HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

ALICE SPRINGS

Monday, 20 April 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:

In view of the unacceptably high morbidity and mortality of Aboriginal and Torres Strait Islander people, the Committee has been requested by the Minister for Health and Family Services with the support of the Minister for Aboriginal and Torres Strait Islander Affairs to inquire into and report on the following matters:

(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

ALICE SPRINGS

Monday, 20 April 1998

Present

Mr Forrest (Chair)

Mrs Elson Mr Quick

Mr Allan Morris

Committee met at 9.27 a.m..

Mr Forrest took the chair.

CHAIR—I am very pleased to open this, the seventh day of public hearings of the committee's inquiry into indigenous health. It is an inquiry referred to us in June last year 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.

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 to the health status of those communities, and that there still exist barriers to access to mainstream services for Aboriginal and Torres Strait Islander people.

I need to say on behalf of committee members present, and those who are not, that, after 20 years, we feel the same sense of frustration that Aboriginal communities feel. This is the first formal hearing of a federal parliamentary committee in 20 years. That frustration still exists.

The hearing in Alice Springs today follows previous hearings in Canberra, Hobart, Adelaide, Perth, Brisbane and Townsville, and provides a further opportunity to explore issues with representatives, locally based organisations and individuals who have made submissions to the inquiry. Today's hearing also enables members to familiarise themselves with local issues before conducting a series of visits to communities in the region over the next three days.

It is planned that following this there will be further hearings in Cairns and visits to Far North Queensland and the Torres Strait Islands in the first week of May. The committee is also intending to visit remote and rural areas of Western Australia and Arnhem Land to gain first-hand experience of living conditions in those areas.

As I have already indicated on previous occasions at hearings of this inquiry, we need 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 practical strategies to move on from here.

I would like to introduce the committee to representatives here today. Mr Harry Quick is the Deputy Chairman. He is the member for Franklin, south-east Tasmania. Mrs Kay Elson is the member for Forde, an outer suburban Brisbane seat. As Chairman, I am from a rural seat in the north-west corner of Victoria, and I represent a significant number of Aboriginals. Mr Allan Morris, the member for Newcastle, a New South Wales coastal seat, was a former Chairman of the committee in the prior government. He is a useful member because he has some very good initiatives around Newcastle. There are actually 14 members of the committee, but we are not all here today. Members go to some

inspections and not others; there is a difficulty with programming everybody.

I would like now to welcome representatives of the Central Australian and Barkly Aboriginal Health Workers Association appearing before the committee.

[9.30 a.m.]

ABBOTT, Mrs Kathy Anne, President, Central Australian and Barkly Aboriginal Health Workers Association, PO Box 9264, Alice Springs, Northern Territory 0871

ELLIOTT, Ms Rosemary, Project Officer, Central Australian and Barkly Aboriginal Health Workers Association, PO Box 9264, Alice Springs, Northern Territory 0871

FRY, Ms Debra Gwen, Project Officer and Registered Aboriginal Health Worker, Central Australian and Barkly Aboriginal Health Workers Association, 1st Floor, 24 Parsons Street, Alice Springs, Northern Territory 0871

McMASTERS, Mr Tony, Acting President, Central Australian and Barkly Aboriginal Health Workers Association, PO Box 9264, Alice Springs, Northern Territory 0871

CHAIR—The committee has already authorised your submission and its publication in the volumes of submissions in connection with the inquiry.

I would like to give you an opportunity, Debbie, to make an opening statement to summarise your report to us. It has been some time since it was sent in. I have to say that the committee is very keen to conduct the inspections that will follow on from this formal hearing today. We have heard lots of good things about on-the-ground activities and we are anxious to have a closer look at some of those. We would like to hear from you as to why your particular emphasis could hold the key to delivering better health outcomes, because that is what the real determinant is. It would be a fine recommendation to achieve.

Ms Fry—We have some papers here so I will read through them first, and then you can ask some questions later, if you like. The main issue is how to improve Aboriginal health. We say indigenous health service structures must be strengthened. Our focus is on those structures relating to the Aboriginal health workers.

The four main strategies we propose today to achieve this are, first, to promote and support development of regional health worker associations; second, to develop appropriate remote indigenous health worker education; third, to investigate legal impediments affecting Aboriginal health workers in the eight Australian legislatures; and fourth, to end financial inequity in remote practitioners' incentive programs. Excuse me, I am a little bit nervous.

Mr ALLAN MORRIS—If that is a written submission, we might be able to get copies of that rather than having you read through it.

CHAIR—Just relax with us. It would be much more comfortable around a camp fire, but that is really all this is. It is just a chitchat. The formal part of it is simply to get

the evidence so that we can refer to it and study it later on. Please relax.

Ms Fry—Strategy A is that the Department of Health and Family Services must support development of regional health worker associations. Usually Aboriginal health worker issues have been represented at planning forums by non-Aboriginal health workers. The result of this paternalism is a waste of indigenous health resource and a waste of state moneys on poorly informed projects—for example, the national Aboriginal health worker forum proposal, the national Aboriginal health worker competency standards and the development of inappropriate educational structures. How can health planners consult with a work force that has no proper channels to represent itself?

The primary recommendation of the 1997 National Aboriginal Health Workers Conference was for the Commonwealth to support and fund the establishment of regional health worker associations, as a 1997 report to the Commonwealth states. However, our association is the only fully operational independent health worker association in Australia. The fact that our association has been so successful is largely due to the opportune use of generous funding obtained through an alliance of health professionals and the community controlled sector. This funding option is no longer available for other states. The funding of health worker associations will be cost-effective for the Commonwealth. We recommend that the Office of Aboriginal and Torres Strait Island Health facilitate the establishment of regional health worker associations and provide ongoing funding support.

Strategy B is to develop appropriate remote health education for an indigenous health work force. The 1979 House of Representatives Standing Committee on Aboriginal Affairs reported—

CHAIR—Was it that long ago?

Ms Fry—Yes, it was 1979. It reported that:

The Aboriginal Health Worker training program developed in the Northern Territory should be a model upon which the state training programs are based.

The praise was justified. The NT health worker training was based on the recognition that health education and provision of primary health care services must be inseparable. Aboriginal health workers were selected by the community. Aboriginal health workers learnt on the job, as trainees, in their community. Aboriginal health worker trainees were provided with basic health literacy and numeracy training. Aboriginal health workers were required to achieve basic clinical competencies. Employer, trainee, clinical team and community were tightly bound.

The sad fact is that this NT model is being destroyed, undermined by the combined interests of educational institutions, short-term Territory health cost saving and inappropriate national training agendas. Even the reasonable desire by Aboriginal health

workers to have a proper career path has been used to undermine the very grassroots of our profession. Educational institutions receive money for bums on seats and not success in the work force. State health services do not see training as their responsibility and the Commonwealth has not addressed this issue.

Few remote low literacy health worker recruits have any life experience of mainstream work or education. At great expense, they are dragged long distances off their communities to sit in classes, often taught by poorly experienced earnest lecturers with little idea of the students' needs or skills. They return to the clinics run by overworked nurses, with neither time, obligation or understanding how to follow up the student. Some remote students sit it out, knowing that this procedure is what is needed to get a job. Most others drop out. They are often mature age people with family responsibilities, shamed by literacy problems, harassed by domestic problems when away from home, unable to live on Abstudy, confused by irrelevant lecturers' concerns and poorly supported in their community clinic.

To compensate for the shocking standard of primary and secondary education in remote communities, all the job literacy based training models have been grafted on remote communities. After 10 years of this model in the NT, Aboriginal health workers, their communities and grassroots health teams unanimously recommended that entry level education for remote indigenous health professionals be work and community based. Despite overwhelming support for community based training, Territory health services have progressively abandoned the old delivery mechanisms in the name of professionalism. It is more likely that changes have been undertaken so the state health sector can off-load its training responsibilities.

The community controlled sector has kept many advantages of the old training system. The bigger centres have also some of the advantages from being registered training organisations. However, they largely get funding for training by a wide variety of time consuming and unpredictable funding sources.

Meanwhile, the Commonwealth has funded the development of national Aboriginal health worker competency standards tied to AQF3 base level competency training. Please note here our strong revision to our published submission to the inquiry regarding AQF levels for entry level to be the profession, as contained in the accompanying article.

The high AQF3 level training outcome will often only be achieved by lying about performance or by forcing many remote people out of the work force. By bracketing all Aboriginal health worker recruits into the same high AQF level, either primary health care training funding will be channelled away from Aboriginal health workers or else those Aboriginal health workers wishing to progress to high certification levels will be hamstrung in the absence of reputable qualifications.

Currently skilled health workers have very few training options to specialise and

develop their career path. In short, the current competency standards, even when customised, will not allow proper remote entry level training and will, therefore, also disadvantage high achievers. Please note that these same processes are emerging for other community service competencies. Currently national competencies do not cater for remote needs.

We recommend training for the remote indigenous health force must be community and work based. Primary health care providers must have core funding for primary health care training delivery. Communities—through health councils, community boards or their clinics and students—must be funded to determine their own health education delivery mechanism and needs. The Commonwealth Department of Health and Family Services must take responsibility for streamlining and funding remote primary health care education. The Commonwealth must assist communities in the provision of adequate remote infrastructure to support community based educators.

Remote primary health care training funding must not be tied only to inappropriate national competencies, AQF levels and educationalists to agendas. We recommend the promotion of professional development of Aboriginal health workers by improving resources for higher education and clinical training. The Commonwealth must accept the intimate relationships between educational achievement and health in remote Aboriginal communities.

CHAIR—Are these strategies A, B and C consecutive strategies—they are not alternatives?

Ms Fry—Consecutive strategies, yes.

CHAIR—One after the other. This is really an excellent submission. It is punchy, you have recommendations. To save you the trouble of reading all of it into the *Hansard*, we can simply agree to have it transcribed. I have let you read it because it has helped you relax a little bit.

Ms Fry—Yes, I am a bit nervous.

CHAIR—But you could simply summarise your recommendations, if you like. The committee has read your previous submission and this is reiterating that again. Clearly, you are frustrated about the style of training Aboriginal health workers. We have heard that and that is why we are here. We would be keen to tease a little more out of you and use the time more practically if that suits you.

Ms Fry—There are just a couple of other things.

Mr ALLAN MORRIS—If we incorporate this as part of the *Hansard*, it gets written into the *Hansard* as if you said it anyhow, and then we can talk about it.

Ms Fry—Okay.

Mr ALLAN MORRIS—Which means more time for questioning and talking to you about what it means.

CHAIR—Are members happy to have the document incorporated in the transcript of evidence? There being no objection, it is so ordered.

The document read as follows—

CHAIR—Would you like to just condense the summaries that occur with strategy C and D? Other members might like to add to the comments that you have made.

Mr ALLAN MORRIS—You also mention a submission and an accompanying article.

Ms Fry—Yes, we have that. I will just finish with the recommendations. We recommend that the Commonwealth Department of Health and Family Services fund a national inquiry into the legal impediments affecting health worker practice in each state and territory. The Department of Health and Family Services must recognise health service delivery in remote communities is based on multi-disciplinary remote teams and allocate incentive program funding accordingly. The Department of Health and Family Services must recognise remote health service delivery by non-GPs needs proper financial remuneration.

Basically, just to go on from what we have here, the association since its formation has been working very hard to overcome a lot of the issues that affect Aboriginal health workers: the training and career structures and professional issues. One of the things that worries us is that we are being steamrolled by other people's agendas into accepting things that will not work out there for us. Too often we have had people standing up—the bosses, the managers and so forth. They are on the panels that decide how the health workers will train and how they will work.

Unfortunately, until the formation of the association, we have not had a voice to be able to get on those panels and to have our voice heard. We believe that if we are able to establish associations throughout Australia we can achieve the same sort of work that we do here. We believe in working together with the doctors and nurses and supporting proper teams.

We think it is very important for the improvement of Aboriginal health that the grassroots from all over have input into saying how their health can be improved. They are the ones that know how to do it and they are the ones that we need to hear about. So, until we get associations up and running, you will not be able to hear their voice and you will have the same ineffective health care delivery service that is happening out there today.

Mr QUICK—How does the community decide who the Aboriginal health workers are? I am coming from about as far away as you would ever want to get. Community A has got, say, 200 families, and you have specific health needs. Do you decide, 'We need six to work in collaboration with the state and Commonwealth health services', or do you need four or do you need two? Are they chosen because they have got a particular spot in the indigenous hierarchy of that community? Can you give us some sort of background?

Ms Elliott—This is obviously Kathy's question. I would just like to introduce

Kathy. Kathy is one of the longest serving Aboriginal health workers in the Northern Territory. She has worked for about 25 years. She started in the community control sector and then she was a health care worker, educator, manager for Territory Health Services for a lot of years. She has the basic skills; she knows more about that question than anybody else in Australia, really.

Mrs Abbott—I guess part of it is the process—that is, it is important for education and training that the Aboriginal communities have their say in terms of selecting the individuals, mainly because there are sensitive issues such as avoidance relationships, especially when you have some committees there which have come together in terms of different tribal groups and things are very sensitive in terms of their approaches. So they actually take on the process in terms of the status of that person, but also gender too, which is important, because I think while the communities have been very proactive in selecting helpers it is mainly with regard to the elderly status of the health care worker. I think the younger generation in some way have not matured enough to be able to take on most of the sorts of decisions that people need to talk with government departments about, or even to doctors and nurses.

Mr QUICK—The young people who hopefully gain an educational advantage and perhaps get into some tertiary medical training, how are they going to fit back into the system that has been developing over the last couple of hundred years or so with Aboriginal health workers? How are they going to fit in, and how are they going to reflect modern medical trends in order to narrow the gap between indigenous and non-indigenous lifestyles and health outcomes?

Mrs Abbott—Again, it goes back, I guess, to the selection in terms of life experience. For a young person who is about 18, 19 or 20, if they are going to talk about women's health, really it is a very sensitive issue in terms of where they stand with the whole community full of grandmothers because that person has not got the actual authority or the status to be able to talk about women's issues on, like, anatomy. I guess a lot of committees selected young people such as within a family model, like a husband and a wife with two children or something, or a young person with responsibilities who has got children. That is how they in some ways reflect the responsibility of that person.

Ms Elliott—Could I just say, when mentioning tertiary education, this is the Northern Territory we are in. We are not referring to the east coast. We suspect our principles apply there too but, meanwhile, we are talking remote and northern remote. To talk tertiary education is nothing to do with what we are talking about. We are, of course, really in favour of developing career structures that can incorporate people being able to articulate from health worker training to being a nurse or a doctor if they choose to.

However, at the moment we are mainly concerned with absolute grassroots entry level. That is what we are concerned about. We are concerned that everybody is so concerned with this educationalist, sort of literacy based training, that the grassroots has

been decimated. Given that most Aboriginal health issues are not to do with medication, they are to do with everything, the very people Kathy is talking about—that is, the people with responsibility, knowledge and power in the community—are completely deleted by the current training system.

It is those people Kathy is talking about that can address the big issues about community structure, family, all the destruction of the community. It is those people who can address it. Young kids might have better literacy, although that is, I would say, doubtful. They may have better literacy, but they do not have anything like the power, knowledge, status of the people Kathy is talking about who are precluded in the current education agenda.

