
# HOUSE OF REPRESENTATIVES

## STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

**Reference: Indigenous health**

**TOWNSVILLE**

**Wednesday, 18 March 1998**

**OFFICIAL HANSARD REPORT**

**CANBERRA**

HOUSE OF REPRESENTATIVES
STANDING COMMITTEE AND FAMILY AND COMMUNITY AFFAIRS

Members

Mr Forrest (Chair)

Mr Quick (Deputy Chair)

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| 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*

TOWNSVILLE

Wednesday, 18 March 1998

Present

Mr Forrest (Chair)

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| Ms Ellis | Mrs De-Anne Kelly |
| Mrs Elizabeth Grace | Mr Allan Morris |
| Mr Jenkins | |

The committee met at 9.00 a.m.

Mr Forrest took the chair.

**CHAIR**—I am pleased to open the sixth day of public hearings of the committee's inquiry into indigenous health, as referred to the committee in June last year by the Minister for Health and Family Services, Dr Michael Wooldridge, with the support of the Minister for Aboriginal and Torres Strait Islander Affairs, Senator John Herron.

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 the significant improvements to the health status of these communities that we would all like to see. Barriers still exist to access to mainstream services for Aboriginal and Torres Strait Islander people.

The hearing in Townsville today follows previous hearings in Canberra, Hobart, Adelaide and Perth last month, in Brisbane yesterday, and here in Townsville today, and provides an opportunity to explore issues on which the authors of locally based organisations and individuals have made submissions—submissions for which we are very grateful. This process will be followed by further hearings in other cities in the next few months. The committee is also intending to visit remote and rural areas in central, northern and western Australia to gain first-hand experience of living conditions outside major urban centres. As a committee, we think it is vital to visit these low population centres to get first-hand experience.

As I have indicated on previous occasions, I stress that this 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, to combine the collective experience of everyone who has worked in this area and to arrive at the best possible practical strategies to improve the status of indigenous health. We are looking to find opportunities to build on individual successes. It is not all bad and some good things have happened, but there is an impatience and, I think, a bipartisan resolve to make some progress on this issue. As a nation, we are embarrassed at how we compare with the performance of other comparable countries in respect of treatment of indigenous populations.

[1.39 p.m.]

**KENNEDY, Dr Christopher John, Manager, Townsville District Health Service, PO Box 670, Townsville, Queensland 4810**

**MUDGE, Professor Peter Rowland, Clinical Dean, North Queensland Clinical School, University of Queensland, PO Box 1805, Townsville, Queensland 4810**

**CHAIR**—Welcome. I think hearing the two of you together will provide us with a useful exchange. You are obviously already working in close cooperation. Is there anything you would like to add to the capacity in which you are appearing?

**Dr Kennedy**—As manager of the health service, I have responsibility for the publicly funded health services in Townsville, Ingham and Palm Island. With Palm Island in my electorate—if I can use that word—that is my particular interest today.

**Prof. Mudge**—The clinical school is situated in Townsville, Cairns and Mackay, with a particular emphasis on rural and remote and indigenous health in the north of Queensland.

**CHAIR**—Before proceeding further I would like 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 the proceedings of the House of Representatives itself. This means that any deliberate misleading of the committee would be regarded as a contempt of the parliament, but the process also offers the capacity to offer parliamentary privilege to witnesses, enabling them to be as fearless as they feel the need to be to give the committee the best evidence.

The committee has already authorised your separate submissions, from both organisations, in its publication of volumes of submissions in connection with the inquiry; so they are already part of the public record. The best environment in which our committee operates is with question and answer, and we would like to get to that as quickly as we could. But I would like to give you both an opportunity to make an opening statement. Things have moved on a little bit, since your submissions in September or so last year, and you may wish to bring us up to date on several initiatives which you described in them before we proceed to questions.

**Dr Kennedy**—Thanks, Mr Chairman. The situation on Palm Island has been a source of concern to myself as district manager and also to government departments and, indeed, the Aboriginal council, particularly in relation to youth suicide. Recently there has been some adverse publicity in the *Sunday Times* in Great Britain about that very matter.

My involvement with that issue over the last few months has led me to believe that while the history of the island and how people came to the island is, of course, important, it is the lack of ability for people to have jobs and carry out normal activities over there

which is fundamental to a lot of the health issues. We have a large input into the health services there. We are building an $8½ million hospital and health service. It is administered as a combined service, that is, a hospital and a community health service combined. The community side, which we regard as very important, is one which will work with the people and have input from the people.

With the appointment of a recent council—the local government council—we have had greater input and also interchange with them than with the previous one. This has led to a very good working relationship, particularly over the last few months. Not only do we discuss the plans and the issues regarding the building of the hospital, we are also talking about a much better way of oversighting and managing the health services, which I outlined partly in my submission.

Queensland Health, as you are probably aware, has taken a lead organisation role in the Queensland government approach to youth suicide. The figures on Palm Island lead us to believe that 10 young men have committed suicide in the last two years and, although homicide seems to be decreasing, youth suicide has been increasing.

We recently had Pierre Baume and a high powered workshop being carried out here in Townsville at the end of last week. Aboriginal men from the island attended that in conjunction with others from other organisations as well as Health. We have recently initiated a new response to the problem, which involves developing a men's business group. Using a community development model, we are putting a substantial amount of funds into supporting basically three full-time equivalent type positions. They will work with that business group to try to detect early signs in young men who might be threatening suicide.

The very important issue to me is that it is not being sponsored by us. It is being sponsored by a couple of young men who have actually threatened suicide themselves. Young men on the Aboriginal local government council are involved. It is a partnership arrangement. For the first time for a long time, there is a glimmer of hope that we might break through in this area. Also, they are very inspired and encouraged that the government is helping the local initiative to this extent. We are committing $115,000 immediately to this project, which is simply for the salaries and for facilitating that involvement. So it is a joint working relationship between a local initiative, with the heavy backing of their local council, and the local health service.

I have sat down and spoken to the people there; that is, a combination of counsellors and local young men and health workers. The enthusiasm for this is really encouraging. So it is early days, but we are hoping that we can make a break through just in this one area. Flowing on from that, we are actually working at the primary health care model to work through what other issues the men's and the women's groups and the other groups are really concerned about. We are hoping this will be the catalyst for broadening it out to look at all the health issues there in a much more effective way. So that is bringing you up to speed of what has happened in the last few months.

**CHAIR**—That sounds like good progress. Professor Mudge, perhaps you would just like to make an opening statement as well. I would like you to note that we met with Dr Hayman in conjunction with the Queensland government on Monday this week in Brisbane. I think I speak for all members of the committee when I say that we were very impressed with his resolve. Perhaps you could bring us up to date on how far things have advanced. I am particularly interested in responses that have occurred in negotiations for a program that you have submitted for funding.

