HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

SYDNEY

Thursday, 11 June 1998

OFFICIAL HANSARD REPORT

CANBERRA

HOUSE OF REPRESENTATIVES
STANDING COMMITTEE AND FAMILY AND COMMUNITY AFFAIRS

Members

Mr Forrest (Chair)
Mr Quick (Deputy Chair)

Ms Ellis
Mrs Elson
Mrs Elizabeth Grace
Mr Harry Jenkins
Mrs Johnston
Mrs De-Anne Kelly
Mr Lieberman
Mr Lloyd
Ms Macklin
Mr Allan Morris
Dr Nelson
Mr Quick
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

SYDNEY

Thursday, 11 June 1998

Present

Mr Forrest (Chair)

Mrs Elson	Dr Nelson
Mr Jenkins	Mr Quick
Mr Allan Morris	

Committee met at 8.33 a.m.

Mr Forrest took the chair.

CHAIR—I open this public hearing of the committee's inquiry into indigenous health as referred in June last year by the Minister for Health and Family Services, Dr Michael Wooldridge, with the support of the Minister for Aboriginal and Torres Strait Islander Affairs, Senator John Herron. The committee is looking at improved coordination, planning and delivery of indigenous health services against the background that past structures for the delivery of health services to indigenous populations have not resulted in significant improvements to the health status of those communities. Barriers still exist for Aboriginal and Torres Strait Islander people to access mainstream services.

This hearing today in Sydney follows previous hearings in Canberra, Hobart, Adelaide, Perth, Brisbane, Townsville, Alice Springs and Cairns, and gives the committee a further opportunity to explore with the New South Wales government department, representatives from locally based organisations and individuals who have made submissions to the inquiry.

I have said at the opening of every inquiry—and I would like to stress it again—that this inquiry is being conducted in a spirit of collaboration and cooperation with Aboriginal and Torres Strait Islander people. The committee realises how important it is to have proper consultation, and there is a determined resolve to prepare a report to finally satisfy what is a vexing and frustrating issue for Aboriginal and Torres Strait Islander people—as well as for the rest of the nation, I believe. We have seen some successes and we have seen some bad outcomes as well. In addition to the formal inquiries, we have been conducting some on-site field inspections and so forth.

[8.34 a.m.]

AGIUS, Mr Timothy Charles, Director, Aboriginal Health, New South Wales Department of Health, 73 Miller Street, North Sydney, New South Wales

CHAIR—I am very pleased today to welcome before the committee Mr Tim Agius from the New South Wales Department of Health. Before proceeding further, I need to point out that, whilst this committee does not swear its witnesses, proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives itself. Therefore any deliberate misleading of the committee may be regarded as a contempt of the parliament. This also serves to protect witnesses so that they can give fearless evidence to our inquiry.

The committee is anxious to receive a submission from the department and I understand that is fairly well prepared now. Please do not be tempted to try to read all of that into the *Hansard*. We can do that formally later. There are probably some opening comments you would like to make before proceeding to questions from the committee.

Other committee members come from all parts of Australia. May I introduce Mr Harry Quick, deputy chairman and the member for Franklin, Tasmania. Mrs Kay Elson is the member for Forde in suburban Brisbane, Queensland. Other members will be coming shortly and I will introduce them when they arrive.

Mr Agius—Thank you, Mr Chairman. Firstly, I apologise on behalf of the New South Wales Health Department for the delay in presenting a formal submission. We certainly indicated when we were first made aware of the inquiry that we would be keen to prepare and present a submission to the committee. I want to talk mainly about the relationships and structures that exist in New South Wales which enable better collaboration and coordination between the Commonwealth, the state and, more importantly, the people who are affected by this, the Aboriginal community.

The delay of the submission, you may appreciate, is due to the complexity of the New South Wales health system. With 17 area health services throughout the state, it is quite big and quite complex. In preparing our submission, it was essential that we drew on comments and feedback from the areas who are working extremely hard with Aboriginal communities and Aboriginal medical services to better coordinate their efforts to address Aboriginal health at the community level.