Mr QUICK—Under strategy B, you mention here that health workers are selected by the community. My first question was, on what basis, and you have answered that, I guess. They learn on the job as trainees in their community. Obviously, you are in the top sort of echelon. Do you go about selecting people to replace you in the system? How is that done? Are there people in their 30s who show an obvious inclination or a rapport with health issues? Do you take them under your wing and say, 'Look, here are the things that you need to learn'?

In my mind, taking our cultural sensitivity into account, we have got this huge disparity. We have been pussyfooting around for 20 years but we still do not solve the problem. Now if you have got the answers, we would like to know how we can achieve what you consider to be achievable. So that is why I am asking all these, what sometimes might appear to be, impertinent questions. How do you go about selecting the people to replace you and what sort of financial resources do you need to say, 'Look, these are the things that you need. You need to learn A, B, C, D, E and F or whatever, and, in order to do that, you need money to hire a truck to take you to the Alice Springs Hospital so that you can develop relationships between the people there that are keen to improve the standards for our community', or whatever it might be.

So, how do you go about training your trainees and how do they receive their basic health literacy and numeracy training so that, if there are forms to fill out, they are not overwhelmed by all the bureaucratic paperwork that someone shoves under their nose? What sorts of competencies? Is it a basic St John's Ambulance first aid certificate, or is it an advanced certificate, or is it an understanding of resuscitation and CPR or diabetes training and all those sorts of things?

Ms Elliott—Excuse me, what is the question? You have asked so many questions.

Mr QUICK—I am asking Kathy how does she choose the people to replace her and how does she decide what they have to learn, and how does she ensure that they learn what is needed. That is basically all the things on page 2 about Aboriginal health workers.

CHAIR—Leave the question there. We will try and take them one by one.

Mrs Abbott—Firstly, I can only reiterate my experience in terms of working in the Congress medical services when they were first newly appointed. It was a sort of medical service in Central Australia. We were approached by the community, but a lot of consultation was given, or done by a doctor and two Aboriginal field officers that went around looking and talking to the people about what type of service they wanted additional to the hospital system.

So, basically, they said, 'We would like four cultural brokers who speak languages', for instance. There were two Aboriginal ladies who spoke language, but there was me and another girl who spoke English more fluently. So, therefore, we were able to cover, I guess, the communication more effectively that way.

In terms of how we went about our duties, we all learnt the same things on an equal basis, according to what the nurses and doctors taught us. Basically, we started our internship as a team and operated how a general practitioner would function.

When it was time for me to leave, I wanted to be able to look at how effectively the health service would run without having to be dependent on me. Basically, the other three did not have that interest like I did. I guess motivation was up to the individual to be able to stimulate themself in the area of interest. A lot of people sometimes get pushed into being managers or educators and it is often not their field of work.

I advertised for other applicants to be health workers. First of all, you had to tell them what the role of the health worker was to be able to establish the interest there. It so happened that my cousin, another Abbott lady, who had more higher education than I had—I only went to grade 7 and she was a second year student—actually stepped into my shoes. She developed her own style which had that leadership to be able to lift the other three up.

The other three, in some ways, made their appointments according to their specialisation. One branched off to be a dental health worker and another one branched off to be a fringe camp worker working alongside the community health nurse, and another one just stayed within the operations of the health service.Eventually, each individual picks their own area of interest. They are limited in terms of going. I think that for a lot of the health workers that I had the opportunity was to be able to learn on-the-job literacy and numeracy and training, especially when trying to communicate with a diverse type of group coming in to look at the service.

Most of our training was clinical and five years down the track we took on board St John's first aid because it was not part of the package that we got trained in. It so happened that seven health workers went to a wedding up in Darwin and none of us knew how to attend a person who had a cardiac arrest. It took the ambulance a long time to

come. A lot of people were shouting for us to respond, but we were frozen. We just did not know what to do.

I swore at the time, being a manager of the health service, 'The health worker must learn first aid.' I think that is part of where we could save a life, whether it is in the service or outside.

Mr QUICK—Have you drawn up a basic list of competencies that you see should be vital for all Aboriginal health workers in your part of the world.

Mrs Abbott—Yes, we have that.

CHAIR—That is what this document condenses, is it?

Mrs Abbott—Yes.

Ms Fry—Mr Quick, I was out in a remote community a few weeks back, and I asked female health workers why there was not a male health worker working in the community. They said, 'Because we have no-one we can trust,' and that is basically all it boils down to. If they have not got the trust, they will not support them in that position. The person must be of high standing and have respect in the community, and that is what the community selection process means.

Mr QUICK—So that community theoretically is disadvantaged until someone comes up, and there is no likelihood of bringing somebody else in from another community because of the cultural sensitivity.

Ms Fry—No.

Ms Elliott—Just one thing, the community selection process, which used to be very strong in some communities, especially community controlled ones, has now broken down because of the literacy requirements from Batchelor. The community still has to sign the form saying, 'Yes, we approve Jenny to be a health worker.' They still sign a form, but they have not selected that person themselves. They have just approved it after the process has all happened.

Kathy's story is that the past experience has been broken down. Now you are not getting the 40-year-old responsible people. You are getting a 19-year-old girl with no status, because she might have slightly better literacy.

Mrs ELSON—When you said high standing, did you mean within their own community rather than education ability?

Ms Fry—Yes.

Mrs ELSON—I found a conflict there. You were handing over your position because you did not think you had the education, whereas you had the community standing. I thought that was why you thought that someone who had a higher education was better at your job.

Mrs Abbott—No, it is not that. It is just that Lana had the relationship of the community dynamics.

Mrs ELSON—I am sorry, I got that mixed up. I thought you said you only went to grade 7 and she had a higher education and you thought she—

Mrs Abbott—No, that is not a disadvantage.

Mrs ELSON—I would have presumed that, in your community, standing would have been a lot better than the education. But if you are going to send them off to be health workers or bring them to the Territory to do it, do they need an education standard to be able to understand the procedure?

Ms Elliott—That is a hard question.

Mrs ELSON—Yes. It seems to be a mixed one. Hands-on to the community to me is far more important.

Ms Fry—A lot of the health workers are saying that, when they started training, they had very low literacy and numeracy, but they gained it through working. They gained their literacy and numeracy as they worked. It was on-the-job training. What they were learning clinically meant they were also getting the written as well. That is how a lot of them taught themselves to read and write.

Mrs ELSON—Within the communities, there is a lack of education.

Ms Elliott—Definitely.

Mrs ELSON—And that is where the problem lies.

Ms Elliott—They used to have basic literacy and numeracy training in the package that Kathy used to be involved in, but now that is all gone. There is no basic literacy and numeracy training anywhere.

Mrs ELSON—In any of the remote communities?

Ms Elliott—No, there is nothing. There is just the normal structure in adult education. You can go and do competency Z in anything you like now, but there are no adult educators out there and no literacy or numeracy backup. A lot of the remote

communities say the off-the-job training is an excuse for people to go to town and get drunk.

Mr QUICK—With satellite communication and distance education, surely the communities have linkages into distance education.

Ms Fry—A few have in the remote communities out there but, unfortunately, there are so many that do not have it.

Mr QUICK—Are there any communities that use distance education effectively to upgrade the qualifications of their people in whatever field they want to undertake? Are there none in the Northern Territory?

Mrs Abbott—Yuendumu has the Tanami network which was looking at distance education for children. Rather than having kids go into town, they would have a network there so that the students could get it.

CHAIR—I am familiar with the Tanami. In fact, in one of our previous reports we recommended some funding and that actually came through.

Mr ALLAN MORRIS—Could I pick up the thrust of what Ms Elliott and, I think Ms Fry, were saying. In the article you were talking about the production of an AQF2, which is a lower level of care. You were concerned about the loss of the earlier package or hands-on community based program. I understand that. But one would also require that communities have access to high quality capacity as well. We need to have a way in which we could have people both working at the very primary health level fields and only an associated geographic level, or people working in terms of better hygiene and community activities rather than simply in health.

Unless we have people who could then migrate their way through to become doctors, nurses or health workers we have lost the plot. We would always be sending in strangers who are both insensitive and inappropriate. It seems to me that, whilst you are pushing a position to fill in the gap below the AQF3—and I take your point fairly strongly and accept that fairly well—you do not seem to be putting forward a proposal as to how you get beyond the AQF2 and AQF3 to go upwards as well.

Ms Fry—Our proposal for community based educators would allow our health workers to do their job in the community. They could then work their way through the levels, get their certificates of attainment as they accomplish the skills needed, so they could then go on to do a higher certificate level. We are saying to allow us to train in the community with community based educators and we will gain those skills. As we gain the skills, we will go up higher in our career structure to achieve higher standards.

Mr ALLAN MORRIS—That would mean your working in with other accredited

organisations at the higher levels. What you are really saying in here is that you cannot really do that because these people do not relate to you.

Ms Fry—No. We are fighting for the base entry level to be a health worker. At the moment we—

Mr ALLAN MORRIS—Yes, I accept that, and I am very supportive of the thrust of your submission. I have got no problem with that. I am just trying to actually link that into the rest of the world. I am saying that unless we link that into the rest of the world, we may improve primary health care but we will still have problems with cardiac arrests, cancer diagnoses and all the other kinds of issues that people will still have. So in here you are basically saying that the organisations that related to their higher accreditation and their higher training did not relate to you?

Ms Elliott—No. We could have written an eight-page submission and gone into higher education. We have got just as many ideas about the higher education side of it as the entry level. We are very concerned about the nurses development, remote nurses, post diploma training—and that is great. The health workers would like that, too. We just do not have space to go into that at the moment. We think that unless we target this entry level, there will be an emptiness there. So we want to extend it at both sides. We want lower and higher, but we are just concentrating on lower.

Mr ALLAN MORRIS—Yes. You made that point very well. But tell us what we could recommend that would help influence the accrediting and training institutions? You are saying that the system was taken over by people who do not know what they are doing, they are really pushing it up too high a scale and they have lost the plot. And I think that that is a fairly pertinent comment. But how do we get those people to actually recognise, firstly, the things you are putting forward here, but secondly, to be able to be influenced by yourselves in the longer term?

Ms Elliott—Could I just say that we are new at this game, and to try and find your way through the woods of all the changes in education at the moment is a nightmare. I am sure that you all know this nightmare because you are trying to do it yourselves. In the end we do not want to get bogged down in all that bureaucratic stuff because it is changing too much for starters.

Basically, the key demand is that education for primary health care services means a core funding. It is not education department business; it is health department business. Education of the workers is part of primary health care issues and we do not want to actually even know about—

Mr ALLAN MORRIS—These programs—

Ms Elliott—We are trying to keep out of the whole education debate in a sense

and just leave it to the health department as their responsibility.

Mr ALLAN MORRIS—I accept that. So you are saying that the DEET funding that was there before as vocational training should have, in fact, been picked up by health.

Ms Elliott—No. The DEET funding can remain at certificate 3 or 4, or whatever they like. They can keep doing that. We are not trying to steal money from—

Mr ALLAN MORRIS—No. That is okay.

Ms Elliott—We just need educators in the community to provide education according to how the community perceives the need.

Mr ALLAN MORRIS—So you are saying in your submission that DEET were providing that and then it moved up market and money went and DEET went.

Ms Elliott—That is right.

Mr ALLAN MORRIS—And that should be a health function and not a DEET function anyhow.

Mrs Abbott—It was our vocational training through DEET. That is what we did. But that is where it went to Batchelor, and Batchelor has gone a bit higher again.

Mr ALLAN MORRIS—Yes. You are saying now that health should take those responsibilities to put that program back because it is primarily a health function and not an education function?

Mrs Abbott—Yes.

Mr ALLAN MORRIS—Is that a fair way of determining it?

Mrs Abbott—Yes.

Ms Elliott—They have bucketed it at the moment, certainly in the Territory—I do not know about anywhere else—but they have just thrown it all away. They have abandoned traineeships because they have not got the money.

CHAIR—They have not got the money, or they do not think that it is appropriate. That is what I am trying to get a handle on.

Ms Elliott—Both, maybe—who knows? They will not tell us. We have asked them. We write and we write and they will not tell us.

Mr ALLAN MORRIS—So you are saying to us then that we should be seeing health at that primary level, at the hands-on level, in much the way that DEET was in the past, and education and DEET and others should perhaps be involved at a higher level, helping to take people up, above and beyond that primary health care stuff. Is that a fair interpretation of what you are putting forward?

Ms Fry—The association has been involved for nearly two years now with the national competency standards. We have been working with ITAB, AMSANT and Territory Health Services in the customisation process. The competency standards allow for the higher ed. As you grow, so your education grows too. It is all there for people who want to go up further, so you could become an educator if you wanted to, you could become a manager or a specialist, once they are customised. So we have the road map there to follow. It is just that we do not want to lose that bottom rung to the ladder which is what they are trying to enforce on us.

Mr ALLAN MORRIS—What you are saying to us is that we should recommend to the Commonwealth parliament that the Commonwealth should ensure that funds should go the states for health, particularly Aboriginal health, and that part of that funding should be devoted and dedicated towards in-house training of primary health care workers at a lower level than the academic AQF3.

Ms Fry—Yes. They can build on it. They can achieve those higher levels. We do not want to cut them off from achieving them at all.

Mr ALLAN MORRIS—I think you have helped me with that now because I was puzzled as to how you saw the metrics feeding together, and I can see now what you are saying. So the Commonwealth should be saying to the states, 'Here is money to be spent on Aboriginal health', and that part of that money should be going towards the training of health workers. It should be seen as being a health responsibility, not somebody else's, and it should be tied in by the Commonwealth to the states to make it a requirement of that funding.

Ms Elliott—Just a little thing that might be specific to the NT, because we do not know everywhere else. They have got a registration board here—

Mr ALLAN MORRIS—Who is 'they?'

Ms Elliott—The health workers have a registration board.

Ms Fry—It is the only one in Australia.

Ms Elliott—In the past, they were trainees and they got trained on the job and, once they achieved skills, they became registered and then they were in whatever career structure they had. Now, Territory Health are saying they do not accept trainees. There are

no trainees; it has to be all Abstudy. In remote communities there are registered, qualified health workers who have to suddenly spring out of the ground when there is a job vacancy. I am just concerned to say that, with that training money, which it should have, it is not all for post-registration in-service training, it is for basic entry level training. Sure they need the money for refresher courses, the in-services, all of that stuff, but it is for entry level traineeships.

CHAIR—At what level would that be when you say that?

Ms Elliott—Primary health care service provision.

CHAIR—What detail is it? Is it just some preliminary stuff about, 'This is what the human body is'?

Ms Elliott—The basic skills or what?

Ms Fry—You do pulse, respiration, clinical procedures such as sores, suturing and that sort of thing, and some of them fix broken bones. It depends on the needs of the community. They actually work to suit the community. They get the skills they need to look after the community.

CHAIR—It assumes already some literacy standard?

Ms Fry—A lot of the health workers that cannot read and write get the sister to fill out the form. They just refer it on to another person. If they have not got the reading and writing skills it does not stop them from doing the work. They are very effective out there. They just get other people to write for them.