**Prof. Mudge**—The answer to that is none. There has been no response at all to our submission. I find that rather disappointing, to put it mildly. That is not why I have come. I have come because I want the committee to know that, if you have the opportunity, as I have had, to go to America and look at the programs they have in place, it is very impressive. The reason they are getting better results in America is because the American indigenous people own the health program. They own the health program because they have trained enough indigenous Indians to be able to do it. This is where we are failing. The reason they have success with it is because they do really simple things. They just get kids at a very early age and get them interested and motivated. That is where we have failed.

The University of Queensland has graduated two indigenous graduates in medicine. Noel Hayman is one of them. He is a very impressive man. He came with me on the trip to America and, as you know, is a co-signatory to our submission.

I guess that is the major message that I want. This does not take a lot of funding, and it does not take a lot of insight. It is simply a matter of borrowing what other countries have done, seeing how they have done it effectively, and at least piloting something in this country to see whether we can have the same results. I am conscious of the fact that there are presently about 60 indigenous people in medical courses around the country. Most of those are at Newcastle, and they are also spread in other places. But that is not nearly enough people in the pipeline. We need a lot more people in the pipeline if we are going to meet the health needs of this part of the country. The other problem is that they are doing things in Brisbane. They are doing things in Newcastle. These are other countries for the indigenous folk who live in this part of the world. We need to have something here that is appropriate for indigenous people here.

**CHAIR**—It is not just the United States. We already have on evidence Norway, Canada and New Zealand. It is certainly a message that we are picking up everywhere we have been.

**Prof. Mudge**—Our figures are the worst in the world now.

**CHAIR**—Yes, to our eternal shame, I think. We have been fearless in putting that on the record thus far.

**Ms ELLIS**—When did you send the submission in?

**Prof. Mudge**—January last year.

**Ms ELLIS**—No. How long ago did you put forward the proposal for the pilot to government?

**Prof. Mudge**—In January 1997.

**Ms ELLIS**—I want to pursue a slightly different tack for just a second. Dr Kennedy, I am a bit ignorant about the socioeconomic position on Palm Island. Can you give us what the population is and the breakdown between indigenous and non-indigenous people—I gather it is almost all indigenous—and what is the employment status over there? What are the activities on the island? What is the way of life for people over there?

**Dr Kennedy**—There are approximately 3,000 people. There is anecdotal evidence to suggest that the last census did not capture all the people who live there, owing to various logistic problems. We are currently going through and issuing Medicare cards to all the people who live there and probably in a month or so we will have a much better idea of the exact number and what the composition is. I would be guessing here but there might be 50 non-Aboriginal and Torres Strait Islander people on the island. They are employed mostly through the Department of Health, the Department of Families, Youth and Community Affairs, the catholic school and the other state school there. So there are not many non-indigenous people on the island.

There are some indigenous people working in those services. We have Aboriginal health workers and some people working in the hospital as assistants in nursing, some clerical staff and, similarly, the other organisations do as well. The local council runs the hotel and the store is run I think by the Department of Families, Youth and Community Affairs. Apart from that, there is not a great deal of activity. I believe many years ago they used to grow a lot of crops and do a lot of fishing, and there were semi-commercial activities going, but there does not seem to be much of that happening at all now. I am not an expert on exactly what they do, but it would appear there is a very high level of unemployment. A number of them are drinking alcohol during the day and at night. I have been told that only about 30 per cent of the population drink alcohol, which is a real surprise to me, but a number of those do it in a despairing way. From a hospital point of view, we have quite a lot of activity in the evenings and even up to midnight with fights and incidents usually related to alcohol drinking.

**Ms ELLIS**—We had some really interesting discussions in our public hearings in Brisbane on the health and wellbeing of indigenous people beyond the care in a health clinic, in other words, what it is that we believe enhances or gives them an opportunity in the first instance for having relatively good health and wellbeing outside of that immediate primary health care, if I can use that in the narrowest term. There was a lot of discussion about activity, employment, ownership of their community and all those other very important issues. Given your experience in working in the medical field with indigenous communities, could you give us your view of what you think is the basis for expecting to

have a community develop itself into a position of relative health and relative wellbeing?

**Dr Kennedy**—Certainly I do not believe the arrangements on the island with the deed of grant in trust enhance their self-worth. They do not own their own houses, and I do not believe they have motivation to keep them in order. Housing is a huge issue. There is an improved housing program under way, and many new houses have been built, but there is still overcrowding. Maintenance to keep the housing up to standard is a huge issue. A lot of the things that most of us would take for granted as a personal responsibility, such as house maintenance and keeping things looking nice, actually seem to be in the hands of the local council

I think that fundamental welfare mentality is probably an issue. There is simply a handout of money and nothing to do other than to go and buy alcohol and drink it, or that sort of thing. Certainly, having the ability to have some sort of small business, owning your own property and house and being able to improve your lot is fundamental to their own self-worth, and that is fundamental to health.

One of the examples, perhaps, is a clean-up campaign that our health promotion people got involved with late last year. That took a while to get going but, once people became enthused, they started to take an interest and pride in keeping the streets clean and the rubbish in rubbish bins and were starting to look after things. Just that small program seems to have inspired a few people at least to feel a greater sense of self-worth.

**Ms ELLIS**—This morning, when we were here on another inquiry, one of the people from the Townsville Council made reference to a project in one of the suburbs here, Garbutt, to do with a successful community based program—I do not want to use the word, 'assimilating,' I am trying to think of another word—where the community health of indigenous and non-indigenous people living together was being treated and dealt with in a very positive fashion.

That prompts, in my mind, a question: is it possible or worthwhile, where you have that sort of positive community program occurring, to somehow get a measure of the improvement or otherwise of the general health and wellbeing of the indigenous people in that sort of environment, given that the evidence this morning was that it was all very positive, that there were great things occurring within that community at the beginning of that process and that they were very optimistic that it would continue that way? That feeds from my previous question—that is, the basic health and wellbeing of our indigenous people. Is it worth considering that sort of benchmark measure?

**Dr Kennedy**—We might ask Professor Mudge for his comments, too. I understand that there are measures that can be surveyed, if you like. In fact, at the moment, there is this wellness survey going on, starting in Bowen, with North Queensland and the rest of outback Queensland, in terms of indigenous health. So there would be various measures that you could take of a person's wellbeing, how they perceive themselves, then you could put into place certain actions and then resurvey. I know there has been work done in

various places with regard to those sorts of things.

Yes, I think we should be able to agree with Aboriginal communities about what it is that they regard highly and get them to rank it and to then survey later on what it is they regard highly and how they feel about it. From my background as a doctor, I am impressed that you can see people in appalling situations who are happy, and you can see people in really good situations who are appallingly miserable, so it is subjective. But it is to do with how you perceive yourself and what ability you see of improving and enhancing where you want to get to.