Our submission itself is probably similar to what you have heard in other states, given that you have already been to other areas. Instead of attempting to read through our submission, which would probably take about 15 minutes, it is probably easier that I just highlight the main areas that are included in our submission.

One thing I do want to talk about and answer questions about, in particular, is the partnership that we have with the Aboriginal community control peak organisation in New

South Wales which is the Aboriginal Health Resource Cooperative. As a result of the signing of the framework agreement, the partnership that existed in New South Wales was enhanced and consolidated. It was reviewed and a formal partnership agreement was signed between our minister and the Aboriginal community with AHRC.

I would like to come back to that if you will allow me. Other areas obviously, as I indicated, are similar to other parts of the country where we have talked about state and Commonwealth relationships, structures, coordination, time frames, funding collaborative arrangements, work force issues and service issues and other matters.

After the discussion, I would like to summarise some of the key issues from our perspective. Instead of going over stuff that you no doubt have heard elsewhere, what I would like to do is talk a bit about how we work with the Commonwealth and the Aboriginal community in New South Wales .

Firstly, the arrangement that we have with the Commonwealth, through the framework agreement, includes the four key players—that is, the Department of Health and Family Services; OATSIHS; the state ATSIC representative, Commission John Delaney; New South Wales Health; and the Aboriginal Health Resource Co-op.

We meet every three months as the New South Wales Aboriginal Health Forum, and we have core agenda issues such as health planning—local Aboriginal health planning and state wide health planning. Obviously, during those forums we also talk about a number of other local issues or, more appropriately, state wide issues. I believe that has been working successfully since signing the framework agreements and that the relationships between the respective parties continue to get better all the time.

The partnership that New South Wales Health has with the Aboriginal Health Resource Co-op—if you will allow me, I will refer to them as AHRC—is unique and continues to improve as far as relationships with the state health system go, not only at a state level but throughout the state itself. It enables the department to work with the community in the development of policy, strategies and planning. If the department itself is developing a particular strategy—again, which comes about as a result of consultation with the community—the department takes the lead role in the formulation and the drafting of that policy but works very closely with the community to ensure that there is community input and, more appropriately, that the policy we are developing actually addresses the needs of the community.

For far too long, not only in New South Wales, previous policy development has lacked Aboriginal community involvement, and most of the time those policies have missed the mark in addressing Aboriginal health. So I believe that the partnership we have enables us to do things better and to do them with the community.

The partnership has been operating for some years. I have been in New South Wales only since February 1997, after having spent a brief stint with the Commonwealth,

and I believe before that the partnership was operating and, I guess, finding its way. Now it has certainly established itself as a very good arrangement to address Aboriginal health in New South Wales.

We have been working extremely hard with the partnership, and in fact only last week or the week before at our partnership meeting the partnership itself was actually able to sign off on four policies which we have been working on with the partnership and the community over the last 12 months. In fact, the partnership actually signed off on the Aboriginal health policy for New South Wales Health in New South Wales. It also supported an otitis media strategy, which has taken some 18 months to two years to develop, and a family health strategy for the Aboriginal community in New South Wales.

The other strategy that the partnership endorsed was, more importantly, an agreement to develop, improve or upgrade—whatever word you want to use—the New South Wales Health information data systems. We recognise that New South Wales Health does not have as good a health system as anywhere else in the country but, having realised that, over the last 12 months we have set about to work with the community in improving our system. The purpose for that is to give us a better reflection of, or a more accurate account of, the health status of Aboriginal people in New South Wales. That process of improving the system will involve the community itself.

One of the issues that was identified that is addressed in the submission is better coordination. Through the community's involvement in the development of the information system, we are hopeful that we will be able to work a lot closer with the Aboriginal medical services that are established in New South Wales. I believe there are some 30 Aboriginal medical services. The information systems that exist in the country are fragmented and there are no links in any way. When you present statistics on Aboriginal health, they are not necessarily accurate. The situation is always under-reported but hopefully once we improve our system here, the health status statistically will probably go through the roof.

CHAIR—That is not just peculiar to New South Wales by the way. We have not found that situation any different anywhere we have been. I get annoyed about that actually.