Mr ALLAN MORRIS—What we have been looking at doing in terms of working with the states, and one of the things that has come up so far has been this problem about the Commonwealth and the states in terms of Abstudy or state scholarships. One of the things we are probing already with one state government, and we are probing it with others, is the possibility of the Commonwealth and states combining, because the education and training of people from remote areas is not just that they are from an interesting background, it is much more expensive that it would be for a person living in Sydney or Melbourne.

One of the things we are looking at is trying to persuade the states and Commonwealth to actually cooperate in traineeship type arrangements or cadetships or scholarships where they can actually do both, and that part of the training will be spent back in their own communities or their own country towns. There is a problem about doctors in remote areas and specialised health staff. What you appear to be saying is that the Northern Territory government is actually excluding itself from any of that at all. It is actually either Austudy or Abstudy. It is saying that education is not one of its

responsibilities in the health field overall.

Ms Elliott—They have done this against the advice of almost everybody on the ground. They have done it in a completely unaccountable way. They refuse to reply to correspondence. They refuse to do anything. They are completely non-accountable.

Mrs Abbott—When the communities select the health worker they do it on the basis that they know that person is going to work in the community. They have seen them work within that health service centre. But, suddenly, in some ways they make the people who have been selected accountable to both ways. At the moment when you are selected or even go up for training it goes to a bigger, wider thing like the state. You are employed by the state and not by that health service in the community from within. What we are saying is that we need money to be able to get them into the system of the health service, not the Territory Health. That is a bigger thing.

Mr ALLAN MORRIS—So job ownership must be down at the lower level.

Mrs Abbott—Yes.

Mr ALLAN MORRIS—Not simply be a mouthpiece for somebody in Darwin who tells you what to do. So the community must have respect and regard for that person who is actually there, and the job is owned by the community, even though the person is trained elsewhere or has other responsibilities.

Ms Elliott—I would just like to pick up this thing about the cost of remote education. I am not an accountant and I do not know this sort of stuff really, but I would take a punt that the cost of the proposal we are making is much cheaper than what you have currently got. You try bringing an Aboriginal health worker student from Docker River—a long way away—to do a course in Alice Springs or maybe even Batchelor, up near Darwin; how much do you think the administrative structure costs? How much does it cost, and how many of those students, those bums on seats, actually end up working?

Mr QUICK—Could I be the devil's advocate and ask, presuming you keep him or her in Docker River, is there the expertise and skills to supplement whatever they are learning from Alice Springs, Darwin, Brisbane or Sydney?

Ms Elliott—There will be once you have funded remote based education. What we are saying is, you fund some remote educators at the entry level primary health care, you fund them out there which means build them a house—that is expensive, but once it is there it is there—you pay them a wage and they just wander around, they are controlled by the community. They are not part of the big bureaucracy. We are not trying to make an educational edifice over them. They are funded by the community, they are out there doing the basics, they are getting the health workers trained and that is what we include here—the disabilities, the drugs and alcohol, the mental health, all of those health

promotion-type issues. They are doing stuff out there; they are training up the people.

When the workers actually get some skills, confidence and pride in their job, maybe they can look out and say, 'Gosh, I'd like to go and do that course in Batchelor', and then fly them out because they have already succeeded. You are improving them. All that is happening now is that Batchelor flies people out at enormous taxpayers' expense, and half the time they just drop out. There are not even jobs for them out there; there might not even be a job for them. It is a bum on a seat for the educator, but there is no job out there. You will have to understand—I am talking really remote—these people have no life experience about work practices and education practices. To suddenly say, 'You're going to go and do a course and then you're going to come and be a worker'—I mean, really!

Mrs ELSON—How many come back? Do you have any figures?

Mrs Abbott—Some tend to come back to the community once they have done the training but they are too frightened to even go back in the clinic. So the actual ageing population that we have got is health workers who did it in the 1970s. They are still hanging on and hoping we can have these young people. In some ways it gives back to that community, to have that on-site educational package that we are trying to sell. That is the way the Aboriginal people can then look at the young people getting into the work force, not taking them away outside the community. You have to establish the roots back from within.

Ms Elliott—We are not having a go at higher education from Batchelor. That can develop. We are not having a go there at all, but at the undergraduate level, the entry level has gone down.

CHAIR—Might I suggest to you that their inappropriate thinking is driven by the need for national standards and that that is driving it, so therefore we have to get a standard. In fairness to them, perhaps that is a perspective that they adopt which you can say is inappropriate. How would you comment on that?

There is also the other concern that the on-the-job training requires someone to be doing the training and that takes them away from the clinical contact that they are supposed to be doing as well. There is an extra need for funding of the trainee also located in the isolated communities.

Ms Fry—The nurses that are working out on the remote communities are saying that their work time is full-on clinical. They have not got the time or the resources to train health workers and it is a problem. Unless they go away to Batchelor, where else are they going to get their training? They have to come into town and do training through Congress maybe, but they are still away from their community.

Mr QUICK—What is the current pay structure for Aboriginal health workers? Are there levels 1, 2 and 3?

Ms Fry—Yes.

Mr QUICK—How much do they earn? Can someone tell me?

Ms Fry—The basic starts at $21,000 for Grade 1.

Mrs Abbott—It varies between the community control service and the health department. The health department's salaries have gone up more than the community control service's salaries have.

Mr QUICK—How much does a base grade Aboriginal health worker get a year?

Ms Fry—If they have a full-time position, they get $21,000 a year. A lot of our health workers are part-time. As they are only paid part-time positions you could halve that.

Mr QUICK—And what about a top-of-the range Aboriginal health worker who has been around and runs the community?

Ms Fry—There are still some out there that have not had a wage rise in 15 years.

Mr QUICK—What do they get?

Ms Fry—They are still paid on $25,000 or some incredible low amount and they run their clinics.

Mr QUICK—So you have a person theoretically on $25,000 a year—

Ms Fry—Yes. It is really hard.

Ms Elliott—This is the issue about the Medicare thing. THS has a new award. It is brand new. The top level health workers who have mainly management positions are on very reasonable pay I do not think you could sneeze at. But the problem is that there are grade limitations, so in remote communities currently there are only X number of higher positions. It does not matter how good you get at saving lives, there is only one grade 2 position out at your place, honey, that's it. That woman is stuck on whatever it is—$28,000.

You have to understand that health workers are variable. Some of them run the whole community in terms of health. They can do anything—look at babies, suture. Some

of them can do very little. But there is absolutely no incentive to take on more clinical responsibility while there is this grade limitation. I do not know how you get round that.Class 6 at THS has good pay, but it is all management currently, although everything is in flux at the moment.

Mr QUICK—Can you give me an example of an Aboriginal community like Yuendumu? Do they have 10 or 15 or six or two Aboriginal health workers?

Mrs Abbott—They only have seven basic health workers there.

Mr QUICK—For a community of how many?

Mrs Abbott—A community of 1,200.

Ms Elliott—Twelve of them are sitting down, aren't they?

Mrs Abbott—Yes. In 1970 there used to be 12 for every 100 because of the different skin groups.

Mr QUICK—Who decides how many you have? Is it up to the Commonwealth department to say, 'We'll give you an allocation per capita,' and if you have 1,200 people you need 12, one for every 1000? Does the community decide it? Does ATSIC have a go?

Mrs Abbott—No. The department does it by ratio. For every 100 you get a full-time health worker.

Mr QUICK—At what level?

Mrs Abbott—It varies. For instance, my community used to have a grade 2 and a grade 1 health worker. It has a population of 135.

Ms Elliott—One of the submissions in here by Plan Health recommends it should be a one to 50 ratio, although it would slide in the towns. In big urban centres you would not need one in 50. But that is probably right. Of course, the more out-stations there are, the more problems there are.

Mr ALLAN MORRIS—Have you read all the submissions so far yourselves?

Ms Elliott—Most of them.

Mr ALLAN MORRIS—If you wanted to make any observations on some of those submissions that might be helpful to us, given your experience and where you come from, in terms of helping us understand better and if someone says something that you do not think is very accurate or good advice. We get submissions from people from all over the

country. Some of those are really very good and some are probably not so good.

CHAIR—The observation you have just made is very valuable for our assessment of the evidence.

Ms Elliott—The main thing is that at least half the submissions use the term 'Aboriginal health worker'. That is it, end story.

Mr ALLAN MORRIS—Your submission today raised what I see as a real problem. With this question about legal things, on page 4 about Aboriginal health workers you say:

A national legal framework for Aboriginal health workers is neither possible nor desirable.

That is a bit disturbing. I would have thought that it is important for your clientele to have a legal framework simply so there is some protection available for the workers themselves who have some sense of professional registration and recognition at the two levels if need be and so both their patients or their clientele are protected. I was a bit puzzled. There needs to be a recognition of a health worker and some recognition of standards of some kind. How you would pitch those and how you would define those could be argued.

Ms Elliott—I am looking at those who establish regional health worker associations. Because the variation in practice is so great, you could not possibly—

Mr ALLAN MORRIS—Perhaps we should be putting funds into helping establish those associations. Perhaps one of your recommendations should be that the Commonwealth should be prepared to insist that the states assist in funding the establishment of regional associations across the country.

Ms Elliott—That is our first recommendation.

Mr ALLAN MORRIS—It is not quite in there at the moment.

Ms Fry—I thought we had it. On page 2 at the top, we say:

We recommend:

Office of Aboriginal & Torres Strait Islander Health to facilitate the establishment of regional Aboriginal Health Workers Associations and provide ongoing funding support.

Mr ALLAN MORRIS—I was looking at the ones at the end there.

Ms Fry—Since our association has been formed, we have been able to access other panels such as the rural incentive program—CRANA and that. We are very keen to establish teamwork.

Mr ALLAN MORRIS—On page 2, was that not your recommendation but the recommendation of a conference—of the association?

Ms Fry—But we do recommend that.

Mr ALLAN MORRIS—Okay, so you are personally—

Ms Fry—And it was our recommendation from the NT conference too, I might add.

Mr ALLAN MORRIS—That was not clear from my reading of it. You were quoting it, but you were not necessarily recommending it. That is why I was puzzled.

Ms Fry—All right. We will clarify that.

Mr ALLAN MORRIS—So you are saying that you very much personally recommend that kind of view.

Ms Fry—Most definitely, yes.

Mr ALLAN MORRIS—Good.

Mr QUICK—Is the problem of Aboriginal health workers completely different in, for example, Darwin, Katherine and Alice Springs compared to that of people in the traditional homelands or are the problems exactly the same? When we make our recommendations, do we need to suggest that perhaps there should be more financial compensation for more rural and remote areas compared to the Redfern indigenous people who have different community health problems compared to perhaps Darwin, Kintore or Yuendumu or other places?

Ms Elliott—I would be a bit worried making a recommendation there because the health workers in the urban areas would be dealing with more alcohol related issues which they might not have in their communities here. You would really have to look into saying we should fund some more than others. I do not think I would be happy to give an answer.

Mr QUICK—If you have a problem in Darwin it is just a matter of getting in a car and racing across town. But if you are seven hours away by truck—

Ms Fry—Yes, that is true.

Mr QUICK—you need to have something based in your community or wait for the Flying Doctor Service to come in. It has rained and the runway is inoperable. In order to strengthen Aboriginal health workers in certain areas, initially to balance the scale you

ought to have some positive discrimination in funding and training. Ms Elliott said about keeping the kids there rather than taking them out into higher education. In order to balance things up, obviously they are not doing so at the moment. I would imagine if you are an Aboriginal health worker in Alice Springs that it would be a lot less stressful than in some of the remoter communities.

Mr McMasters—In the town, in the remote community out in the bush, I think we have all the same problems as health workers. When you start in a health worker job, you are stepping right out of your comfort zone. You have to step into the mainstream, and it is really hard. You have just come in off the street, you might as well say, and you are just going in and doing medical work and all that stuff and you are not properly trained. There are lots of expectations put on you, and you cannot fulfil the expectations.

Mr QUICK—So can you answer this question for me, Mr McMasters? In a community like Alice Springs or Darwin where you have different tribal groups coming into the town for whatever reason, is there an expectation that there are Aboriginal health workers for each of those groups within those big cities? Or, if you are from tribe A and there are no Aboriginal health workers there, do you miss out because tribe C cannot look after you because of the cultural sensitivity? Is that the case?

Mrs Abbott—I think both the health department and the community control have done a fair share of trying to accommodate the different tribes that come to access the service. They have employed a lot of people with different languages to be able to deliver that primary health care service in terms of their programs. I think the department has more or less preventative programs where they have employed Aboriginal people to be educated for the communities but, again, it is like somebody commuting out when really you should be having somebody within. I think non-Aboriginal controlled services have not got additional money to be able to be generous in terms of their programs, so they need money to be able to employ people to do preventative programs.

Mr QUICK—As you probably realise, we are wandering around, flicking here and flicking there, trying to get a picture of what is happening around Australia. If we went to community X, and they have got the best system operating, and if only all the other communities were operating like community X—are there examples where we can go to? Given all things being equal, community X—despite not having enough money—has skilled operators and it is doing a bloody good job and they are the lighthouse. If the money was there and all the other communities could be exactly the same as community X, where is community X?

Ms Fry—Rose, would you like to expand on that?

Ms Elliott—I do not know whether it is true. I am just wondering whether it is true what I am going to say. Nganampa Health Education, which is a South Australian mob—I do not think you have got a submission from them—have a very interesting

education system. They are SA; they are not NT.

Mr QUICK—We have got to wander around.

Ms Elliott—In terms of health worker education stuff, you should talk to the health worker educator, Cindy Cole. I think she has got a lot of ideas and a lot of experience there.

Mr QUICK—What worries me is that *A Current Affair* and *60 Minutes* highlight, 'This is the worst in the world', but we never see, 'This is the best.' We have looked at them and figured out how they operated, what they went through and what they have got. If we provided the funding for all the other places, using that as a model, we can replicate that around Australia and save a hell of a lot of money, time, energy and lives.

Ms Elliott—I think there is one place that is doing pretty well at the moment, but I do not think you could replicate it. It is Urapuntja Health Services. They have actually got some funding for—

CHAIR—For Mr Quick's benefit, yes, we will be going to both of those tomorrow.

Mr QUICK—I thought it would be good to ask these people because they are the experts in this part of the world.

Mrs Abbott—Lake Nash, which is on the Queensland border, have a good immunisation program, I guess, in terms of getting community education and even the team involved with the mothers. Their record system is really spot on. I have seen that.

Ms Fry—So are Anyinginyi in Tennant Creek. Are you going there?

CHAIR—It is the good operating models, effective models, that we want to look at.

Ms Elliott—Also, a lot of the community controlled here have tried to develop an Anyinginyi Congress, Danila Dilba. They have tried to develop their own education thing. They have got their own education services and they are producing excellent health workers. They are doing a half-way house. Because they are not remote, they can do certificated courses. They can become RTOs, registered training organisations. Even in those places, their funding is not secured. There are some good experiences there. The Congress is coming, so you can ask them what their needs are. I do not think they have got any secure funding. What about in Territory Health Services?