**Ms ELLIS**—Professor Mudge, did you want to make any comment?

**Prof. Mudge**—Just to say that the fundamental problem on Palm Island is that for the majority of people in the older generations who live there it is not their land. What we do not understand from our culture is the importance of land and their belonging to the land. The social dislocation that goes with that is profound on Palm Island, and this has been well documented. That is the fundamental problem. As the generations move on, that will change of course, because it will come the country of the new people but they are not living in indigenous situations.

The difficulty I have with the project you speak about is that they are a group of indigenous people who have chosen to become westernised, by their choice, by living in a westernised suburb and adopting westernised ways. That is fine and good, but they are a very small proportion of where the problem is. If you guys go out west and north, you will see how different it is when you get to those places, and they are the people we need to reach because that is where the problem is.

I do not think there is anything wrong with the word 'assimilation'. Once you get the assimilation that you speak about, you will move the indices of health towards that. We know from other migrating populations. We know from what happens to Japanese who go to America—that their health deteriorates to the American standard. So we know that will happen, but processes of assimilation are not very politically correct at the moment, and I think there are a minority who choose that.

What we are trying to reach is the group of people who have chosen to continue living in the communities in which they are, where the standard things that have been implemented over 200 years in this country have failed and we need to look at the root causes of why that has failed.

**Ms ELLIS**—Thanks.

**Mrs ELIZABETH GRACE**—I would like to follow up on what you just said about the Palm Island residents not being native to that area. Where have most of them been brought from? Has it been from around the Townsville region, or have they come from Mount Isa way, further west and that type of thing?

**Prof. Mudge**—They have come from very distant parts, some of them, and they were mixed together racial groups who did not speak the same languages. The early history of Palm Island has been well documented. Thea Astley wrote the book on Palm Island. It is well worth reading. It is fiction, but it creates some of the history of Palm Island. That was the origin of it. So people were mixed together who did not belong together on land which for them was strange. There were very few indigenous people on Palm Island at the time that became a settlement. It was a relocation of people who were a nuisance in the places where they were taken from.

**Mrs ELIZABETH GRACE**—It sounds a bit like Doomadgee, because I believe there were four different groups of people put together in Doomadgee, which is one of the problems they have up there, too.

**Prof. Mudge**—It is a Queensland problem, and this has been part of previous policies that we are now reaping the effects of.

**Mrs ELIZABETH GRACE**—I would like to follow up a little further than that. Would it be too fanciful to think that we could relocate these people on Palm Island back to their natural environment, their native environment? Is that being too silly? Is that stretching it too far?

**Prof. Mudge**—I do not think it is silly. I think it is a sensible approach to the problem. The difficulty is that they have been distanced from their lands now for such a long time that the relocation process would be quite difficult. The land that they have come from has all changed for one reason or another. The ownership of it has changed for one reason or another. The complexities of that, I think, would defeat us. So that makes it a really hard problem to solve.

**Mrs ELIZABETH GRACE**—So we are better to just try to ride it out, as you say, and wait for the next generations to come through.

**Prof. Mudge**—I think the sort of thing that Chris Kennedy was talking of—getting from within the community themselves the answers that they want, finding out what it is that they want and then trying to facilitate that. That is the only way we are going to solve the problem.

**Dr Kennedy**—I just have a quick point. I believe there are something like 36 different groups on Palm Island, only two of which came from there. But since it is going back to about 1912 or 1914, somewhere around there, there are people who were born and bred there and so were their parents. So in a sense they do belong to some degree already and, to relocate them, may cause more distress than trying to improve things.

**Mrs ELIZABETH GRACE**—Thank you for that. I have another little pet hobbyhorse, and that is housing. I find it quite strange and have long questioned why we expect these people to live in a three-bedroom, one-bathroom kitchen cottage, particularly

in this climate and then wonder why they knock the walls out and live outside and things like that. Has anybody on Palm Island—you say you are doing a lot towards rebuilding and building housing and they have a maintenance program—done anything there to design or ask the residents of Palm Island what type of accommodation they would like to live in and how they would like it designed? Or are we still going out there building corrugated iron tin shack type things with steel louvres so they do not hurt themselves and all that type of thing?

**Dr Kennedy**—I do not think that it is quite that bad, but I am not sure that it is ideal either. Certainly, some of the housing does not appear to be particularly related to what you described in terms of flexibility. I understand that there is an architect, a chap called Paul Phileros, who has achieved a breakthrough in indigenous housing design in some of the communities further north. I heard about that last week. I think that that is a really good point: there should be housing built in the manner in which people want to live. One of the things over there is that they do not seem to believe in verandahs very much, and most of us who live in the north would love a really wide verandah. So there are some real issues in housing, you are quite right. I have a thing about housing too.

**Mrs ELIZABETH GRACE**—It seems to me that it is a problem that we have never really consulted on. We have just gone ahead and assumed that this is the type of thing that is suitable. I wonder, seeing that there is a rebuilding program going on, whether this could be or should be part of the program; that is, consultation and some redesigning. We might save ourselves heaps and heaps of dollars by doing it right the first time instead of the fourth or fifth time.

**CHAIR**—We have spoken on two occasions now with Dr Ian Ring—once in Canberra when he was part of the AMA expert panel and again on Monday in Brisbane. We were asking about the difficulty that there appears to be in getting good indicators of where there are improvements. He advised that he works very closely with your service and he talked about Palm Island. Is that something that is important to pursue? I suppose, from your point of view, you would say, 'Well, it's all anecdotal. If we have a focus on prevention we're naturally going to get a good outcome,' but we have to get some documented evidence that that is occurring so that we can identify and target good programs. It seems to me that the issue is not about the amount of money; it is about spending it in the appropriate places. To do that, you need to have a good indicator that it is operated, worked and delivered well. Could you bring us up to date on your perspective on all of those?

**Dr Kennedy**—I agree with you. I am relatively recent to Queensland, but I have worked in Papua New Guinea. I think it is absolutely fundamental, as Professor Mudge said, that unless we can get the people themselves involved in the working out of those parameters we are really wasting our time. As I said, there is a glimmer of hope that this is really happening—and happening quite quickly—over on Palm Island.

We asked Professor Ring to visit, and he and I went over to the island on Thursday

of last week. We sat down with the health professionals there and met with the chairman of the council. There is a major consultation occurring over the next few weeks on exactly this sort of thing. What are the parameters that they wish us to put emphasis into? My idea is that it is alcohol and all these things. But what do they really want? We have to identify what it is we want to achieve, how we will get there and what the final outcomes will be. I agree with you—it is not a matter of throwing money. I am not in the housing area, but I think housing is critical. Self-esteem is critical and that may be the most difficult of the lot.