Mr Agius—I would imagine that once that actually happens people will become alarmed but an alarming situation exists today, even before we improve our systems. What that will do is tell us more accurately how bad it really is. That is very briefly the presentation.

CHAIR—Who are signatories on that partnership agreement?

Mr Agius—The signatories are the minister, currently Andrew Refshauge, and the AHRC. The partnership is signed by those two heads.

CHAIR—The cooperative is a representative body. How is it representative? Are they elected people?

Mr Agius—I understand the AHRC will be in after my presentation and I would imagine that their presentation will—

CHAIR—That is a good response. I will ask them.

Mr QUICK—How have you solved the use of indigenous identification in your data collection to fully cover every person who presents at a clinic whether it is out in outback Wilcannia or at a hospital in Tamworth, Sydney or Newcastle so that we get an actual, real database?

Mr Agius—I would expect that any system that you develop will not give you an accurate account. It will still be under-reported because the identification of origin is dependent upon the individual deciding to identify. There is no obligation for the individual to identify. What we are intending to do is actually run a campaign pointing out the benefits for Aboriginal people in identifying when they present to a health centre anywhere in the state. The choice itself remains with the individual to identify. Every effort will be made to encourage the individual by pointing out the benefits when people identify.

Mr QUICK—In those 17 health regions is there a common form when people present for the first time?

Mr Agius—When someone presents to a centre there is provision currently on the form to identify. The problem is there has been a reluctance to identify because of the repercussions, stigma or whatever reasons when Aboriginal people identify when they present to a centre. At the same time there is always a reluctance on the part of the admission clerk or the admin person sitting behind the desk to ask the question for fear of intimidation or repercussions. At the moment we have a situation where someone presents; the clerk may or may not ask the question and the patient may or may not answer the question.

Mr QUICK—It is obvious in certain parts of Australia that people are of indigenous extraction. Do people automatically tick the box when they go through?

Mr Agius—I do not think so. I do not think that administration or clerical staff are prepared to make that assumption just because I appear to be Aboriginal. It is important that the clerical person actually asks the question.

CHAIR—I introduce Mr Allan Morris, the member for Newcastle, and Mr Harry Jenkins, the member for Scullin in Victoria. Mr Agius is appearing on behalf of the department.

Mr ALLAN MORRIS—Is there a submission?

CHAIR—No. We will have a submission by the time we have our private meeting next week to formalise it. It is in draft form and subject to being approved before it is submitted to us.

Mr QUICK—Do you have the same model for Aboriginal health in each of the 17 health areas? I would think that there ought to be a couple of models. We have Aboriginals living in the Redfern area and Wilcannia. Their needs are totally different. Then you get out to Central Australia and there is obviously a difference between Wilcannia and those people. Do you see the need for perhaps three models in order to maximise the outcomes for the people?

Mr Agius—In most communities there are some similarities. The models themselves may vary from community to community. What we attempt to do is work with a community to develop a model that is most appropriate for their needs in the area. It would be difficult to try and develop a blanket model that would be used in every area. As you say, the circumstances are a lot different between Wilcannia, Dareton, Walgett and Brewarrina compared to those in Redfern. It is a matter of working very closely with the community to develop collaborative services in each area.

Mr QUICK—Are we right in saying that, up until recently, there has been a blanket approach to the whole issue of Aboriginal health and we have not got into specific models to deal with specific areas and their problems?

Mr Agius—I am not sure what you mean by 'blanket'?

Mr QUICK—Basically having an Aboriginal health policy, and irrespective of where you are in New South Wales or Victoria or Queensland, there is an assumption that you have various problems in areas of the heart or kidney, so there is a policy for dealing with the kidney problems of Aboriginals. I would imagine the problems in Redfern would be a hell of a lot less than perhaps out in some of the more remote and rural areas. The need for allocation of money and setting of priorities would be totally different because some people might be into mainstream in Sydney, whereas in Wilcannia and in even more remote areas you deal with what you have on the ground. If it isn't there, well stiff!