Mrs ELSON—I want to ask you this as you are the best one to answer this question. You have been involved in the health area for Aboriginals for the last 20 years. I

am trying to get the answer as to why things have not changed over those 20 years. You have been hands-on in the community. Why aren't Aboriginal people accessing the services out there? I think you said there were something like 1,000 or 2,000 people in one particular area. What percentage of those people would actually access health, and what is the reason they are not accessing health?

Mrs Abbott—The health problems that you have got today were not there at the time when a lot of us health workers saw a lot of those things. Most of the things were common problems that we had to treat. Again, it is sort of like what we are saying, in terms of getting money to be able to specialise, to meet the needs of the community, often that money is not there—or even the position and the training.

Mrs ELSON—The services are not in some areas?

Mrs Abbott—Yes.

Mrs ELSON—And that has not changed over 20 years.

Mrs Abbott—Services are still the same. In terms of just looking at that basic primary health care delivery, a lot of people are saying, 'We want just the basic health service; we don't want our mob to go and be doctors and nurses.' They had a vision where a lot of us would have been doctors and nurses. That was the answer in the 1970s. It is still the same answer, too, but we will never ever get us wanting to go any higher.

Mrs ELSON—Because it means leaving the community, does it?

Mrs Abbott—Yes. I guess it means a whole lot of things. If you uproot your grassroots, you have basically lost your whole identity and status within the community. It is really hard. I guess the whole community expects to have the training delivered within and the resources to be within.

Mrs ELSON—How many non-Aboriginal people have been working in the health industry in the areas where you work? Has it been a high percentage compared to the Aboriginal health workers?

Mrs Abbott—More and more, I guess, because, again, the Territory Health Services have just finished.

CHAIR—At least that aspect has improved in 20 years. The participation—

Ms Elliott—No, more and more whites.

Mrs ELSON—That is what I was trying to determine.

Mrs Abbott—Just in terms of the restructuring of Territory Health Services, they are at the stage where they are implementing, restructuring, in remote area community centres, looking at education and looking at more additional staff. A lot of that is going to be more non-Aboriginal people because, again, their duty statement that is written for that particular position does not allow for our mob to get competitive.

Mrs ELSON—So nothing has changed. So that is why the system has to change, because it is not encouraging Aboriginal people to come into the health system. It has not been working at the moment. In other words, it is non-Aboriginal people who are doing the majority of the work.

Ms Fry—Even the things like the job descriptions and that, they are not targeted for Aboriginal people. There are quite a number of different things as to why they will not go into it. The selection criteria and that, they might think that they do not have the skills, that sort of stuff.

Mrs ELSON—So is there anything in the Aboriginal education system—I am talking about the six-year-olds starting school—that encourages them in the area of health? To me, it has to start in their education so that they understand the important issues of looking after themselves. Is there a lack of education in that sense?

Ms Fry—The Aboriginal people practise health promotion right from day one. From the minute they are born they are into the preventative treatments, culturally, with the smoking and the children and that. Maybe our ideas of education and theirs are a little bit different.

I believe that they are getting an education, whether it is from mum, nana or grandma. They are passing on that education all the time. If they have not got a teacher there to give it to them they are getting it from somewhere else.

One of the things we are doing at the moment, and Kathy is involved in this, is a history of the Northern Territory health workers. What we plan to do with that document, once it is finished, is to use it in the schools by going to school career days and really promoting Aboriginal health workers as a career. If that is answering your question—

Mrs ELSON—How long has that area of health education for Aboriginals been taught in the schools—as far as accepting responsibility for Aboriginal health goes?

Ms Elliott—I think you have to see schools out in remote communities where you might have a school with something like two teachers who have to do everything. They might have 60 students and they often have to shower the kids and be everything in the universe to them—it is a nightmare for them.

Mrs ELSON—I know, but you have to start somewhere. That is what I am trying

to say. The system is not working—

Ms Fry—When they have the education program the health workers actually go into the schools and deliver health promotion in the schools. It is very effective and there should be a lot more of it.

Mrs ELSON—That is what I was trying to determine, whether there is somebody going into the schools rather than giving the responsibility to the teachers who have more responsibility than they can handle. That could be the answer.

Ms Fry—Yes.

Mrs Abbott—We are also thinking that a lot of the Aboriginal health workers are at the stage of having literacy and numeracy training and they are very effective in terms of preventative programs.

Mr QUICK—Where does the Central Australian Aboriginal Congress fit into what you guys do? Are they—I will be impertinent—part of the problem? I am going to ask them the same question.

Ms Fry—How do you mean part of the problem?

Mr QUICK—You were talking about how it should be bottoms up. We have ATSIC and the Central Australian Aboriginal Congress. What is the relationship between those two and you guys?

Ms Fry—The Congress itself is a community controlled organisation so it has its own community representatives directing them and it has its grassroots structure there.

Mr ALLAN MORRIS—I am not sure whether you are aware of the processes but you will get a copy of the *Hansard* of today. I notice some of your friends who have been listening have wanted to say things and so on. If there are things you want to say to us, having read the *Hansard* and seen what we have been asking, please feel free to drop us a note. This is not necessarily the end of the discussion. You can, if you wish, send us some more material arising out of today that you think, with hindsight, you should have told us about.

Ms Elliott—I would like to read a statement from someone. 'We are going through a holocaust, we are into genocide and we need to provide primary health care on the communities and primary health care education as part of core funding. That way people will stop dying from liver disorders, suicide, heart, kidney, diabetes, et cetera.' That is a statement from the gallery.

Mr ALLAN MORRIS—You are welcome to send more material to us as a result

of today.

CHAIR—As a committee we may feel the need to talk to you again as a result of what we see over the next few days as well. I would like to thank your association for the trouble you have taken. It is a very good punchy submission, as I said before, with some recommendations that we will address. Thank you for your time.

Proceedings suspended from 10.44 a.m. to 10.59 a.m.

BOFFA, Dr John, Senior Medical Officer, Central Australian Aboriginal Congress, PO Box 1604 Alice Springs, Northern Territory 0871

LIDDLE, Mr John, Director, Central Australian Aboriginal Congress, PO Box 1604, Alice Springs, Northern Territory 0871

CHAIR—Before we proceed, I need to point out that, while this committee does not swear witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives itself. It is a formal process in order to get what you have to say, the important things you have to say, on the record for us to consider while we are writing our report.

The committee has already authorised the submission received from the Congress, and these are part of the publicised volumes of the inquiry. There is no need to feel the need to reread all that into the record, it is already there. Mr Liddle, you might have an opening statement to make to condense what the Congress's concerns are and then we will proceed to questions from the committee.

If I could introduce Mr Harry Quick, deputy chairman, a Tasmanian, Kay Elson from Queensland, Allan Morris from New South Wales and myself from Victoria. Mr Morris has been chairman of the committee before; he is well versed in activities associated with our inquiry. Mr Quick serves on another standing committee on Aboriginal and Torres Strait Islander Affairs.

We have read your submission. There is no need to feel that you have to re-brief us. We are anxious to get to some examples of bottom up, good results—that is, good results, driven from the bottom up. That is why we have come out here to Central Australia to spend some time in the next few days.

I am aware that Congress has been saying for a long time that there is a need to drive health reform for Aboriginal people from the grassroots. We are wondering on this committee why on earth it is not happening. But it is our objective to make some recommendations to parliament to do something about it.

This is the first inquiry we have had in 20 years federally, from a parliamentary committee's point of view. We do not want our current activity to be regarded as just another inquiry. We are really quite serious and we have got a bipartisan resolve to see something done. This is your opportunity to make sure we make the right recommendations. Over to you, Mr Liddle.

Mr Liddle—Thank you very much and I would just like to thank the committee for coming to Alice Springs and making time available for people to come and speak to

you. Basically, I would just like to give a bit of an overview of what Congress is.

Without boring you, I would just like to say it is an organisation that is heading into its 25th year of operation. During that time, it has not been all plain sailing; it has been very rough seas over that time, in regards to us getting the recognition from all the authorities around Australia and especially within the Territory.

When the Congress first started, it basically started as a political organisation. In the early 1970s, there was a lack of representative organisations that spoke on behalf of Aboriginal people in this area. Land councils were not in existence, legal aid organisations were not in existence and nor were other organisations that currently provide those types of services to the Aboriginal people of this area.

Some of the issues that Congress fought long and hard for were things like encouraging people to actually go and vote in local and federal elections. We used to have a lot of resistance, especially in the rural areas, from pastoralists who encouraged the resident Aboriginal population on their stations not to take the opportunity to vote. They did that through a number of ways. One of them was intimidating people by saying, 'If you vote, I am going to throw you off and you will have nowhere to live,' and those sorts of things. Congress, over the years, has had lots of long hard fights with people on the cattle stations. That is only one of the issues that Congress has fought about.

During that time it has grown from a staff of about three full-time people, in an office maybe even a little bit smaller than this room, into a large organisation with a budget of about $4 million. Most of that comes from OATSIHS. We do get some money from Territory Health Services. Most of the money comes from the Commonwealth.

Our board, which basically oversees the operation of that through me, is elected every year at an annual general meeting. We have to go and face the community to tell them what we have been doing over the past 12 months. Sometimes that is a bit rocky, as with most Aboriginal organisations that have to go through the AGM process. But it is a good thing. People can come along and have their say and make their views known on what they think of the organisation or how the service is provided.

We offer a seven-day-a-week, 24-hour operation in our clinic. Our clinic starts at 8.30 in the morning and finishes at 8 o'clock at night. Our doctors are then on call after that through an after-hours number. On Saturdays and Sundays, there is a morning clinic at our main clinic.

We are also trying to get back into one of our original operations of Congress. That is to have a mobile bush clinic operation that goes to people living on out-stations or land that has been handed back to them through land claim processes and through a scheme which the Labor government had a few years ago in regard to handing back stock routes—the core red areas, in bureaucratic terms. They are basically the stock routes that

have been handed back to communities. Some are only 100 yards wide in some parts and sometimes they go to five or 10 miles wide. Sometimes they are only basically a house-size block or maybe five or 10 acres or something like that. Most of the land is very narrow and usually the water and other services that people require are not there. People are basically living there in deplorable conditions.

The main thing that they want to do is get away from the effects of living in town or in fringe camps around Alice Springs or in other parts of Australia where people have come back to their land. It has been a long hard struggle to try and maintain some sort of services to those people. We do that service once a week. We visit these communities within 100 kilometres of Alice Springs and we have three people working on that. A doctor goes out once a week and two health workers do the rounds in a fitted out van.

CHAIR—Is Dr Boffa clinically involved as well?

Mr Liddle—He basically oversees the medical side of our operations. Do you want to enlarge on that, John?

Dr Boffa—The clinic itself sees about 22,000 patients a year. We employ eight medical officers and about 18 Aboriginal health workers. Going back a couple of years, we had enormous difficulties recruiting medical officers. We were down to two and a half at one stage which meant that two and a half doctors would maintain the after-hours service whilst they were running the clinic.

That has been improved upon. That situation has been improved largely through effective cross-program coordination, which is one of the things that Congress has been advocating since the transfer of health back to Commonwealth Health. We have been able to get the rural incentives program, which is a program within Commonwealth Health but not in OATSIHS's area, to provide effective assistance to help us recruit medical officers, so we are now fully staffed.

I think the clinic and basically all Aboriginal health service clinics are underutilising their potential for early detection of diseases. The workload is patients coming in who are very sick and have so many complex medical problems that, unless you have adequate resources, it is often all you can do to treat them here with the problems they present with. You have not necessarily got time to take the opportunity to ensure that you are doing effective yearly screening for chronic diseases, such as making sure that while they are there, no matter what they present with, you are making sure they have not got high blood pressure or renal disease or other chronic health problems.

Congress has a quality assurance program that is registered with the Royal Australian College of General Practitioners. Part of that program is to ensure that every patient that comes through the door has one of those yearly screens done in addition to their presenting problem. That has been a major step forward. At various times that is not

always possible because of staffing levels and workloads. In a lot of community health services that is a goal that they could not possible realise at the moment. They are basically treating the people with their presenting problems full time and are unable to take the opportunity to effectively put in place early detection programs. That applies particularly for substance misuse.

It has been shown that taking the opportunity when someone presents to do a brief intervention for alcohol, smoking or any other substance misuse is very cost-effective. It is much more cost-effective than funding programs outside the primary health care sector that attempt to find and sit down with and talk to people in their communities. One of the success stories of Congress is that there are large numbers of Aboriginal people coming through the door. In a given year, 22,000 people come through the door. Some of those are multiple consults, but we have about 19,000 active client files in any one year.

With the help of OATSIHS we are now getting a new medical information system. That is quite important because at the moment I could not tell you how many of those patients had been multiple times and how many had been once and, of our whole client population of 19,000, how many of those people come in every year and how many we do not see. That is information we need to have to be able to effectively plan. It is information we will have once we have the new medical information system, which is being installed at the moment.

Here we are in 1998 and an organisation as large as Congress has not got an adequate medical information system through which we could effectively give you the answers to those questions, which are very important. It would seem that taking the opportunity through primary health care services to look at early detection programs is a much more cost-effective and efficient way to go than to be funding all sorts of programs outside of the primary health care sector.

Basically, we have a very active clinic. It is open from 8.30 in the morning until 8 o'clock at night and then it is on call. It is open on weekends—Saturday 8.30 to 12.30 and Sunday 8.30 to 12.30 and then it is on call. It is a 24-hour service, which is very important.

CHAIR—In your submission you have very good statistics on some of this, but really you are saying that it could be better. One of the things that you have said in here is that the only intervention that makes an effective, immediate difference is intervention in respect to pneumonia. Are you saying that, while you are busy treating that, you do not have time to check whether they have kidney problems or other problems?

Dr Boffa—Yes. We have instructed all our staff to make time. We do a weekly file audit as part of our quality assurance program to check on every practitioner in our clinic on whether they are making time to fill in those check lists, those early detection process. We are constantly at staff to do it. Probably more than 50 per cent of the patients

that come through the door are having that done. But we want it to be 100 per cent and we want to be able to identify, if it is a resource issue, why that is not happening. It is a very important mechanism for providing comprehensive care for patients.

CHAIR—On page 5 of your submission, you also are able to say childhood mortality has dropped significantly and give examples. Are they from your own records?

Dr Boffa—No. That is from data.

CHAIR—Is that just national data?

Dr Boffa—The Territory health department has an epidemiology section which is headed by a fellow called Dr John Condon. Just in the last probably five years, he has started producing data in a way that I think is amenable to organisations like ours getting it and making use of it.

For instance, most recently, back in 1995, he looked for the first time, in publishing the birth weights of Aboriginal children, at breaking down the birth weights by region and separated the data for the Northern Territory. For the first time we could look at data that was broken down into Alice Springs urban, Alice Springs rural, Tennant Creek, Katherine, Darwin and Arnhem Land. Darwin urban was separated from Darwin rural. In doing that he was able to show that in that year the birth weight of Aboriginal children in Alice Springs, for the first time, was better than the birth weight of non-Aboriginal children. That was the first time in history. That was a very important statistic for us. Data is not broken down in that way.

For instance, even the latest figures that he has just released show the continuing trend in improvements in perinatal mortality, infant mortality and birth weights of Aboriginal children, such that it is getting close to a situation where it is only twice that of non-Aboriginal people, which, although it is unacceptable, is better than four times, which it was 10 years ago.

