course for indigenous peoples at UNE. It is a partnership between the Institute of Health Managers and UNE. We have 12 indigenous people who are going through the course. They are getting experience in community control as well as mainstream. Every six months they get a new working situation where they have to adjust in a practical sense while they are doing their course externally. By gaining that experience seeing how different systems work, hopefully they will be able to put more positive structures in place.

Dr Dowd—I think another big obstacle that we sometimes encounter, but it need not be such an obstacle, is in our systems trying to always ensure that we have the appropriate representation of Aboriginal people. I have just seen so much time and energy—and I have been part of it at times through committees—spent on trying to get it right. I think the lesson is not to try, to just step back and let the Aboriginal groups that are involved get it right. When it comes to something that people are committed to and there is a common goal there and it is a priority, it will happen. I do not understand how that happens. They know and they are really the best people to be doing whatever has to be done—whether it is conflict resolution, negotiation or consultation with their own groups—to say, 'This is the representation we want.'

Our structures, in relation to your original question, often inhibit that. For example, in the territory where I was 18 months ago, there was difficulty where the Aboriginal groups had actually done what I am saying. They knew what they wanted. Basically, they wanted more than one person to represent eight or 12 different groups, but the structures did not really permit that. So you get difficulties with that.

Mrs DE-ANNE KELLY—Is the voting system that has been imposed by us for ATSIC representation perhaps too paternalistic? Would it be better to allow the Aboriginal community to dictate how people are represented on that?

Prof. Eckermann—No, I do not think so. The ATSIC system covers a whole range of people. What Toni is talking about is a local group making decisions on a local level. Once you get a regional brief and you get a whole range of people involved, I think they will still work it out by themselves. I think there is no other way but the voting system.

Dr Dowd—As long as people have access to the information they need to understand the system, because often that is a major barrier. People are not well-informed about our system and how it works. Therefore, they are not seeing opportunities. They are not thinking of the strategies to work the system to the best interests of the community.

Mrs DE-ANNE KELLY—What do you see as the major steps that have to be taken to improve indigenous health?

Prof. Eckermann—I personally think communities have to be given an opportunity and access to the sorts of support that they need to develop their own strategies for their own communities. That goes whether it is an urban community or a remote DOGIT community. So they know, 'Okay, I have a chance to do this,' but some groups will not participate. For example, half the people in Inala may not want to be involved in that sort of planning exercise or three-quarters of the people in Brisbane may not, but then other communities will. They need to be able to take up that opportunity with support. I am not saying that they do not need support.

When the DOGIT communities were created, there was a thick report from the department itself which indicated the kinds of training that were required if these communities were going to be local government areas. Nothing ever happened. So there has to be that support there. From that, they can develop strategies and they can develop priorities. They will also be more than happy, in my experience, to identify performance indicators, but those may be different from what governments may expect.

Dr Dowd—The biggest obstacle here in Queensland in relation to the Aboriginal health program, which I was involved in evaluating—

Prof. Eckermann—Do you want a copy of that? I will give you a copy.

Dr Dowd—The biggest stumbling block I could see besides the Commonwealth-state wrangle that went on for decades over funding was the centralised structure. So I feel fairly strongly in relation to your earlier question. I do not believe primary health care—the holistic thing, the processes—can be achieved well through a centralised bureaucracy. That does not mean, in my experience, that Aboriginal people say, 'Well, get rid of the bureaucracy.' I think the people that I have worked with have an incredible ability to compromise and to meet situations halfway, to try to make the most of the mainstream, particularly in terms of resourcing and what can be offered. It is the opportunity to be able to adapt that and use it at the local level in a way that is relevant, that is going to be sustained over time and that, ultimately, is going to give more decision making and, if you like, a change in the power base to the big agenda.

Prof. Eckermann—The example of lower payment there—

Mrs DE-ANNE KELLY—I am sorry to interrupt you. I do not mean to be rude; I beg your pardon. Are you referring to the suggestion by the Royal Australasian College of Physicians?

Dr Dowd—That was the example, I think, that came up.

Mrs DE-ANNE KELLY—Yes. What was it—the national indigenous health service?

Prof. Eckermann—There is NACCHO, the National Aboriginal Community

Controlled Health Service, which is a good voice for a whole range of people.