It is also critical to get people interested in doing things, so small business and all those sorts of areas are very important as well. With respect to whether you can get very far with those without answering some of the fundamental questions of people feeling aggrieved that they have been forced onto the island, I think that that is probably background. I think we have a lot to learn about post-traumatic stress syndrome. We know about it a bit now in terms of bushfires and wars, but there is also post-traumatic stress syndrome related to what has happened to people, such as in Bosnia or wherever, and also to people on Palm Island, which we still have to learn about. We have a very skilled professor of public health, Professor Hunter, who is a psychiatrist and is helping us with this. I think he has a lot to offer to us about these areas as well.

**CHAIR**—If you think it is worth while, please encourage him to contact the committee secretary.

**Prof. Mudge**—You should talk to Professor Hunter. He knows as much about Aboriginals in Northern Australia as anybody in the country.

**Dr Kennedy**—He is linked in with the University of Queensland and Professor Mudge's clinical school, but he resides in Cairns.

**Prof. Mudge**—He is a psychiatrist who has done a lot of work in the Kimberley and is now working in the Cape. We have made him a public health professor, with an interest in psychiatry.

**CHAIR**—It would be good to get some information like that on the record. I know that is what Mr Jenkins will want to pursue. It would be good to get that documented on the record. I agree that it is something that the rest of us do not seem to have made the connection with. I can, in a way, because I have seen a lot of Vietnam veterans where I come from. I sit back and think, 'What is wrong with these guys?' After a while you can understand if you stand back a bit. We will pursue that.

**Dr Kennedy**—There is a fascinating correlation between the decrease in homicides and the increase in suicide. Apparently, in mental health experience it is not uncommon that one goes down and the other goes up. It is self-destructive behaviour—either against your environment and other people, or against yourself—because of whatever is inside that is boiling to come out. That needs to be teased out. I think Professor Hunter could help.

**Prof. Mudge**—Professor Hunter has an international reputation for his interest in genocide.

**CHAIR**—We will follow that one up.

**Mr JENKINS**—Before going to some questions about the proposal for recruitment of indigenous people into the health work force, Professor Mudge, from your work in America can you tell me whether the native Indian Americans have the same relationship to the land and similar spiritually to indigenous Australians?

**Prof. Mudge**—Indeed they do. It assumes different forms but its similarity is very strong.

**Mr JENKINS**—Do they have the same sense of dispossession?

**Prof. Mudge**—Yes.

**Mr JENKINS**—During the committee's visit to Adelaide we were interested in the Aboriginal medical service which was borrowing from some of the work that they had seen with native American Indians—I forget which tribe. What form does your proposal for talent identification of young people take?

**Prof. Mudge**—Someone has to go into schools and ask the teachers. We reckon that in Northern Australia we could do that because we can identify the schools across the Top End that have reasonable populations of indigenous children. There are a number of differences with America. Their health system is very different and so on. One of the differences with America is that many of the Indians live on their own land—what we call reservations—and so they have schools that are entirely run and owned by Indians, so they can go into the schools and identify the Indian kids because they are in the indian schools. We do not have the same thing here.

Communities like Doomadgee or Palm Island would apply, but there are others that do not, so it is going to be more difficult to identify those children. If you look at schools like Larrakeyah, Broome and Cairns High and so on, you could actually sit down and work that through, but you have to have the education department on side because there are educational implications of this as well, which I mentioned in my report. You have to be sure that children who are identified as talented get the science they need, because if you look into why they do not get into medicine, it is because of science.

They start missing science—it is not cool if you are black to be interested in science, so the teachers do not bother to teach them science. They get involved in a vicious circle. That was happening in America and they broke the cycle by, when they got the kids into the camps, spending half the time doing science. They got science teachers in to design games and fun things that would teach the kids fundamental science. You have to make that link between education and health for this to work, otherwise it will not

work.

**CHAIR**—At what age would the intervention occur?

**Prof. Mudge**—Grades 5 to 6 is where they are getting them in America first, and then again in high school, and then again as premed. They take them three times. Not all children go to all three things, but that is when, both at the University of Washington and the University of North Dakota, both of which have very successful programs which I have visited, that is the three times when they take them in. The premed course is to pump them up with stuff so they can get through first year. The other two times they spend a lot of time doing science—although they also spend a lot of time doing cultural indigenous things.

**Mr JENKINS**—Would the youngsters who would be identified in this way be placed under greater pressure within the context of the internal tribal relations, clan relations? Does it place them under undue pressure or place them aside from normal relationships?

**Prof. Mudge**—I do not believe so. I think the Aboriginal and islander people who have graduated in medicine in this country have a range of problems that relate to their origins but I do not think that is one of them. I have not talked to many of them but I do not think that they feel as though they have been separated from their family.

**Mr JENKINS**—Does it go to training right across the board and health professions? It is not only medicos?

**Prof. Mudge**—Yes, it does. It is all professions. In America it is all professions. It is mostly just doctors and nurses at this stage. Other health professionals have not come into it to a great degree yet. It does go right across.

**CHAIR**—Dentists?

**Prof. Mudge**—I am not sure about that.

**Mr JENKINS**—The other aspect I want to explore is a new degree course called Bachelor in Indigenous Primary Health Care.

**Prof. Mudge**—That is a course run by Cindy Shannon in Brisbane. She presently has some funding for an outreach of that to Cairns. That is seen by some as being a process by which indigenous students could then go on and get into medicine. The difficulty that they will have perhaps with that is that there is not very much science in it at this stage, but there are ways of fixing that. You can give people time to catch up with the science, but that is the course that I think you are speaking about. We do not have a direct link with that course at the moment here in North Queensland. Although there are some people from North Queensland who are doing the course, it is very Brisbane based

and very focused on Brisbane, and that is a problem. Brisbane is a long way from here, whether or not you are an indigenous person.

**CHAIR**—Brisbane is as far from Townsville as it is from Melbourne where I have to get to tonight.

**Mrs DE-ANNE KELLY**—I would like to congratulate you on your idea, the outreach program into the Aboriginal communities and the pipeline to many students. It is a very fresh new idea that we have not had put to the committee before, so I thank you for that. The submission that was put to the federal government, to which department and minister did you address that?

**Prof. Mudge**—I am reluctant to get too involved in this. It went to the office of the Minister for Health and Family Services and went from there signed by the director-general. I am not sure which particular office it went to. I assume it went to the ATSI office and the new ATSI department. It was at a time you will recall when there was a change in the way health was going to be implement for ATSI people. It was taken away from health and given back to the ATSI department. It may be that, in that process, it slipped between the tiles. That sometimes happens at times of change. It may also well be that the minister had a formal letter back to his office thanking him for the submission and saying that it was being pursued; such correspondence I have never seen.