In presenting that data, we have asked for that data again to be broken down by region because when you break the birth weight data down by region you see that in Arnhem Land there has not been a great change but in Alice Springs there has been a massive change. Then you start to ask why that has happened. Our analysis is that that has happened for a number of reasons, one of which is, importantly, access to primary health care services. Another one is that women in this region have their own organisations through which they have greater control over their lives. They have Congress Alukura, they have arts collectives, they have women's councils and they have organisations that women have set up for women which women run. Another one is that we think there is probably better access to education in Alice Springs for women. I do not mean health education; I mean general education—although in our submission we make the point that that is still a major problem.

They are the three things that internationally have been shown to have an impact on birth weights and child mortality. Those three—access to primary health care, empowerment of women and education levels of women—are very important parameters in terms of improving that. I think the improvement that has occurred has probably happened because of those three factors in Alice Springs.

The data that has been presented is starting to be analysed in ways that are useful to us but it still needs to continue down that process. Now we have regional planning forums where the primary health care sector, the Territory health department, the Commonwealth health department and ATSIC sit down together; that has only just started in the Northern Territory. This is an opportunity for us to say we need this data broken down in this way for us to make sense of it and for us to be able to accurately say what is going on in Aboriginal health.

Mr QUICK—On page 6 you say:

. . . there is no simple, clear-cut medical intervention that prevents any of the top five causes of premature death for Aboriginal men and women.

That is a bit frightening.

Dr Boffa—It is. That is why we put that table in there. What we are saying—and it is an analysis that needs to be clearly understood—is that Aboriginal health has changed in the last 10 to 20 years. The birth weight of children and the mortality rates of children have very significantly improved, as I was just saying. You could expect that access to Western medicine through Aboriginal health services has played a big role in that and Western medicine has a very good ability to impact on the sort of illnesses that children were previously dying from.

When it comes to the illnesses that young adults—and we are going to say something today about youth suicide—and the community older than that are dying from, you are getting into the realm of problems that need to be looked at in terms of the spiritual, cultural and economic basis of those problems. Western medicine does not have easy solutions to problems such as youth suicide and to problems such as substance misuse.

Mr QUICK—Or 17 per cent of men dying from motor vehicle accidents.

Dr Boffa—Yes. That is largely and primarily alcohol related. Again, this chart is a way to show that if you look at data in a different way you come up with a different answer. Previously, before this was published in the medical journal, again by the Cunningham group, which is the epidemiology branch in the Territory, people were looking at the overall data for mortality for Aboriginal people. If you look at that you will see that ischaemic heart disease is No. 1 and cancer is even up there as a significant cause

of death.

CHAIR—They are up there on the mainstream.

Dr Boffa—Yes, they are up on the mainstream too. If you listen to what the community is saying, the community is always struggling around the fact that people are dying before their time and that is what is really impacting on the community. We could then reanalyse the data and look at the top five causes of death in terms of years of potential life loss before 65; you would get a different priority ranking. You can see that the community, when they are worrying about substance misuse and petrol and those sorts of issues, are quite right in saying they are the number one things that are killing people too young.

That is why we are arguing you need comprehensive primary health care as a way of delivering health care that delivers sick care, so it makes sick people well, but at the same time an organisation like Congress is active on a whole range of other fronts to try and address the underlying issues that are causing these health problems.

And so Aboriginal medical services are in a unique position to be able to do both. They are not just medical services that deliver sick care. I have just said that as well as delivering sick care we have early detection programs in our clinic. But if you go outside the clinic to the area that John is primarily involved in, it is in the area of health policy and community development programs where Congress is trying to tackle the issues that are causing these problems here. And that needs to be recognised because too often government thinks all that is needed is medical services. That is needed, and it has an important impact on child mortality and child morbidity—more on child mortality—but medical services on their own have very little impact on the things that are causing these problems here. You need a comprehensive primary health care service that is prepared to actually consider what are the broader issues that are causing these problems and what sort of strategies the community can put in place to tackle them.

Mr QUICK—Are there similar data for other states and territories?

Dr Boffa—Not that I have seen. Not broken down in this way. Again it is something that shows that the epidemiologists in the Territory are becoming responsive to the dialogue that they have been having with the health services. And the health services are putting their hands up and saying, 'Look, what people are complaining of still is alcohol, petrol, youth suicide and things like that.' That is what people are coming through the doors of the office saying—'What is Congress going to do about this?' And yet, when you look at the data, programs come down to ischaemic heart disease, cancer, breast screening and this sort of stuff—which is important but not adequate for the sort of primary problems that people are confronting.

CHAIR—Could you run us through some initiatives on all of those? There is the

youth suicide one and the substance abuse preventative stuff.

Mr Liddle—We have been funded from Commonwealth health as one of 13 pilot programs around Australia; they are social and emotional wellbeing projects that have been set up in major cities and towns around Australia; there are 13 of them. They have basically been in operation for about nine or 12 months. With the people that we have got there, they are basically dealing with counselling youth and their families about the stress and strains that they are living under. In this town I think over the last 12 months we have had most probably eight youth suicides. We had one last week. Something needs to be done about it. I think it all links into the other problems that are listed on the table where people just find it hard to want to live in this sort of environment.

Mr QUICK—Were those eight all Aboriginals?

Mr Liddle—Yes. A couple were non-Aboriginal above that.

Dr Boffa—A couple were non-Aboriginal above that.

Mr Liddle—Yes. So it is an epidemic that we are trying to come to grips with.

Mr QUICK—So that is almost one a month.

Mr Liddle—Just about, yes.

Dr Boffa—And that is new.

Mr Liddle—Yes. We had a death in custody about a month ago—three weeks ago?

Mr QUICK—What do you mean that is new, Dr Boffa?

Dr Boffa—If you go back, prior to July last year there had been maybe two suicides. There had been a very small number over the previous five years amongst Aboriginals—not a great number. In the last 12 months or less—since July last year—there has been that sort of rate, mainly in Alice Springs, but also in the surrounding areas.

CHAIR—Harry, could you just let Mr Liddle finish. What we want to find out is what you are doing differently that you feel is having success. Youth suicide is a problem across the whole sector. What are you actually doing here that is different and that you feel confident is working? It is getting through that there are all the cultural issues and everything else, but it is youth in general who just do not feel good about themselves. The number, whether it is one or eight, does not matter; it is still unacceptable. That is probably what we really want to get our hands on here today. That is just one aspect. What are the things that you feel that you are achieving, driven by the grassroots level,

that you feel are successful.

Mr Liddle—Sometimes I wonder whether we are achieving anything, to tell you the truth. Back in the late 1970s, I sat down with a mate of mine and we counted up all the blokes of our age who were still alive. We counted 28 people who had died out of about, say, 50. These were people we had grown up with, gone to school with, played sport with, and all that sort of stuff. I think this trend, or epidemic, has come from the late 1970s and early 1980s and I think it is due to a lot of pressures that people cannot cope with. I do not know how many liquor outlets there are available, but if you just take the time to have a look around town, you will see that they are everywhere. We have even got the service stations that sell alcohol.

Congress, along with other Aboriginal organisations in town, has been advocating for years a reduction in the number of liquor outlets in town. Congress actually bought one a few years back and we relinquished that liquor licence as a way of reducing the number of actual licences available in town. Once you relinquish a licence, we were told, that licence cannot be given to anyone else. So that was just our way of making a statement. When we bought the licence, there was a large amount of alcohol stock in the shop. We actually poured that down the drain in a public ceremony. We were trying to get the Northern Territory government to implement a buyback scheme, as they did with the barramundi licences up in the Top End because there were too many barramundi licences. The Northern Territory government would not do that for alcohol licences, but they do for fishing licences.

We were trying to get them to come to grips with this problem that the Northern Territory has got in regard to the availability of liquor. It just seems to get back down to the one problem: that Aboriginal people are always suffering as a result of the liquor outlets, whether they are direct sufferers because of alcoholism, or whether they have experienced people keeping them awake at night. So it ranges across that whole cross-section.

It is very difficult for Aboriginal organisations in Alice Springs to try and maintain the fight against the availability of alcohol. I think that is where most of our problems come from.

Mr QUICK—When we were in Perth we saw evidence of the Aboriginal community there running their own bus service. They went around and picked up drunken indigenous people off the streets and put them into safe houses and had them working through a dependency program. In that way, there was less confrontation with the police and less jailing, and all that sort of thing. Is there something similar happening through the Congress? Would you like to see something like that operating?

Mr Liddle—There is something like that operating in Alice Springs at the moment where they have got the Tangentyere Council running a night patrol service. Basically they

intervene or try to assist people who may be seeking the opportunity to get into trouble, or get noticed by the police. So they try and make sure that that does not happen. Sometimes they take those people home, or take them to what we call in Alice Springs the 'sobering up shelter'. Drunkenness is not a criminal offence in the Territory.

Mr QUICK—But drinking in a public place is, isn't it?

Mr Liddle—Yes. But the law is not policed very well. It is a two-kilometre law. You are not supposed to drink within two kilometres of the licensed premises and if you look at most of the towns in the Northern Territory, if they use the legislation to the letter of the law, they could effectively throw most of the Aboriginal people out of towns on that basis. They have not really used the legislation as much as they would like to, I think. There have been calls over the last few years to get the Northern Territory government, through its police force, to use the two-kilometre law to its full extent.

Mr QUICK—In your submission there seem to be a plethora of Aboriginal health organisations. We have got the Aboriginal Medical Services Alliance Northern Territory, the National Aboriginal and Torres Strait Islander Health Council and the National Aboriginal Community Controlled Health Organisation. There are all these subgroups and substructures. Why can't we have what I call a mainstream Aboriginal health service?

Dr Boffa—This takes us back into something that we did not want to talk to you about. One of the ways that the Congress has been trying to deal with the crisis problems that come into our clinic is to work very hard trying to set up a national framework upon which these problems are going to be able to be addressed in the years ahead.

CHAIR—Just on that, the Northern Territory has not signed yet. How do you feel about that—frustrated or—

Mr Liddle—It was supposed to be signed in October or November last year. We only just came back from Darwin last week where AMSANT, as the body of alliance of all the Aboriginal and medical services in the Northern Territory, have actually signed. Wooldridge has signed and we are hoping that the Northern Territory government will sign—

Dr Boffa—In the next few days, I think.

Mr Liddle—So the pen is poised at the moment.

Dr Boffa—In answer to your question, I think that it is important to realise that if we go back to the situation that existed prior to the transfer of Aboriginal health funding to Commonwealth health, there were many more players in Aboriginal health. One of the reasons it was essential, and why Congress and Aboriginal health services in the Territory pushed for that transfer, was that in those days we set up the situation of what we called

intersectoral conflict. A key strategy in public health is that the health sector has to work with other sectors to address some of their big pictures.

Under ATSIC though, unfortunately, we had a regional council process where every organisation was at the table competing for funds from a bucket of money that was far too small. ATSIC had $50 million for Aboriginal health—the Commonwealth health sector has over $30 billion—so you had Aboriginal health services, Aboriginal housing associations, Aboriginal legal services, Aboriginal land councils, and everyone was around the table vying for funds which included the national Aboriginal health strategy funding. In terms of what existed then, you had the Commonwealth government set up with the health minister, the health bureaucracy and the health department not having much of a say. But through ATSIC, the health services and all the regional councils, there were a million other bodies advising about health. One of the big reasons we pushed for that transfer was that there would be one department and one minister—the health minister, who sits on cabinet, who has got power, who cannot buck pass, who has responsibility. We are saying that the Commonwealth government has to accept its constitutional responsibility for Aboriginal health. We wanted that translated into a commitment to fund primary health care.

As well as that, to be within Commonwealth health, we wanted to get what we called cross-program coordination happening. We realise that OATSIHS by itself is never going to be able to address Aboriginal health, in the same way as ATSIC could not. But within Commonwealth health there are other sections—the Medicare PBS section, the general practice strategy, and all these other branches—and because of the transfer they are starting now to be aware at least that they have got obligations to Aboriginal health. They are starting to actually direct more of their resources in directions which we think are going to help.

Another reason for the transfer was that we wanted simple funding arrangements. For instance, prior to the transfer, Aboriginal health services had to get their funding from multiple places. With the transfer, OATSIHS has become the major funding body for Aboriginal health services and we have been attempting to negotiate a three-year funding cycle so that every year we do not have to vie for funding to provide essential services.

I think that, in answer to your question, there is one Commonwealth department that is totally responsible for Aboriginal health and there is one peak body advising that department on Aboriginal health, and that is the National Aboriginal and Torres Strait Islander Health Council. At the state level that is mirrored by having a framework agreement which has the Commonwealth department—OATSIHS—the state health department, and the Aboriginal and Health Services state affiliate there at the table. In fact, we have simplified the process so that we should be able to stop this situation.

An example of things gone wrong in Central Australia has been the way that governments have approached the problem of petrol sniffing. That has been approached in

the old way, and if you look at what has happened with renal that has been approached in the new way.

The old way was that Territory health would call four, five, six or seven meetings and Commonwealth health would call four, five, six or seven meetings. The last meeting, which was a very large meeting held in Alice Springs, excluded the primary health care services. So none of us, including Congress, were there even though we are dealing with the problem. Each of the two governments ended up doing its own thing about petrol sniffing, completely unrelated to the other. That is going to stop. There has now been agreement from OATSIHS that that was the wrong thing to do and we are going to bring the whole strategy for substance misuse under the regional planning process.

Another example, which is a good example, is what is happening with renal disease. Congress got funding from the NHMRC some three years ago to conduct a 12-month research project looking at the whole problem of renal disease, which, again, is in epidemic proportions. There are about 62 Aboriginal people on dialysis in Alice Springs and it is rising at an exponential rate. After that 12-month research project which Congress did, recommendations were made about what needs to happen to improve the situation.

We ended up setting up a renal forum which included the primary health care sector, Territory Health, OATSIHS and ATSIC, which is a mirror of what is now being set up in terms of the regional planning process. That forum has been able to get on and start setting in place a strategy which I think is going to address a lot of the problems that are occurring in terms of renal disease. One of the key features of that was that, virtually immediately, the Territory health department and OATSIHS jointly funded a position for a renal coordinator whose job is to get on and work out a memorandum of understanding between the different service providers across all the major areas, including housing and accommodation, renal transplantation, dialysis issues, patient treatment, joint case management—the sorts of things that need to happen.

Because we are working together on that, the other thing that has happened now is that we have been funded from another section of Commonwealth Health for two social workers. So, for the first time, for those 61 people on dialysis there is 0.25 of a social worker at the moment. As you can imagine, when people have to relocate to town, and they are on dialysis, they have all sorts of problems with finances, with housing, with everything, and there were no social workers to deal with that. So through this process we have been able to get agreement that that needs to happen and we have been able to get funding.

The way of the future is to work collaboratively through regional planning processes—which requires a framework agreement to be signed; otherwise it is a farce. But if that happens I think we have a future. The strategies that Congress has lobbied so hard for over the years are getting put in place. If they are put in place, things like substance misuse, youth suicide—the sorts of things that are still in crisis proportions—

will start to get addressed because they will be addressed collaboratively, not competitively, and not with one government doing one thing and one government doing another, which has been the greatest problem in Aboriginal health, without any transparency.