Mrs DE-ANNE KELLY—I am not saying that the national thing should not happen, but we so often go to that. With our recent work through the Royal College of General Practitioners, with the implementation of the Aboriginal health module, there is incredible motivation and good intent in the medical educators to get that curriculum in place, to get it implemented. It has been a two-year process and, just now, people are really grappling with the how of implementing it. I think, sadly, what is happening is we are looking for a national way of doing it, and doing it nationally is going to involve very few Aboriginal people when it comes down to it. By the time it filters down to the various local, regional or even state and territory levels, it is just not going to happen as well as it could if it went the other way.

Prof. Eckermann—Noel Hayman gave a good example of how the community itself was doing things and saying what it needed.

Ms ELLIS—My question is very quick and, unfortunately, it is very vague, so please forgive me for that. I am recalling what Professor Eckermann said about self-determination in all of this. I made reference earlier this morning about the *Dying Shame* documentary, with some funding being pulled out of a locally created program. My vagueness is around my recollection of a similar initiative that I saw on a documentary on the ABC, a little while ago now, about a group of Aboriginal women—I think it was around the Alice Springs area, but I am not sure—who decided that they and no-one else could do something about the alcohol problems of the males in their community. They set down some very stringent standards and criteria for their menfolk. Are you aware of that? I am sorry for how vague I am about it. It has been suggested that it may have been Yuendumu. I am wondering whether you are aware of it and, if you are, whether you know how it progressed. It was a very ground-up, community driven initiative by the women of the community because of the alcohol and the physical abuse in their community.

Dr Dowd—I am not aware of it. I am visiting Yuendumu in a few weeks, actually. I know the Yuendumu women were working fairly closely with some of the women in Tennant Creek who were involved with the Julilakari program, but I am not aware of that particularly.

Prof. Eckermann—The women also danced through certain parts of Alice Springs.

Ms ELLIS—This is a perfect example, is it not, of what you are getting at—which is when an initiative comes from that level of the community, that is when you step in and say, 'Okay, what do you need? How can we help you facilitate this?', rather than going in and saying, 'You have got this problem; let us tell you how to fix it'?

Prof. Eckermann—But, when we did the survey of south west Queensland, communities were quite clear about what problems they had. They were quite eager to

identify those—even things like sexual abuse, family violence and so on. People were incredibly honest. So, if you give them the opportunity to identify what strengths they have and what they need to address those issues then they will own that. I know that is a catchphrase—you 'own the problem' and so on. I do not mean it like that. They really will have some control and whoever—for example, me, Toni, a doctor or whoever—comes in will have to work within that framework. So, our positions will be quite different.

Dr Dowd—Many Aboriginal people, in my experience, get burned out by all the lobbying they have to do with so many different sectors or departments. I heard Rob commenting to you this morning on the Aboriginal health program in Queensland; he indicated that he had been a director of the program for a number of years. They were committed in principle to being holistic, collaborative, intersectorial—whatever jargon we use—but, in reality, the structures did not operate like that. We still see, in the work we are doing now—not just here in Queensland but interstate—that there are still so many examples of where there is that compartmentalisation and fragmenting. So, often understandably, Aboriginal people just—you know.

Prof. Eckermann—Can I make two more points, please. I am also involved a lot in Aboriginal education. I heard today a good deal of comments about trying to encourage indigenous people to become doctors and nurses. I have no problem with that. But if that is the main thrust of the educational strategies that you are going to be proposing, you are likely to have the same dismal failure as we did when we proposed 1,000 teachers by the year 1990 or whatever the date was. The educational strategies and the educational profiles have to be much more comprehensive than that and they have to take account of things like the integrity and the value of Aboriginal health workers and the training of those people. They are not assistants for somebody else.

Mrs DE-ANNE KELLY—Can I interrupt you a moment. I did not quite grasp the point that you were making there. You were saying they do not have to be answerable to somebody else? Can you elaborate for me, please.