Can I say one more thing. This is not my idea; this is simply an idea that I have pinched from America. The Americans were very keen to share their idea. The recommendation I would make to this committee is to ask one of them to come out and talk to people. Nothing is more inspiring than having one of them here telling us what they have actually done. That is where I got the idea and the inspiration from. I was so impressed with it, I went back to America a second time for two months to look at it in more detail.

**CHAIR**—We did speak in Hobart with an indigenous Australian who had observed first hand some work in prisons with the Creek indians in Canada. We are very encouraged to try to make that link and we do not mind plagiarising from someone else who has done it better.

**Prof. Mudge**—The guy who runs the program in North Dakota is highly educated and very aware of what he is doing. It is a national program. They have got doctors on 20 of the 46 reservations in America with this national program that is funded. He is a very inspiring guy to talk to.

**Mrs DE-ANNE KELLY**—Professor, I notice in your submission that the state of North Dakota has a population of 650,000. The area north of Rockhampton in Queensland alone, forgetting the Northern Territory and Western Australia, has a population of that size with no medical school. So the facts speak for themselves, don't they? Really there is a tremendous need up here.

I notice also in your submission you make the point that this cannot be done at a distance because of the preponderance of the Aboriginal and Torres Strait Islander population in the north. It has to be addressed in the north. Would you elaborate a little on the need for that, please?

**Prof. Mudge**—I am not very good at remembering numbers so I cannot be sure of the numbers, but I think it is 10 per cent of the population of this part of the world are indigenous whereas across the country as a whole it is somewhere between one and two per cent. That gives you an idea of the relative difference. Quantity-wise we have more indigenous people living in North Queensland than most other places in the country.

The other thing that is important as far as the area is concerned is that northern Australia is seen as one country by indigenous people. They do not see the state boundaries as being relevant. That applies to some of our public health training as well. We have got public health training coming out of Townsville going across to Broome and to the Northern Territory. So they do not see the barriers in moving laterally like they see barriers moving south in terms of their culture.

**Mrs DE-ANNE KELLY**—I know you pinched your concept, but I still think it is a great idea and I still complement you for it. How do you ensure that students stay at school long enough to benefit from the support, the scholarships and program you mentioned? One of the real difficulties that we have is retention rates for Aboriginal and Torres Strait Islander and South Sea Islanders in our schools. There is a whole multiplicity of reasons why those retention rates are low, but how would you address that?

**Prof. Mudge**—You address that by the people you appoint to keep in touch with the children that you recruit. That just requires enough funding to be able to actually physically do that. You are going to lose some because children of all types change their mind about what they are going to do, but you need to keep in touch with them. You have regular meetings and visits with them and so on. You would have to have people on the spot in different parts across northern Australia who would take that role on and keep in touch with those children and be a counsellor for them. Ideally, of course, those people need to be indigenous people if you can find them.

**Mrs DE-ANNE KELLY**—Are the entry criteria for students into medical schools generally across Australia now skewed towards people who may have high academic achievements but perhaps not the social skills to be doctors willing to serve in different circumstances?

**Prof. Mudge**—The problem is that the typical medical student is someone like me who went to boarding school in the capital city, then went to a medical school in the capital city and then graduated from medicine having lived in the capital city and married a spouse in the same capital city. I have been there for 13 years or something like that. That is typical. In fact, I had rural origins, which is why I am here in Townsville now.

**Mrs DE-ANNE KELLY**—Now you have let the secret out.

**Prof. Mudge**—And I was a rural doctor for 13 years so my rurality came to the fore. Chris Kennedy's history is not very different from that, I suspect, as well.

**Mrs DE-ANNE KELLY**—So you are both rural people?

**Prof. Mudge**—This is what we are doing in this country. We are producing high academic standards within the more expensive schools and that is promoting a very similar model of medical education. We are addressing that in Queensland by changing to a graduate medical course. Those of us who have supported that move have used this as an argument to support it. We can take in people from the humanities and other degrees instead of just having everybody coming out of a science stream.

**Mrs DE-ANNE KELLY**—I have heard the opposite argument. I will not debate the point with you here. This is not the time to debate that probably.

**Prof. Mudge**—I do not think it is a problem to get them in; it is a keeping them in and making sure when they get in they are comfortable. North Dakota have got a very clever program. In America they give everything names and I cannot remember the name of the program. But when the indigenous students come into the course, they are told by the dean they have a special program in their medical course that allows them to spend two years doing the first year. This is a program that is available to everybody. The reality of it is that it is the indigenous kids who use it. But the fact is that that program is available to everybody.

Many of these indigenous students who come in are mature entry students. The woman I met had 11 jobs in 18 years, two small children and just started medicine. She was using this option because she could not manage first year without it. You have to have excellent people who are supporting the medical students in the course. If you ask them what they do, they say they spend half the time baby-sitting or getting up at night and going helping with problems at home. They are available 24 hours a day.

There are some details in this that need to be sorted out. There is no problem in getting them in; we can get them in. The dean in our medical school has the option of admitting into the course students from indigenous origins who he thinks are appropriate. That is not the problem. It is what happens to them when they get in. They have to be mainstream. You must not make special cases of them. They must be seen to be competing on the same playing field as everybody else and being assessed the same. What you have to do is support them so that they keep up on the way through. You have to have some flexibility and you have to teach the faculty how to deal with this because the faculty does not want to have students dropping out and coming back in. So there are complexities in it.

**Mrs DE-ANNE KELLY**—You mentioned the disproportionate number when

compared to the funding and the Aboriginal and Torres Strait Islanders in other states. When we were speaking to the Queensland government yesterday morning the point came out that there are also 6,000 South Sea Islanders and several hundred Papua New Guineans in Queensland as well who have specific health needs. So really our population is far greater than the one you put in your report. This is really a big question up here in the north because, as you know, we have a very large South Sea Islander population. Would you extend the proposal that you have to South Sea Islanders and some of the Papua New Guineans who live within our territorial boundaries?

**Prof. Mudge**—Of course, it is called an indigenous program.

**Mrs DE-ANNE KELLY**—Yes, but they are not indigenous. That is the trouble. They are classified not as indigenous.

**Prof. Mudge**—Okay.

**Mrs DE-ANNE KELLY**—Typical Canberra bureaucracy, I am afraid.

**Prof. Mudge**—We would give it a suitable name that enabled that. I cannot remember now what the Americans call it. They have got a particular name. They have got the problem of Cuban Americans, Mexican Americans, black Americans and so on and they have got a name that covers everybody. We could do the same thing if we needed to. We can call it whatever we like. If it is a duck and it quacks like a duck, it is a duck but we can call it what we like.