Mr QUICK—Am I right in thinking, Mr Liddle, that you deal across state boundaries; that the people that you deal with in Alice Springs do not necessarily just come from the Northern Territory; they perhaps come from South Australia, Western Australia and Queensland?

Mr Liddle—Yes, they do. Alice Springs is a regional centre for three states, or I suppose you could say four states. You have got western Queensland, the bottom half of the Territory, with people coming from up to 500 to 600 kilometres away, and they come from the eastern goldfields area of Western Australia and from northern South Australia. Even though Congress is based in Alice Springs, I would say that about 45 per cent, maybe 50 per cent, of the people that we see are from areas outside of Alice Springs and a lot of them are from the other states.

Mr QUICK—So how are you working with the other states to deal with potentially their own state residents?

Mr Liddle—That is a problem.

Mr QUICK—As Dr Boffa says, obviously things are changing but we have got these arbitrarily drawn lines that say, 'You are in this state or that state.' Perth, Adelaide, Sydney and Brisbane are a hell of a long way away from where you are, yet you have got the problem right here in your own backyard. How do we develop strategies to ensure that the various ministers—

Mr Liddle—It is basically because we are a regional centre. Hopefully, with the signing of the framework agreement, we can lock those states in to put their hands in their pockets, basically. Until now there has been a gentleman's agreement, but sometimes it is not worth the paper it is written on. I know that there have been discussions between the three states with regard to STDs—sexually transmitted diseases—and other issues like that, but it does not cover all the aspects of Aboriginal health. The Territory, South Australia and Western Australia have been working for about three or four years with regard to an agreement. They have got a framework set up whereby they can monitor and design programs that can look at finding ways to reduce the amount of STDs in that area.

Mr QUICK—Is there a similar Congress in the northern part of the Northern Territory?

Mr Liddle—It is basically much smaller and much younger—it would be about five or six years old. They find it very hard to work with their state counterparts, people

from THS in Darwin. We have got a very good working relationship with our people that we deal with, and we go through Territory Health Services, but the relationship is not the same in the Top End. We are trying to encourage our sister service in Darwin to establish those relationships. Hopefully, with the signing of the framework agreement, things should go ahead.

Mr QUICK—Do you see that one of the solutions to this very intricate problem of Aboriginal health is that we somehow develop, encourage, sponsor—whatever the word is—congresses as peak lobbying bodies around Australia, and perhaps have eight or 10 of them, as we have regional councils. Is this the way to go? Then they would act as a filter for community groups who are saying, 'We know what our particular people need.' Their effectiveness in lobbying Darwin or Canberra is divide and conquer, but at least they have got you there as an umbrella organisation. As Dr Boffa said, it links in with the National Health and Medical Research Council and all those sorts of things. Do you see that as the way to go?

Mr Liddle—I think Congress advocated that from the year dot. Around Australia I think there are 90 to 100 equivalent services. Some of them are much smaller than Congress, which would be one of the largest and oldest in Australia. Our policy over the last 25 years has been to encourage other communities, other places, especially within the Territory, to establish their own health service. With the one in Darwin, we assisted that community up there establish that service. We also assisted Utopia, which you are going to, by the sound of it. We worked very closely with Utopia, and we continue to do so, and with Nganampa Health also.

Our plan is to spread our tentacles and try and encourage the communities to become interested in running their own health service. Once they have basically got on their feet, we say, 'Righto, that's it, you can take it over.' That has always been the Congress policy, to help people to set them up, then to say—

Mr QUICK—But you do not want 100 representative bodies, do you? You would be best to have perhaps a maximum of two for each of the states; otherwise you are going to end up with a system that we have had for the last 25 years where nothing ever changes.

Mr Liddle—There is only one representative body in the Territory, AMSANT—the Aboriginal Medical Service Alliance of the Northern Territory. We are members of that. We were one of the founding members of that. On that basis, we have also advised the federal government on lots of Aboriginal health issues. One of them was the transfer of ATSIC health funds into Commonwealth Health. We like to think that that idea came from us and we still stand behind that concept.

You mentioned ATSIC and the issues that the regional councils have to deal with, and John Boffa mentioned the small amount of actual dollars available to regional

councils. Especially in a town like Alice Springs, if you have got a large number of Aboriginal organisations, ranging from housing and education to media, they all have to compete for that small amount of money that is in the regional council bucket. We just thought it was a way of freeing up funds to enable these other organisations to put their hand up and try and get some of those funds.

We do not have to go through the regional council process anymore. We have therefore freed up the amount of money that was being spent by ATSIC on health services like Congress. So that has now given other organisations or councils a chance to put in submissions.

Dr Boffa—But in terms of tying the states in, which is part of what you were saying before and which we think is very important, we have been arguing that the Commonwealth government should take sole responsibility for funding of primary health care. You have got a situation where state governments play a dual role: they are both a funder and a provider of primary health care. We think there is a potential conflict of interest in that. And they are virtually the sole funding agencies for Aboriginal health services and, through Medicare, they are the sole funding agency for primary medical care for the rest of the population.

In Aboriginal health, state and Territory governments still put significant amounts of funding into primary care, although most of the expenditure on Aboriginal health that they tell the Commonwealth about is through the secondary and tertiary sector because people are sick. That is often used as an argument to say, 'We're spending this much money; we shouldn't put any money into primary care.' There is a double disadvantage going on. Because people are sick and are using hospitals more, they then do not get access to primary care resources.

In the strategy we have put up over the years the way to tie the states in is through several mechanisms. Firstly, the National Aboriginal and Torres Strait Islander Health Council has the states represented on it from AHMAC, so they are at the table. We are saying in our submission that the link between the national council and AHMAC has to be made stronger and more transparent. We are suggesting that the chairperson of NACCHO be present at AHMAC so that the Commonwealth minister ultimately has to play the role of making all the state ministers accountable and fulfil their requirements. We cannot do it.

That is the role the Commonwealth has to play and it is the role the Commonwealth has not been prepared to play since the 1967 referendum. They still hide behind the states rights rhetoric. When states say, 'You can't interfere with our business,' the Commonwealth is likely to say, 'You're right, we can't interfere with your business.' Even though often the Commonwealth is well aware that what is going on at the state level is wrong, and will not lead to improvements, they do not necessarily intervene.

We are saying that has to stop and the Commonwealth health minister has to take responsibility for ensuring that the states are committed to the outcomes that they agree to through the state forums and at the national level through the National Health Council and the Commonwealth. Because that process needs to be made transparent, it is really important that NACCHO is represented at AHMAC level as well as in the health council. That is something we are saying—to try and get better transparency. Otherwise the states can run off.

The convention on petrol sniffing which happened in Alice Springs was organised by the states. They invited the Commonwealth and excluded the primary health care sector. They came into Alice Springs and had a meeting about petrol sniffing, talking largely about petrol sniffing on the A-P lands. Nganampa might have more to say about this. Then the Nganampa health council people found out at the airport that the meeting had taken place.

That sort of stuff happens because the states are still potentially operating outside the agreed processes that we are putting in place. They can only be strengthened if AHMAC and the national health council have a stronger relationship.

Mr ALLAN MORRIS—Is there any data available as to the population ratios in the homelands movements in the last 20 years—the number of people living in remote communities and back in homelands as opposed to 20 years ago?

Mr Liddle—I am sure there would be. I do not want to bore you, but we always seem to be having some sort of survey being done on Aboriginal people, especially in the Territory. I am sure the Australian Bureau of Statistics should be able to provide that information.

Mr ALLAN MORRIS—It is just that part of the question becomes a question about getting services. There has been an active homelands movement taking place for a very long time now, which I think we would all agree with and support. Whether or not that has shifted the population or changed population mix, I really do not know. I have not seen any figures on it.

Dr Boffa—The demographics of our service have changed. Over the last 20 years we have gone from a service which mainly serviced Aboriginal people in the town camps—because that is where people all lived—to a service which had to service maybe 1,200 Aboriginal people in the town camps and 4,000 Aboriginal people living in the town itself. That is where we were in the 1980s. John talked about red areas or excisions before. Since 1990 there have been about 950 people move from town camps and town houses onto excisions within about 130 kilometres of Alice Springs. We have had to try to tailor our medical services to meet the needs of some people who have now moved from town to these communities outside Alice Springs. They are often living in family groupings of maybe 30 or 40 people and scattered across a very wide area.

That is good in terms of people getting out of town. They get out of the chaos and that is why they do it, as well as because of their affinity to the land and their desire to live on their land. Since that happened in 1990, we have not been funded to provide a service to those people and the services that were funded got withdrawn. We have been picking that up ourselves. I am going to a meeting tomorrow on a community, hoping to be able to get some funding to pick up the service that we are providing. We want to expand that service because there are more and more people moving out of town and we want to be able to provide a better mobile service to those people.

Mr ALLAN MORRIS—But would those communities in many cases not have primary health care like water and other common services?

Dr Boffa—No, most of them do.

Mr Liddle—Most of them have housing and water, but they have to generate it themselves.

Mr ALLAN MORRIS—Has that kept pace with the population though?

Mr Liddle—In some places it has. I was previously the chairman of the Alice Springs ATSIC regional council. In that area, which we basically service, a lot of money has been spent getting people basic services.

Mr ALLAN MORRIS—You could perhaps take on notice the question of whether or not any surveys or papers have been written about the implications of the homelands movement. I certainly support the homelands movement in terms of getting away from fringe camps and so on, but it has had associated with it the problems of getting services into those communities, particularly health services and educational services. You can point us at whether any work has been done.

That brings me to my second question. There are three questions I want to ask, but the second question out of your submission is an educational one. You make the point that, in 1996, only one Aboriginal person passed year 12. That really gets to part of the problem that communities are trying to come to terms with—the training of indigenous people. It seems that what we are being told, and have been told for some years now, is that we take the children away to towns for their higher education and then perhaps university. By that stage, they are no longer in tune with their own communities, so the capacity to get them back to remote communities or smaller towns seems to be lost.

The suggestion has been that we may have to look at modifying the educational system in terms of delivering services to people where they still retain some connection with their communities and perhaps access to courses with standards different to intensive education systems in the major cities. This is not just for indigenous people. It may well be for remote non-indigenous people as well. Is there any suggestion as to how we can do

that?

Mr Liddle—It is very hard. This is one of my hobbyhorses around town. I see lots of kids that should be at school that are not. I always say it is the parents' responsibility—but that is my personal view—to make sure that those kids get to school and become educated. There are some relatives of mine where the grandparents can read better than the kids because the kids are not attending school. We are on the verge of having a generation of uneducated people—people who have to take over from me and others. It is really worrying for me to try and get children interested in going to school, becoming educated, then going out and becoming the leaders of our community.

As I said, when Aboriginal people were in missions and settlements, those grandparents in their youth were educated up to a basic primary school level. If they are still alive, and not many of them are, they can read better than the grandchildren. That just shows something about that.

Mr ALLAN MORRIS—Do you have any thoughts on what we can do?

Mr Liddle—I think the education system needs to change. I am not sure whether I am a supporter of bilingual education. Most business in the world is done in English nowadays. Our people cannot read and write English. They cannot speak English properly. They cannot come along and give proper evidence to something like this, for example. They can do it with the aid of interpreters. I am not saying that language is a bad thing, but we have to encourage our kids to become educated. We have to force them to do that.

Mr ALLAN MORRIS—If you were us and you were making recommendations to the government or the parliament, what would your advice be?

Mr Liddle—I reckon there need to be more Aboriginal schools. We have an Aboriginal primary school in town here that seems to be struggling. They are dealing with students living in these types of lifestyles that we are quoting here. We spend a lot of time going to funerals all the time. For people like me, it is like another part on their duty statement. We have to go to funerals all the time. Most Aboriginal people, if there are any in this room here, spend a lot of time going to funerals. It is just a pastime that we just have to come to grips with.

Mr ALLAN MORRIS—Perhaps after today's hearing you may think of some other things. I take the point about Aboriginal schools, and perhaps there could be bilingual studies in schools. So there are two ways but let us know if you have any other thoughts.

Dr Boffa—There is a Senate inquiry into indigenous education coming to Alice Springs soon. From your point of view, that may be something to link with. Education is a health issue and there is an enormous amount of evidence showing those links. Clearly,

there is a problem that they are not going through HSC, and that is in Alice: it is not just the bush; we are talking Alice Springs. People do not have all the answers. But at least let us recognise that it is a fundamental problem, and look into it and treat it with the seriousness that it deserves.

Mr ALLAN MORRIS—You make the comment that the HIV-AIDS program may not be appropriate for Aboriginal communities. One of the points I raise with you is that the formation of the AIDS council gave ownership of the issue to non-governments, if you like. In that sense, the AIDS issue may have relevance in this structure. Ownership of the agenda is—to a large degree, not solely—controlled by the people who are directly affected by it. It is not run by institutions or government departments. So, in that context, it may be that it has relevance to Aboriginal health. It may be that Aboriginal communities could have a bigger say in prioritising and directing Aboriginal health administration and budgets and so on. Perhaps that is a point you may well think about.

Dr Boffa—That is exactly that point we are making. But the point that has been made to us by the power structures is that the HIV-AIDS story is one of Australia's key international public health success stories. But the analysis as to what has led to that success is where people differ. Your analysis is our analysis. We say that success has occurred because for the first time government formed a genuine partnership with the affected group, which is the gay community. Unfortunately, popular mythology has it that the success occurred because the government set up an expert task force with Professor Pennington and other key experts who then advised government as to what they needed to do to address the problem of HIV-AIDS.

You can see parallels there with Aboriginal health. People are using the HIV-AIDS story to say, 'We need to do the same thing in Aboriginal health. We need to set up an expert task force of professors.' Our analysis of the success in HIV-AIDS is exactly what you have just said.

Mr ALLAN MORRIS—What about if you were to call for the establishment of an Aboriginal health council, similar to the AIDS council?

Dr Boffa—There is one: the National Aboriginal and Torres Strait Islander Health Council. It needs to be given recognition as the peak body to advise government on Aboriginal health. People have to stop setting up other bodies. There are still people setting up other communities and other bodies and not giving it that recognition. It is there.

Mr ALLAN MORRIS—Thank you.

CHAIR—Good point.

Mrs ELSON—I am concerned with your mortality rate for males and females, as

set out on page 6. Dr Boffa, you made the statement that there was more information about women and that women were carrying that information through to other women. It concerns me that the mortality rate for males is so high. Is the congress doing anything about trying to educate males through health programs and make them more aware?

Mr Liddle—I think the male Aboriginal people of this area are a long way behind the women. Women have been more organised, more structured and more energetic. I am very embarrassed by that, I have got to say. I am an old-time chauvinist and I am proud of it.

We have been trying to get men together for meetings by saying to them, 'Come on you blokes, take a bit of interest in your own health.' Most of the clinics on the communities and most of the people that deliver health to Aboriginal people are women. So most clinics are seen as women's places.

Mrs ELSON—Have you held these meetings?

Mr Liddle—Yes.

Mrs ELSON—Do the males turn up?