Prof. Eckermann—Aboriginal health workers are not somebody else's handmaiden, handman or whatever. They have integrity in their own right in their position. Unfortunately, because of the professional structures that we have, they are a bit caught like Aboriginal education assistants, AEAs, in the education system. Some people treat them as equal professionals and other people treat them as help people to go and do the scrubbing, the photocopying or something, when in effect they are really the front line of primary health care anywhere, whether it is urban or remote. They have now got national standards; they have got a national competency program and this sort of stuff. They are starting to get a niche in the profession, a place in the profession. They need as much support in their training as do doctors and nurses.

The other thing is the subsidies and incentives for doctors to go to the west and so on. We talked to the Royal College of General Practitioners a couple of weeks ago. They brought this up as one of their major problems. They are really trying to get people out

there, to get them to work in the bush and so on, not just in Aboriginal communities. I said to them what I am saying to you now: doctors and nurses need to realise that this situation that they are working in is the most challenging, the most varied and the most exciting environment in which they are going to work and their profession needs to recognise that—I think one of the doctors made that point—not in terms of giving them $120,000 to re-establish themselves but in terms of making sure that in their own profession they are highly valued.

We have not done it for teachers yet; we are still sending first-year teachers out west for three years so they can come back and live in Port Macquarie or somewhere and have an easier school to teach. That means a real change in attitude in this profession.

Mrs DE-ANNE KELLY—That was a very good point.

Mr JENKINS—I appreciate the comments about the one size does not fit all; the different Aboriginal groupings because of different cultural considerations. We have not have the one model and then say, 'We will use it all around the place,' so I will go to the more general question about the relevance/importance of the reconciliation process and whether this is a process that is of greater importance for non-indigenous people or it is also of great importance to indigenous people, especially the people you have worked with and studied.

Prof. Eckermann—We are also a regional indigenous centre for social and emotional wellbeing in Armidale. I had a group of students in. They got quite hot under the colour, not by anything I said but by something they heard on TV about reconciliation. They said, 'What's all this reconciliation about? We don't want reconciliation.' From the discussion I think first of all they want recognition of what has happened. I think that is the first part. I do not mean that we should go beating our breasts and saying, 'Please forgive me. Please forgive me,' but just an honest recognition that the history of this country has been this way and that has happened.

From that recognition, I think reconciliation can grow, and it is not just important for non-Aboriginal people. One of the things which is influencing Aboriginal mental health to an enormous extent is the after-effects of colonisation. The psychiatrist John Cawte, for example, in 1974, wrote *Medicine is the Law*—a wonderful book—in which he outlined the influence of gross environmental stress on the mental state, on the social and emotional wellbeing of Aboriginal people. Until people can decolonise themselves, that is, actually step back from the hurt and the pain of the past that has been happening to their family and been handed on and on, even if they themselves have not experienced it, unless they can decolonise themselves, there will always be that residue of pain, hurt, bitterness and anger. There is an enormous amount of anger in Aboriginal communities and most of it is turned on themselves rather than on the outside because you cannot do anything about the world out there but you can let it out this way.

Dr Dowd—Can I give a quick example. Through the Binang Goonj three-day

cultural awareness workshops that we do—Binang Goonj means 'They hear but don't listen' from one of the dialects in south-west Queensland—where we have at least 50 per cent Aboriginal participants and maybe a group of doctors, nurses and mainstream professionals, I am continually amazed at how very often, for many professionals, it is the first time they have interacted with Aboriginal people on, for want of putting it another way, a level field. It is not doctor-client or nurse-client. A lot of that anger and hurt—it is not one way; it is two-sided—comes out, I think in a fairly productive way, in that kind of forum. I am talking about a small situation where you have no more than 20 people.

We have not had any mechanism to monitor and evaluate long-term outcomes—we have been running Binang Goonj workshops over the last seven years—but the feedback from doctors and nurses, and certainly from a lot of the Aboriginal health workers, is saying that it is the first time they have interacted. Actually seeing that a doctor has emotions is quite revealing to some Aboriginal people: 'He was almost crying; I think maybe he would understand.'

Prof. Eckermann—It goes both ways.

Dr Dowd—That is right. Also, in the professional roles you are not open in the same way. I guess my message is: I think the more opportunity there is for that kind of interaction—and it takes resourcing situations for it to happen—the more spin-offs there will be in terms of all these health outcomes that we are on about.

CHAIR—Thank you for your time and effort today.

Resolved (on motion by **Ms Ellis**):

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 12.39 p.m.