**Mrs DE-ANNE KELLY**—Probably 'native born to the south-east region' would cover it.

**Prof. Mudge**—We could call it a disadvantaged program because they are disadvantaged people by their own admission. So you could call it a disadvantaged program and that would be fine because that would open it up to any ethnic groups within our society.

**Mrs DE-ANNE KELLY**—That is a fairly negative name, with respect, though, isn't it?

**Prof. Mudge**—Yes. I think we have to be fairly careful about choosing a name. I do not think it is a problem to take those people into our consideration. The Papua New Guineans are a fairly migratory; they do not stay very long. As far as I know, we do not have groups of those people who live here. They come here for boarding school. They come here for training at our university here. They come here on exchanges learning about health and so on. But I do not think they stay here.

Certainly the South Sea Islanders are a special group in Mackay. Chris was in Mackay and knows about them. I am not sure about them. But I think the Papua New

Guineans are a bit of a confounder in this debate.

**Dr Kennedy**—Can I make a comment on the South Sea Islanders. I think it is very important to recognise what Peter pointed out initially that the alienation with the land is fundamental to the wellbeing and esteem the Aboriginals have, to a lesser degree the Torres Strait Islanders and to a far lesser degree the South Sea Islanders—who are really an ethnic group, as your parliament declared. For that major reason they are fundamentally different in terms of their own inner self-worth and self-esteem. I think that makes a huge difference with how you cope with their health problems.

But obviously there are disadvantaged people or people in poor economic and health situations who come from a wide group of people. In fact, in the Townsville district health area we have more people of non-English speaking background than we have indigenous people, which is quite interesting. Certainly the South Sea Islanders, as you note, Mrs Kelly, have similar health indices to Aboriginals, but I think the fundamentals are quite different and they may actually make a difference as to how we address their health issues too.

**Mrs DE-ANNE KELLY**—I thank you for the point you have made, although the health issues are different. One of the South Sea Islander leaders had morning tea at our house on Sunday. He was saying that, in South Sea Islander community, it is natural to have chest pains—or so it seems—and so many of the men die in middle age because they do not think that chest pains are unusual. That is really very sad. It is a tremendous loss. Could you rank for us the most important initiatives that could be taken to improve Aboriginal, Torres Strait and South Sea Islander health in this country?

**CHAIR**—That is a good question to finish with.

**Dr Kennedy**—It is a very personal perspective, but I really believe the land issue has to be recognised and the Wik debate finalised. I think, rightly or wrongly, that a number of indigenous people hang a lot on that. From my understanding, they need to have a reconciliation process which involves the land. I think it is fundamental to their own self-esteem, which is fundamental to health. The second most important thing, I think, is to somehow or other engage a local community area—like we are trying on Palm Island—in meaningful discussions at their level so they do not feel that it is paternalistic or maternalistic. Somehow or other we need to engage exactly what they want. They do not always know what they want, so they need some support in that.

Then we need to have programs—which the chairman has, quite rightly, directed us towards—for accountable, achievable issues; once again, not hugely difficult things, but things that are relatively simple, to our way of thinking. But they have got to see progress, and health care workers like me have to see progress, so that we are all encouraged and motivated to the next step. Once we start I think we will see an escalation, an exponential improvement, providing a real move forward. I think those are two fundamentals.

I would rate fundamental things like housing and sewerage very highly. I think we have to address that environmental issue. The other thing, which is not really health, is what they do with themselves—the employment issue. Even if it is not employment as we understand it, it is the feeling of worth to the community by doing things to help. It is voluntary work as well. If we cannot address those issues, then providing a hospital to help with chest pain is very much a secondary issue.

**Prof. Mudge**—I do not think I can improve on that list. You know my particular bias, which is about educating the health workers. We are doing that quite well with the level within the primary health care—the health care person—but we need the other layers to be put on top of that. That is the only thing that I would add to Chris's excellent list.

**Mr ALLAN MORRIS**—We need to persuade the community to reduce the expectation that doctors need to be geniuses. The idea in the community that only the top one per cent of the population can be doctors is the greatest barrier of all. The fact is that the top 20 per cent can do medicine quite comfortably. If we can persuade the community of that, we might change some of the—

**Prof. Mudge**—That is a very hard task.

**Mr ALLAN MORRIS**—If it is coming from a doctor it might have a better chance than if it is coming from politicians.

**Prof. Mudge**—I agree. That is one of the other things about a graduate medical course. We hope to encourage scientists to stay in science where they arguably can be more creative than they can be in medicine.

**CHAIR**—Thank you, colleagues. Thank you, Professor Mudge and Dr Kennedy. I give you the commitment that I will follow up on where your application is. I hope it has not been buried in a black hole somewhere. I will at least find out where it is and respond to you on that. It sounds like a good idea to me. Thank you for taking yourselves away from a very busy schedule to talk to us.

[2.36 p.m.]

**RAMSAMY, Mr Andrew, Manager, Aboriginal, Torres Strait and South Sea Islander Health Unit, Mackay District Health Service, Queensland Health, PO Box 688, Mackay, Queensland 4740**

**CHAIR**—Welcome, Mr Ramsamy. We are grateful for Mrs Kelly's discussion with you that has prompted a submission from you. Before proceeding, I need to point out that, whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives itself. This means that any deliberate misleading of the committee would be regarded as a contempt of the parliament. It also offers the process of parliamentary privilege to witnesses.

We have a submission from you which was not received early enough to be included in the public record, so I propose to incorporate the submission from the Manager of Mackay District Health Service, Mr Andrew Ramsamy, dated 11 March 1998, in the transcript of evidence for today's proceedings. If there is no objection, it is so ordered.

*The document read as follows—*

**CHAIR**—Mr Ramsamy, I have not had a chance to study your submission in detail. We have 25 minutes for you to convey your message to us before proceeding briefly to questions. I have to say that we need to finish by 3 o'clock because I have to catch planes to get to Melbourne this evening. Mr Ramsamy, would you like to make an opening statement?

**Mr Ramsamy**—My submission is certainly not at an academic level. I am certainly not an academic. I will just give a bit of detail about me. I am currently the manager for the Aboriginal, Torres Strait and South Sea Islander Health Unit. Prior to that, I was the manager for the Aboriginal and Torres Strait Islander Legal Service. I am also a member of the Central Queensland Land Council. I am now a director of the Aboriginal and Torres Strait Islander Legal Service. I am also a member of the Aboriginal and Torres Strait Islander TAFE Advisory Council. I am also a member of the Aboriginal and Torres Strait Islander Medical Service.

**CHAIR**—A lot of hats.

**Mr Ramsamy**—Yes. Basically, all that means is that I am a representative at the community level—nothing more. With regard to my submission, you will note that the manner in which it has been presented is essentially at a community level. It was always meant to be that way.