Mr Liddle—Yes, we have had 50 or 60 turn up to one that we had. People are really interested in getting behind it. They are energetic. All we have to do now is try to get some specific men's services established, I think. As I said, we are a long way behind the women, and I congratulate the women for doing what they have done. They have done a fantastic job. It is going to be very hard to catch up.

Mrs ELSON—You said that a high percentage of road accidents are caused by alcohol. You also talked about buying a liquor licence and destroying alcohol publicly. How long ago was that?

Mr Liddle—We did that in 1991 or 1992.

Mrs ELSON—Was there a drop in road accidents, say, for the 12 months after that?

Mr Liddle—No, because in a town like this we have so many liquor outlets. I think at that time there were 26 take-away outlets in Alice Springs for a population of 25,000.

Dr Boffa—It is 27 now, and that licence got taken up when it was transferred to the new supermarket. It expired, but the Northern Territory Liquor Commission argued that there were 27 before so we could have 27 again, and the new supermarket got the take-away licence.

Mrs ELSON—Are there any other programs that Congress is looking at to try to make Aboriginal people more aware of alcohol and what it does to them?

Mr Liddle—I do not like to be seen as not thinking alcohol is a major contributor to Aboriginal ill health, but we try not to focus on one issue. Even though alcohol is the biggest issue that most of our problems come from, on top of that we have to try to get people to say, 'Come on, we will get the kids to go to school, we will get someone to get a job and we will get the sewerage fixed up in the house'—all those sorts of things. We try to do a comprehensive community development model—that is how we try to do it. We do not just focus on single issues.

What usually happens is that the government says, 'Right oh, there are problems with Aboriginal men dying. Let us set up a specific men's health program.' That isolates us from everything else within the community and, as I said, we have to work with our women because they are pretty powerful and they are usually very energetic.

CHAIR—It is the same in mainstream society too, where the women are motivated. It was the women on our committee that got us to have a men's health forum which we have since tabled.

Mrs ELSON—It is a neglected part of society. If you can fix that problem, you get a balanced result.

Mr Liddle—I think the men's movement around Australia has to really look at itself and say, 'Come on—

Mr ALLAN MORRIS—Is there a problem there with the cultural power structures in terms of the elders normally being men and therefore community values being at odds?

Mr Liddle—It all depends. Women are on most of the councils that are set up in these communities. I would say that most of the major decisions are made by the men.

Mr ALLAN MORRIS—The people here this morning told us that the real needs have changed, that you have to have people involved in health who have power in the community and not too many people who are educated. I would have thought most of the power in the community is actually with the men. If health is run mainly by women but men have most of the power, that would seem to be a cultural thing.

Mr Liddle—There are lots of other issues that people in communities have to deal with, and health is only one of them. To try to get people to say that health is more important than the other 2,000 things that they have to look at—

Mr ALLAN MORRIS—Not more important, but as important.

Mrs ELSON—Are more Aboriginal girls attending school than males?

Mr Liddle—No, I am not sure.

Mrs ELSON—You are not sure?

Mr Liddle—No, education is not my field, I am sorry.

Dr Boffa—It is not very transparent. I do not think we have ever seen figures on attendance rates. It is not something that is made publicly available, to our knowledge anyway.

Mrs ELSON—I was just wondering whether Aboriginal people encouraged their daughters to go to school more than their sons or whether the male Aboriginal had a mind of his own and was not taking too much notice of what his parents told him, because you put the blame back to the parents not taking responsibility?

Mr Liddle—We all have to accept responsibility for some things in our lives. I say that if you have kids, you have to look after them—I have three myself.

CHAIR—I need to wrap it up there by expressing appreciation to both of you for coming and giving evidence today. Published evidence is circulated, and if there is anything further that you would like to comment on, especially on points that Mr Morris made or on anything that you read in here, please do that. We would welcome that extra information. Thank you for your time today.

Proceedings suspended from 12.04 p.m. to 12.14 p.m.

ANDERSON, Ms Alison, Deputy Chairperson, Papunya Regional Council, PO Box 2255, Alice Springs, Northern Territory 0871

CASTINE, Mr Graham Keith, Regional Manager, Commonwealth Department of Health and Family Services, PO Box 8091, Alice Springs Northern Territory

TILMOUTH, Mr William, Chairman, Alice Springs ATSIC Regional Council, PO Box 2255, Alice Springs, Northern Territory 0871

CHAIR—Welcome. Before I proceed, I need to point out that the committee does not formally swear its witnesses, but you need to be aware that the proceedings today are formal proceedings of the parliament and warrant the same respect as the House of Representatives itself. The committee has not received a submission from you, but I understand that you wish to table one today and speak to it. I apologise for the lateness of your attention to our inquiry. Given that we have been at it for eight months, I am surprised at that.

I would like to give you an opportunity to present a brief statement. Please do not feel the need to read all of your presentation. We could simply table it and have it recorded in the proceedings and you can make a summary of it—but I am in your hands to that extent. The main thing we would like to get to is the pursuit of questions so that we can really get to the bone of the issue.

Mr Tilmouth—My apologies, Chairman, for that. The Alice Springs ATSIC Regional Council and the Papunya Regional Council operate under the same regional support unit which has been dysfunctional for the large period of our time as regional councillors and, as a result, the submission that we are presenting is just a backbone of what we would like to talk to in relation to that submission. So I would like to present this, but use it as a talking piece that Alison and I can work from.

CHAIR—All right. I am in your hands then. Make a presentation—do you wish to table it or read it?

Mr Tilmouth—A bit of both.

CHAIR—A bit of both.

Mr Tilmouth—Our main priority is health. Our number one priority is Aboriginal health and it stands to reason because all other issues, including health, education, housing, and employment, are so interconnected with the quality of life and the wellbeing of Aboriginal people that we have made our priority health and everything follows in relation to that.

We also have a belief that health is achievable only when the people who suffer

the greatest disadvantage have ownership and control of the process and the programs that are directly related to it. That includes the problems of substance abuse and primary health where sick people who suffer the worst disadvantage may, in our opinion, have the most say in that process.

The Alice Springs and Papunya regional councils support the health framework agreement on Aboriginal and Torres Strait Islander health between ATSIC, state and the Commonwealth. The key issues covered in that agreement are: improving access to health care and an increased level of resources to reflect the increased needs of Aboriginal people; a joint planning process allowing Aboriginal people participation in decision making; improved coordination and cooperation of delivery of service, and increased clarity in respect of roles and responsibilities of stakeholders.

Thirdly, we find that a lot of people do not have a direct say in relation to how services are delivered to them. We find that a lot of people do not have direct say in how they want the service delivered to them, and their needs in relation to that service are not ever given the full consideration that they entitled to.

Ms Anderson—All their lives Aboriginal people have worked and lived with forced ideas that have come from outside. When Aboriginal people were assimilated, education was worked on them from outside. People wanted them to have education, and health was imposed upon them without proper consultation with the Aboriginal people that live in the communities, and they are the ones that suffer the most. I think that it is about time that we give people the responsibility back and say, 'What do you think is important in your life?' Maybe we could see improvement in health and education if the idea were to come from the people.

Mr Tilmouth—For too long Aboriginal people have worked with prescribed solutions and not solutions that they themselves have thought of. They have worked with solutions that have been given to them. In saying that, the regional councils are extremely concerned over the framework agreement. We also believe that AMSANT, as an Aboriginal body, should be a signatory to that.

We also believe that AMSANT should be more representative of Aboriginal people. We believe that if AMSANT could work towards that then support for AMSANT would be far greater. We are supportive of it now as an Aboriginal body being a signatory to that framework agreement. We have had talks with AMSANT and we want to see if they can broaden their representation to include all those other health areas and also have consumer representation on their committees.

I will just read what I have here:

ATSIC supports AMSANT being a signatory to the agreement as we consider it imperative that community controlled health services be represented.

There is overwhelming community support for community controlled services amongst the Aboriginal population in the NT. A fact which has been confirmed by NATSIS which revealed that 89% of people aged 13 years and over said they felt it was important for Aboriginal people to be involved in the provision of their health services.

The Alice Springs and Papunya Regional Council are looking for the Commonwealth government to take all the necessary steps to ensure that the Northern Territory government signs that framework agreement, without further delays.

CHAIR—Basically everybody else has agreed that up to that it is just the government now, the last signature. Is there somebody else in the background lobbying and making them nervous. Why do you think it is not yet signed? We find it a bit frustrating from our point of view.

Mr Tilmouth—The only conclusion I can come to is that the minister for health in the Territory government, Denis Burke, believes that AMSANT is not a representative body and therefore should not be a signatory to that agreement. We are saying that they are and we are saying that their representation should also increase. It is a situation where not only do you look at the curative model and have people represented from the curative model but also you have people represented from the preventative models as well, such as environmental health and all the social health problems that are experienced by Aboriginal people.

CHAIR—So it is the Territory minister who is not willing to sign up?

Mr Tilmouth—I believe that that is the case. I am not too sure but I think that is very much the case in relation to the framework agreement not being signed.

Can I just go a bit further. We state:

In relation to planning, both Regional Councils believe we have a crucial role to play in collaborative regional health planning. Regional Council representations on the Regional Planning forum would:-

. assist Regional Council in the targeting of NAHS/HIPP, IHANT—

which is the Indigenous Housing Authority of the Northern Territory—

and CHIP expenditure . . .

We do not actually have the health dollars to allocate but we do have a lot of associated programs that are very much in line with the health issue. There needs to be far more coordination so the regional councils can be represented on the regional planning forum—for that simple reason, that we can interlink the NAHS and HIPP and IHANT and CHIP expenditure.

We then go on to say:

. provide community feedback to service providers on complaints about service delivery.

There is a crucial need for collaborative planning and the closure of the Child Health Unit at the Alice Springs hospital provides the most telling example. For whilst the Regional Council supports the efforts of the Territory Health Services—to spend more of the remote area health budget in communities, we are concerned that the closure of CHU was announced without alternative options for paediatric service, antenatal & postnatal accommodation, and services for failure to thrive children being established.

CHAIR—What was the Child Health Unit's focus? What is your perspective as to why that was closed?

Ms Anderson—The Child Health Unit is a unit where remote Aboriginal communities send their children who have been failing to thrive. They stay inside the CHU—the Child Health Unit—for a period up to two weeks, so that they can put on weight, and the mums are trained so that they can look after their children a lot better. The CHU was closed without proper consultation with remote Aboriginal communities, and that affects us. We normally send our antenatal mums in two weeks prior to the birth to the Child Health Unit so that they can be put straight into the maternity ward from CHU.

CHAIR—Has it been reinstated, or is it still closed?

Ms Anderson—No. It is still closed.

Mr QUICK—What was the excuse—lack of money?

Ms Anderson—They are saying that they are going to provide better services later on. They are closing it so that they can better service remote Aboriginal communities by putting extra money in. But nothing is in writing; this is just all verbal. They say that there will be better specialist care out in remote Aboriginal communities, but all this has just been verbal and there is nothing actually written down.

Mrs ELSON—How many women were accessing that service in the year prior to it being closed down?

Ms Anderson—I do not know. Mr Castine might be able to answer that.

Mrs ELSON—I am only interested to see whether they closed it down because it was not being utilised, or whether they closed—

Ms Anderson—It was in full use.

Mr Castine—There were probably 16 or 20 a month. I know a bit about the closure of that unit. They closed it down for a range of reasons which were not properly

communicated to the wider community. There is a question on the table about numbers. There were about 15 a month on a regular basis. It has its peaks and troughs, of course, but that is what they work on an average. It provides, as Alison said, nutritional support. People coming from acute care prior to going back to the community might stay there for a week or so depending on their situation. It is really a question that the Territory health service should answer, not the Commonwealth.

In the Territory's defence, I suppose, they have got a range of working parties looking at the different paediatric issues, accommodation issues, and so forth. I am advised that the Territory Minister for Health has given some indication that there is a little bit of leeway, but they are still targeting the end of June for the formal closure of that unit.

Ms Anderson—Just going back to what Willie was saying about agencies involving ATSIC and Aboriginal people a lot more in the decision making, in this case—

CHAIR—That is a classic example of lack of consultation.

Ms Anderson—That is right.

CHAIR—With a bit of good consultation, it could have got a better outcome for rural and remote areas. Now we have got people offside and cranky by the sound of it. It is just a classic way not to do it.

Ms Anderson—That is right.

Mr Castine—Offside, perhaps, for the wrong reason in that they did not have sufficient information. If they had the full information, it would probably be a different story. There was a bit in the press in the early days following the announcement of the closure that was in relation to there being good programs in the bush which were growing, and so forth. One of the real reasons for its closure was the need in that particular part of the hospital for accommodation of another unit, another ward. So it was accommodation rather than a medical thing. Their advice to date has been that the medical aspects of what the Child Health Unit did will be taken up by other parts of the hospital. But they are negotiating other accommodation arrangements, and all that sort of business.

CHAIR—You have got that on the public record and brought it to our concern. Well done! I think it might be useful to stay there.

Mrs ELSON—Does it close down in June?

CHAIR—It is not formally closed though.

Mr Castine—No, no. Their target is 30 June. Getting back to some of the

questions that you asked Dr Boffa, they are negotiating with the South Australian and Western Australian state health departments because they see a cost factor in treating people from interstate in that unit, which they do. They draw a lot of people from the likes of Nganampa and Ngaantjarra health services.

CHAIR—Thank you. We have interrupted you, Mr Tilmouth. Would you like to finish?

Mr Tilmouth—No, that was just an example I used in regard to the first terms of reference that you put down. That was a clear example that I referred to Alison here who knew more about it than I did. We work very much the same.

I am dealing with this through the second term of reference in relation to barriers. Equitable access to health services is a major concern for improving the health of Aboriginal people. The issues involved in whether Aboriginal people use the service when needed are affected primarily by the distance from the service, the degree of Aboriginal involvement in the service, whether Aboriginal staff are available, the level of awareness of Aboriginal issues by non- indigenous health professionals and the frequency of visiting services.

Clearly improvements in mainstream health service delivery will require the recruitment and training of Aboriginal staff at all levels of service delivery. Further improvements to provision of help to Aboriginal people in the region would be made almost immediately by the greater use of interpreters and translators. In Central Australia there is a lack of health infrastructure, information, training and numbers of specialised services and transport. I would like to go through this one by one with Alison, purely because these points need to be elaborated on.

Firstly, I will add that accommodation is another one, but transport is clearly a problem. No transport system exists between the remote area and the town centre and access to any service, whether it is education, health or housing. We have found that people tend to come into Alice Springs, contrary to popular myth, not for alcohol but to access services—services like visiting relatives in gaol; visiting children in education institutions and delivering money for those young people's upkeep; health and kidney dialysis; education and employment. Even sport and entertainment are a big requirement. While Alice Springs remains the hub and centre for business within the region, you will always have that large influx of people coming in to access services.

Therefore, the regional council believes that the decentralisation of services to regions based on cultural and language boundaries is far more appropriate than for ever and a day dealing with the antisocial behaviour of people who come in. When the only vehicle they have is defected and taken off the road, their transport system is no longer in existence. They fall back onto family or relatives who already live in overcrowded situations and, as a result, the family tends to start suffer financial hardship and the

frustration and desperation of life sets in. As a result, alcohol takes its toll.