The first point is that emphasis needs to be placed on a buddy system or teaming between federally funded Aboriginal and Torres Strait Islander community controlled organisations and their state counterparts. There is a continual seesaw between our community controlled brothers and sisters and us, and I would like to see that seesawing levelled out as much as possible. There has been, to my knowledge, no formal relationship to try to iron out that seesawing, and perhaps there might be something looked at in the future.

The second point is about the Aboriginal, Torres Strait and South Sea Islander community managers forum. For me, that is a body at the grassroots level. It will allow our community some empowerment, some recognition, at the grassroots level. When I say 'empowerment', I mean that it will allow us to try to reduce the duplication that might occur at the grassroots level. That again is leading back to dot point 1, where we had this seesawing between federal and state bodies.

Point three: intersectoral collaboration is a lead-on from points one and two. It means some formal sharing of the load and a suggestion there to put that through a grants system. We do need an intersectoral approach to health and wellbeing. Point four: coordination and collaboration at the local level: a lot of that has been lost in our community, in particular with regard to the loss of a community development worker. That particular position was funded through ATSIC money. The community sorely felt the loss of those positions; that occurred nationally as a result of the reduction to ATSIC funding. It would be fortunate for us to be able to identify some method of returning that

role to the community. Feel free to interrupt me, I am a bit nervous. I am just letting it flow out.

**CHAIR**—You are going really well. Just relax with it. We are here to seek your expertise and your help. It has already been admitted to the record and is part of the evidence already, so you need not feel the need to read it all into the *Hansard*. Perhaps if you could go to the salient points that you would want to make and then questions will draw out more detail. Are you happy with that procedure?

**Mr Ramsamy**—Yes. Basically, from those first four points, you will get the impression that I am looking for some sort of formal arrangement or commitment to intersectoral collaboration; that is, the sharing of the load but on a formal basis. There is no formal basis from what I can see. The second matter is with regard to barriers to access to mainstream health services: some of the simple things have been overlooked. With regard to cultural audits, I just wonder whether the existing Aboriginal and Torres Strait Islander liaison officer positions have a role with regard to cultural audits and cultural reviews. If they do not, I would certainly like to see that included. Confidentiality and privacy is a simple thing and it really has a very great impact on our communities.

**Mr ALLAN MORRIS**—Your comments on that are very insightful. Cultural habits and attitudes vary from culture to culture, as we know. But the point that you are making here seems to be that using members of the community to seek information from other members of the community, when they know each other, is actually a taboo of some kind. Can you explain that a bit more?

**Mr Ramsamy**—The thing about that is that when you know that person is a member of your own community, they are privy to things that an outsider would not be aware of. That puts the person in a position of weakness. With our people, they not only look at the verbal, they look at the non-verbal, especially people whose second language is English. They will go straight to the non-verbals.

**Mr ALLAN MORRIS**—How should we handle that?

**CHAIR**—Non-verbal: what is that?

**Mr Ramsamy**—Body language. What you are saying may not be interpreted the same as your body language is saying. People can simply communicate—

**CHAIR**—The president of Indonesia is taking that stance now, actually.

**Mr Ramsamy**—That point all comes back to cultural awareness.

**Mr ALLAN MORRIS**—How do we handle that? What is your advice?

**Mr Ramsamy**—By giving real prominence to cultural awareness and cultural

training. I know there is a big push on from a corporate level with Queensland Health, and it is good to see, but I would just like to see that reinforced and reinforced again.

**Mrs ELIZABETH GRACE**—I would like to follow that up a little more, please. The previous speakers talked about the need to have people of indigenous origins trained up and working with indigenous people. They talked about how the health workers are being trained and how they are encouraging or wanting doctors to come from the Aboriginal and Torres Strait Islander community and to go back into that community to work. But you are saying that if they come from the same cultural background as the people they are dealing with, there could be a difficulty in communication.

**Mr Ramsamy**—If they are from the same community and it is a sensitive issue.

**Mrs ELIZABETH GRACE**—How are we as an administrative bureaucracy, which is where it is all going to come from, going to be aware of that? Instead of appointing someone to Palm Island who could be culturally sensitive and therefore nobody will go to see this particular person because of that, how do we know who to appoint as person B because they will be more acceptable to the people? That is probably what you are trying to say, too, Mr Morris. Even though they would be aware of a cultural difference, and we can teach them that, the bureaucrats are not going to be aware of that finetuning, that very sensitive area of who is acceptable and who is not. Have you ever thought about that or talked it through or worked out a way of perhaps indicating to us which way we could go in that area?

**Mr Ramsamy**—You would have to speak to the people.

**Mrs ELIZABETH GRACE**—It goes back to speaking to the people. So you would go to Palm Island and ask them if the person was acceptable?

**Mr Ramsamy**—Yes.

**Mrs ELIZABETH GRACE**—It is as simple as that; do you feel that would work?

**Mr Ramsamy**—They will be the clients. It is a funny thing; the community is in a continual moulding and transformation. I think the doctor used the word, ‘multiplicity,’ and that is certainly true. One day you can be smelling of roses, and the next day you stink like hell.

**Mrs ELIZABETH GRACE**—So, again, you have another challenge then to keep continuity of service and things like that. There has to be a fair bit of flexibility built in, doesn’t there?

**Mr Ramsamy**—The pressure on people from the community working in the community is intense. They are continually torn between their professional commitments and their community commitments. It is a knife’s edge, and it is underestimated. But I

guess people who go on to become doctors, who get to that level, really have honed their professionalism and, hopefully, that professionalism will override any community feelings. If that person were from that community, the community knows from childhood and beyond who that person is. They know their familial links, et cetera. I am not really giving you answers, but it is very difficult being in a professional position when you are from the community because you are constantly between two worlds.

**Mrs ELIZABETH GRACE**—That is very interesting. It is not something that I have been aware of—and I am sure there are plenty of other people who are not—that there is such pressure on you. Even though we think we are doing the right thing by putting people of your origins into your communities to work with them, it is not all going to just flow; it has to be monitored very closely.

**Mr Ramsamy**—It has to be appreciated that we can be—I am talking for myself now, being in the manager's position—really beneficial if we do it well. If we do not do it well, then it can go very bad.

**Mrs ELIZABETH GRACE**—Thank you. That has been very useful.

**CHAIR**—This is what happens if you go on too long with your introduction: you get interrupted by committee members asking questions. It might be appropriate for us to now turn to questions.

**Mrs DE-ANNE KELLY**—Andrew, you mention here the Aboriginal, Torres Strait Islander and South Sea Islander Community Health Forum and that it needs to be encouraged. Can you share with my colleagues a little more about how it operates and what its aims are, please?

**Mr Ramsamy**—That particular forum is representative of respected people from three cultures. It is in many respects a unique situation in that we have Aboriginal, Torres Strait and South Sea islanders. You are well aware that South Sea islander people are not indigenous with the Mackay community. The South Sea population is significant. As I mentioned in my response here, that community certainly has a significant impact on the Aboriginal and Torres Strait islander community. We have put this forum together because we in Mackay understand that, for the health and wellbeing to be addressed correctly, the Aboriginal, Torres Strait and South Sea islander communities need to work together.

It is set up based on terms of reference. The terms of reference are still to be adopted by the district. Essentially, at this stage it is just built on goodwill. Each culture recommends their own delegate. The other two cultures do not have a say. That culture brings their delegate to the table that they wish to put on to the forum. It is entirely up to that culture as to who they bring to the table. It is a tenuous forum. We have to continually work on it to keep it together because of the outside influences by the community.

**Mrs DE-ANNE KELLY**—You mention at page three of your submission that there is pressure and envy from native title between traditional and historical members of the community. What do you mean by that?

**Mr Ramsamy**—I hate using percentages, but about 97 per cent or 98 per cent of our community would not be eligible for native title. There have been relationships, family links and people living side by side for years on end. Recently things have changed. Those changes have been good and well deserved for certain people, but for the majority who are historical or who do not meet the criteria for native title it is certainly in a lot of cases not something beneficial. My concern at this stage is to focus on that majority to work alongside with the legitimate people for the area, but I really have a main concern with the majority who are not going to benefit.

**Mrs DE-ANNE KELLY**—What would you rate as the most important things we could do to assist raising the health levels of Aboriginal, Torres Strait and South Sea people?

**Mr Ramsamy**—In my community, and my community perhaps being unlike any other, there is a significant impact on Aboriginal and Torres Strait islander people's health by the South Sea islander community. I am struggling to keep the Aboriginal, Torres Strait and South Sea cultures walking alongside each other because of so many differences and so much water under the bridge. Really, we are at a new stage for our community of trying to get the three to work side by side and to understand that we need to do that because that is the way to address the health and wellbeing of the Aboriginal, Torres Strait and South Sea islander people from the Mackay community.

**Mr ALLAN MORRIS**—I have two things to ask you, but first of all I want to preface my question. I can recall being told by a leader of a community in the Kimberleys about when the bright young men and women got to go to high school or to university. Those young men and women went to Perth and they lost them. They did not have a strong enough culture and they never came back and they never saw them again.

This appears to be the problem we have now. The brighter ones are unable to be trained in some of these fields. Some seem to be citified and, if they leave their community educated, they do not come back, or else they do not go onto school. Can you give us any advice? We have been asking a number of people the same question from different angles, from different perspectives. But, from where you are from, what advice would you give us to take your brighter students and help educate them in a way that makes them likely to come back to Mackay or places like Mackay?

**Mr Ramsamy**—They have to start young. The problem we have in our community in particular is that up to a certain age you are allowed to run free and wild—speaking from experience—and suddenly you get to a point where you have to take on a whole new thing, and to take on that whole new thing is a big culture shock. You have to leave your home community. You have to turn your life upside down to be able to meet the criteria

of going into this new arena. A lot of people just take the easy way out and say, 'Blow that. I'll go back home.'

**Mr ALLAN MORRIS**—Do you have any advice for us?

**Mr Ramsamy**—You have to start young to really give it a good chance. If you do not, you really need to have what I call 'influencers'. There are a number of influencers in our community, people who work very hard to appropriately influence our young people.

**Mr ALLAN MORRIS**—For example, if we talked to you or someone like you and said, 'We are looking for possible nurses, science students or medical students, can you help us work with those younger people and help us maintain and support them both here and when they go onto university or whatever?' would that be a way of doing it? In that way, the community helps to select the students rather than simply the institutions or the high school certificates, or whatever it might be.

**Mr Ramsamy**—It is hard to do that because the environment can change for the person you have in front of you in your home community and for the person who is sent away.

**Mr ALLAN MORRIS**—You do not have to answer it now, but you will get the *Hansard* in a few weeks time and, when you are looking at it, you can think about it. You may have some advice that you can offer that may be a process to help with that. I am not saying there is an answer, but you may want to give it some more thought. The big challenge is trying to find an answer to that question.

**Mr Ramsamy**—One of the things we are working on is bringing Mohammed to the mountain, if you like.

**Mr ALLAN MORRIS**—Or both, so we actually do crossover. Secondly, you make a point in here about the respect for the professionals by their professional institution. I think the point was made to us in Brisbane yesterday that, if we send people back and not treat them as full professionals, it is quite damaging to their communities. I think you make the point in here about that, and I was not aware of that before yesterday—that is, in many cases, nurses were not treated as nurses by the mainstream nursing profession.

**Mr Ramsamy**—The term 'health worker' that I use is for the Aboriginal and Torres Strait Islander and South Sea Islander health workers. They are separate from, I guess, the professional health workers.

**Mr ALLAN MORRIS**—So you are saying that you want people to be respected by their professional peers, not considered to be second class.

**Mr Ramsamy**—Yes. The professional people have to understand that our people

are in a very awkward situation. They are on the knife's edge. If the professionals are not showing the credibility to the health workers, the community is not going to—people have laughed in the face of my health workers.

**Mr ALLAN MORRIS**—I think that is a very valuable point, and I am pleased you have made it. Again, after today you might think about what we have been discussing. If you want to add any more or drop us any more notes, I encourage you to do so. It would be helpful for us to have some more advice on those two things in particular. If not, that is fine. But, if you can, we would be grateful.

**Mrs ELIZABETH GRACE**—Mr Chairman, could I just put on the record my congratulations on a very good submission. There is a lot of material in there, very succinctly put, very easy to read, very easy to understand. You should follow up with Mr Morris's suggestion because in hindsight you will probably think of other things. Having received this on fairly short notice, we have only started to digest it. Congratulations. If there were other people involved, please take our congratulations back to them.

**Mr Ramsamy**—I certainly will. There is a whole community back there.

**Mrs DE-ANNE KELLY**—I would like to offer my sincere thanks, too, for a very useful and well thought out submission, Mr Ramsamy.

**CHAIR**—Thank you, Mr Ramsamy. It is good of you to give your time. What you are actually doing here is connecting you and the people you are delivering to to parliament via a standing committee. Our job is to make sure we convey those views adequately and get the attention of the parliament—that is our challenge. We are not going to be rushing in on this inquiry. We want to do it right because, as I said in my opening statement, we want to see some progress on this. We have been 20 years at it. It has been a good exercise today. We may well talk some more if we have got any further inquiries. You will get a copy of the *Hansard* record, as Mr Allan Morris said. Thanks once again.

**Mr Ramsamy**—Thanks for the opportunity.

Resolved (on motion by **Mrs Elizabeth Grace**):

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

**Committee adjourned at 3.02 p.m.**