We do not believe that alcohol is the only source of the problem. We believe that alcohol is a symptom of the problem. It is a symptom of historical powerlessness amongst Aboriginal people in that Aboriginal people were never allowed access or any input in relation to the services that are delivered to them. I think we are suffering from a created condition whereby Alice Springs is the moth to the flames syndrome, and it will always continue. The health related problems associated with that will always be there as long as the services are kept centrally and are not put back into the communities.

Ms Anderson—What Mr Tilmouth is saying is very true. We have a lot of people from remote communities. I live and work in a remote Aboriginal community, at Papunya. A lot of our people in my area—at Kintore, Mount Liebig, Papunya, Haasts Bluff, Areyonga and Hermannsburg—come in for the simple reason that they have got football on every weekend. They come to visit people who are on dialysis machines in Alice Springs. They come to give their children money—those in school at Yirara College. As Mr Tilmouth was saying, all the services are kept within Alice Springs; therefore, people are coming to access the services that are in Alice Springs. It is about time that we started providing services in remote Aboriginal communities, in order to keep the people out in their homelands.

As Mr Tilmouth was saying, the antisocial behaviour related to substance abuse and alcohol is just one little part of a big problem in Alice Springs, because they have to come in to visit relatives and their children. They have access to grog from the 27 outlets in Alice Springs and they start living down in the creeks in Alice Springs.

Mr Tilmouth—They end up becoming very much permanent residents, with no accommodation whatsoever provided. I can give an example of an old man who came in from the community to access kidney dialysis and was given an out-of-turn house from the housing commission. After about 18 months of waiting for the house, he moved into the house. Within a couple of weeks, he was evicted because the extended family was also with him. There were complaints and he got evicted. He lived for nine months in the creek and every second day attended for kidney dialysis treatment. So he was accessing the services but living in very appalling conditions. Tangentyere Council then took on the role and found accommodation, which is very scarce because they are already taken up. We have housed him in one of the town camps. This is a clear example where access to services—not only health services, but housing, education, the whole lot—is non-existent for these people who come in just to access one service that can sustain their life. That is a very big problem in this town.

The other thing on alcohol is the road deaths that were mentioned previously. We do not see alcohol as the only major contributor to road deaths. We see bad roads—shockingly kept roads. We also see cars sold to Aboriginal people that you and I would not even look at—the suspension is gone. You have a combination of overloading, a very

unroadworthy car, a bad road and alcohol, and you have got a formula for death. Too many times, alcohol is placed at the pinnacle of the road death problem. There is no real consideration given to the maintenance of roads or the scrutiny of vehicles sold to Aboriginal people—they are buying cheap cars off the side of the road which we would not look at. The transport system should be the overriding umbrella, because transport to and from communities is non-existent.

CHAIR—My colleagues will be champing the bit to ask questions. I am just wondering, Willie, whether you have nearly finished your presentation. You could table that and we will incorporate it. Otherwise, they will be butting in on you before long. I propose that we incorporate in the transcript of evidence the submission from the ATSIC regional council. There being no objection, it is so ordered.

The document read as follows—

Mrs ELSON—I would like to ask a little bit more about the transport problem you have. When I was listening to the previous Congress and health care workers, they were wanting the responsibility put back to them for different services. With the transport one, is there anything that ATSIC has done to help to provide a service to get people back to their communities instead of being, as you said before, stuck in town?

Mr Tilmouth—In regard to that, the Alice Springs, Papunya and Yapakurlangu regional council had its own meeting on 30 October 1997. We passed a resolution that members of the Northern Territory central zone will cooperate in the development of a regional transport strategy by forming a transport subcommittee to develop terms of reference for appropriate consultants to undertake a socioeconomic study of the transport system with a view to introducing a remote area transport system throughout the three regions. That was moved at the zone meeting last year.

The reason for the delay is that we have been trying to access funds from program support in the central office of ATSIC to start the subcommittee under way. We have got nominations from the three regional councils, but we also need to get people on board who have a very commercial sense of transport, or who are already in the transport business, to give us the guidance that we need to take. It is a new initiative. It is one that was needed a long time ago. Alison told me that in the Pitjantjatjara homelands they started on a chuck in, chuck in basis; they bought their first airline, and now they have a fully functioning airline.

Ms Anderson—The same with us. We get royalties from gas and oil in our area. We invest 50 per cent and allow the communities to use the other 50 per cent for community purposes. With the 50 per cent that we invested, we bought an airline. I forget the name of the company prior to it, but we call it Ngurratjuta Pinara Ngara. We own that airline.

Mrs ELSON—Has that been successful in returning people back to their communities?

Ms Anderson—Yes. We charge less for people that come from the communities. They get on for only $69.

Mrs ELSON—That is very good.

CHAIR—It is a small, light aircraft, is it not?

Ms Anderson—Yes. We own the Caravan. That is a 14-seater as well. We bought that as well.

Mr Tilmouth—Bear in mind that you have communities that can access royalties through the mining and other activities on their land. There are a lot of communities that

do not have access to any of that. Hopefully, through this regional transport strategy, we can develop the idea that Alison and her community have in relation to the whole of the central Australian area. But it was not only looking at transport in relation to transporting of people, emergency transporting of people to hospitals, and all that; it was also looking at the delivery of stores and building material, and also airstrip and road maintenance. That brings about employment within the region, which ultimately, at the end of the day, enhances quality of life. I believe that is a big lack in the Aboriginal community.

Mrs ELSON—Alison, do you believe that other communities who are a little bit better off with their royalties are prepared to help the communities that are disadvantaged by not having those royalties? Is there that community of interest out there to help other Aboriginal groups

Ms Anderson—Yes. Originally, when our airline started, it was only looking after Hermannsburg, Areyonga, Papunya, Mount Liebig and Haasts Bluff. That is only five communities. But to extend the mail service, because we knew that that could have been bringing money in for our service as well, we increased the service all the way out to Kintore, Nyirrpi, and Yuendumu. Now our airline covers Yuendumu, Nyirrpi, all the way round, and comes back. It even goes into Western Australia.

We have got a Ngurratjuta air map. The mission fellows actually look after all the airlines for us—Ngurratjuta air, Pitjantjatjara air and Ngaantjarra air. If one of our aircraft cannot fly then we will hire the other one to come in, and they do the same with our aircraft. So we work in a partnership with the Pit homelands. We do extend services.

Mrs ELSON—How long have you been doing that?

Ms Anderson—We have been doing that for about seven or eight years.

Mrs ELSON—Is it helping the situation in town? I do not know the history of Alice Springs. Have the numbers increased or decreased?

Ms Anderson—It goes back to whether people can afford that $69 to get on. A lot of people cannot because they are stuck here. They have got no money because their cheques are out in the Aboriginal community. So until someone brings them in or they ring up and ask for the office to send it to Tangentyere or the post office here, they have to wait a week because we only have two mail runs a week.

Mr Tilmouth—Bear in mind too that the preferred transport mode is by vehicle because it gives you access to hunting and that sort of stuff. As well as that, you can take along your extended family a lot better than if you were in a plane.

Mrs ELSON—So road transport is what you are looking into now?

Mr Tilmouth—Yes, that is what we are looking at. There is no transport whatsoever.

Mrs ELSON—What has caused the delay till now? That is what I am trying to figure out.

Mr Tilmouth—The delay is a bureaucratic one.

Mrs ELSON—Within ATSIC?

Mr Tilmouth—Yes, within ATSIC. We have not heard back from the board of commissioners that we applied to for the funding. Our commissioner is on leave now so we are still waiting to hear what happened so that we can start up this committee to try to deal with this transport problem.

Mr ALLAN MORRIS—I am not sure if you were here earlier when I was talking to Mr Liddle about education and the difficulty of getting higher education in the young Aboriginal community in towns like Alice Springs and in remote communities. Can you offer us any advice as to how we can do better, or what we can do to try to get better educational access?

Mr Tilmouth—I will start off. I know Alison is trying to develop a strategy in her community but I will leave that to her to talk about. In relation to education overall, there is a great emphasis on pushing young people into the education system, as there was a push to get people who lived on reserves and settlements through the education system. There are great advantages in acquiring an education but when you are a young kid and you see your parents and your grandparents, all of who have been educated, ending up in a life where they have no control, you begin to think education has given them no benefit whatsoever.

There is no way that the parents can get jobs, and there is no way that they can improve their quality of life. From a child's perspective, when they see the powerlessness that the generations before them have experienced, it is very hard to be motivated into taking on a life that is going to lead to what they see every day where the police are dragging off their parents.

Education, for me, has been a benefit. I was one of the stolen generations. I was taken away and grew up on a mission that had very strong educational links. In fact, I was flogged to ensure I went to school. I do not think we need to resort to those days where we had to force young people to go to school, or blame the parents in relation to the lack of education that their children have. I believe that the whole education system has failed Aboriginal people to the extent that they live now in a very powerless world.

Ms Anderson—I agree with you. We went into a dispute with the Northern

Territory government three years ago because of education. We did a minimum requirement document which was handed to the now Chief Minister four years ago when he held the portfolio for education.

The documents are still with them and they still have not done anything about it. We asked them to give power to the Aboriginal people in the community for them to determine what they think is important for their children's education, and to give a lot more power to the Aboriginal teacher aides. We are actioning that without the help of the education department in the Northern Territory and without the help of the government.

We have a very good school principal who looks at Aboriginal issues thoroughly and thinks that the only way that education is going to improve amongst Aboriginal people is if autonomy is given back to the Aboriginal leaders in the community, to let them stand in front of the white teachers and work as a team. That is what we call team teaching. For every white teacher in our school—I am only talking about my community—we have an Aboriginal teacher aide. They have to do all the planning together and they have to be in class together. Our school is a bilingual school because we feel that through learning to read and write their own language it simplifies English for the children.

Mr ALLAN MORRIS—Where is your community?

Ms Anderson—I live and work at Papunya.

Mr ALLAN MORRIS—Is that process working?

Ms Anderson—Yes. They are learning to speak and read English better because they know how to read and write their own language first.

Mr ALLAN MORRIS—We have been told that when they get to secondary school—this is not just here, but it is all over Australia—they then have to leave their communities and the community loses them and they no longer relate back to the community.

Ms Anderson—That is what we ask as a minimum requirement from the Northern Territory government: that they seriously look at the issue of three high schools for remote Aboriginal communities. We have one at Motajulu near Ayers Rock, which is still scraping to get by. We would like one in our area, which would look after five communities, and one in the eastern communities. We are not asking for very much. We are asking for things that our children are entitled to so that they do not have to move away. Children still run away from Yirara College. They have to leave their home environment. They have to leave their families and things like that. A lot of the time they do not see their parents for up to eight weeks. They get homesick so they run away.

Mr ALLAN MORRIS—So the document you mentioned is one that you put forward four years ago?

Ms Anderson—Yes, we put it forward four years ago to the Northern Territory government and they still have not done anything about it. We still work without their support. We are still doing the things that we have got—

Mr ALLAN MORRIS—Do you have a copy of that?

Ms Anderson—I have not got it here.

Mr ALLAN MORRIS—Can you send us one?

Ms Anderson—Yes, I can give you a copy.

Mr ALLAN MORRIS—You are talking about team teaching with an Aboriginal teacher's aide and a non-Aboriginal teacher working in community schools and often bilingual.

Ms Anderson—Yes, and that non-Aboriginal teacher gives a lot more back to the Aboriginal TA because it is their children and they know them.

Mr ALLAN MORRIS—Yes, it can be bilingual feedback.

Ms Anderson—Yes, that is right.

CHAIR—I discovered this morning that there is a Senate inquiry coming here next week looking at education. I hope you are aware of that. It would be a good point to make to hurry that response up.

Mr Tilmouth—I would like to refer to our submission for a brief minute. The Papunya and Alice Springs regional council urges the Commonwealth government to create and fund an Aboriginal cadetship program on similar lines to that operating out of the Central Land Council. Through the operation of such a program, the region will gain qualified Aboriginal medical staff, which is lacking here. Statistics from the Australian Bureau of Statistics reveal that there is a need for such a program. As at 1996, only 264 indigenous students, Australia wide, were enrolled in medicine and nursing. This is an increase of one from 1992 when there were 263.

Along with the cadetship program, a coordinated training strategy that delivers health worker education and training on communities is a priority. There are approximately 410 health workers working for the Territory's community controlled health services and grant-in-aid community clinics situated throughout the Northern Territory. Without a comprehensive training strategy and without career paths being developed

health workers will remain an underutilised resource. One of the big problems for health workers is that, despite their aspirations to advance themselves and because there is no provision for them to advance themselves, they will remain for ever and a day putting on the bandages.

Ms Anderson—There is no proper recognition for health workers. When a non-Aboriginal nurse goes out to remote Aboriginal communities, the only skill they have is to treat the patient. They have no skills in communication with Aboriginal people, or in understanding Aboriginal communities or Aboriginal people. All that is done by the Aboriginal health worker, but all that is not recognised. They cannot get housing through Territory Health Services, and they do not have half of the benefits that a non-Aboriginal person has, only because Territory Health Services reckon that these people have to be recruited from outside. All these people with these multiskills in Aboriginal communities are not recognised.

Mr ALLAN MORRIS—We heard this morning from the health workers association—

CHAIR—Before you arrived.

Mr ALLAN MORRIS—They made some very interesting submissions about that, which was quite good.

Mr Tilmouth—We would just like to reiterate that point then.

Mr ALLAN MORRIS—Yes; you are obviously endorsing what they put forward.

Ms Anderson—Yes.

Mr ALLAN MORRIS—It seemed very sensible.

CHAIR—I have to wrap it up there. We have a comprehensive inspection organised this afternoon which we do not want to miss. I would like to draw your attention to the weight of evidence we have already got which is published and which you are welcome to peruse. If there is anything at all in it that you would like to respond to, if you have not had an opportunity to do so today, please do so. The committee is always ready to receive extra information.

Mr Tilmouth—Are all the submissions—and I know you are going Australia-wide—available to the public at the end of the day, accompanied by your report?

Mr ALLAN MORRIS—They are available now.

CHAIR—Yes, these are the submissions. There is a set for you now. There are

more coming in.

Mr Tilmouth—So you are going to end up with about seven volumes?

CHAIR—We will end up with a pile of evidence this high, which we will have to digest and form our recommendations.

Mr ALLAN MORRIS—For anybody who is a specialist who wants to follow through, the *Hansard* record also becomes public—in other words, this discussion becomes a public part of the records. So for the very small number of people who really want to dig in and go through it in detail, that will be available as well. Eventually, the report itself becomes the final document.

Mr Tilmouth—I think we will try to get a copy of that. As I said earlier, our priority is health and everything is interconnected—quality of life, as well as sickness; it is all there.

Ms Anderson—Imagine a spider that has to web out—that is the example that we use all the time. You have got health there, the spider, and he just webs out; and if anything is broken, then there is no communication, everything is disconnected. That is the way we look at it. That is the example that we use to anybody when we are talking in our community.

CHAIR—It has been very useful, Mr Tilmouth and Ms Anderson. Mr Castine, it was handy to have you drop in and give some extra information on that child-care unit.

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

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

Committee adjourned at 12.59 p.m.