Mr Agius—Whether it be a state or national policy, there would be a view that it would be a blanket policy. But when you get down to implementation of that in a local community, it is implemented differently from in Redfern. I guess there has always been the assumption of that. I guess the mistake we have made is that, if we develop a blanket model or blanket policy, then we expect that it would work in every area. I think that may have contributed to our not improving Aboriginal health.

Mr QUICK—You mention partnerships. You did not mention anything about partnerships with local government. All the evidence we seem to get is that a lot of the

problems that you are facing are a result of inactivity from local government agencies. There is also a partnership with the education department to ensure that Aboriginal people have an opportunity to gain a proper qualification, so that if they wish they can become Aboriginal health workers, from basically swabbing eyes up to becoming a medical practitioner. Can you give us a brief run-down of the partnership with local government and the education department?

Mr Agius—Yes. Firstly, the partnership that we have with HRC is simply that with the Aboriginal medical services. However, that does not restrict New South Wales Health or HRC from developing close links with those other agencies. In fact, we established formal relationships with the education department to develop the otitis media strategy, for example, because the target group we are looking at are kids between two and five. The second group would be slightly older. We have started that process with the education department and that has enabled us to develop further links with them to address other issues.

With local governments, that is probably correct at a state wide level. We have not formalised or made approaches to form links with the Local Government Association. Certainly at a local level in the community, for example, Greater Murray at Wagga, the AMS and the area health service have a forum which is the second tier of partnerships. The main partnership is with the health department and the AMS.

I cite Wagga as an example where they pull in all those other agencies. They bring in local government, the police, DOCS. I think the forum consists of about 20 representatives. Those partnerships can exist at a local level to address local issues, like unifying efforts to attract specialist health staff to rural and remote areas. In the past the AMS has gone off separately from the area and local government to attract GPs, in particular, to local communities. There is a more coordinated effort. The three parties are on about attracting a doctor to rural and remote areas. Previously we were doing it separately; we are now doing that together.

Mr QUICK—But the Minister for Local Government, if you have one in this state, is in a pretty powerful position because he is allocating money for roads, sewerage and goodness knows what else in his portfolio. We have heard evidence that local government put out rate notices, but the roads are absolutely appalling and there is no comparison with other services that they provide to so-called white areas. What you are doing is fine, but perhaps the Minister for Health ought to develop a bit of a stick approach, rather than hoping that things work their way up from the ground. The evidence that we have seen is that it is an Australia wide problem. Something as simple as sealing a road will mean the kids in the back of the pick-up travelling for a couple of hundred kilometres might have asthma and eye conditions cut by 30 or 40 per cent because the road had just had a spray of tar over it.

Mr Agius—Yes, I would agree. In fact I cited you an example where the community is working together. I could also cite you an example where we cannot get the

local council to the table. That is in the far west in Dareton, where there is a major environmental health project currently taking place in Namatjira Drive, which is the Aboriginal community where every effort has been made to include the local council in that project. It is a major project to improve environmental health issues in that community, but the local council are not being cooperative or supportive.

It varies around the state. There are forums where our director-general sits down with various other key service agencies such as DOCS and the Department of Aboriginal Affairs every two months to get Aboriginal health issues on that agenda to get those issues addressed at that level. But you are right. I take the point.

CHAIR—In the submission that you will be submitting to us, and I hope that is going to be in a matter of days, not weeks—

Mr Agius—No, it will be next week.

CHAIR—Will you be canvassing the issue of training of Aboriginal health workers, even medical doctors, and nursing, and what initiatives are being advanced in New South Wales on those fronts?

Mr Agius—I have mentioned that the work force issue was one issue that was addressed but I do not think it is in the detail that you are seeking. We do identify the fact that Aboriginal workers, the front line people at the community level who address Aboriginal health, do lack adequate training and skills. In fact, it was made very clear to me about three weeks ago at our state conference of Aboriginal health workers whom we employ within the state health system that they lack adequate and appropriate training to address the problem. We have started to address the issues they have identified.

However, there has been some attempt by the Commonwealth to develop health worker training at a national level. In particular, I participate with my counterparts in other jurisdictions with the Commonwealth to come up with strategies to start addressing that problem.

Mrs ELSON—Does that mean the New South Wales health system has not got any initiatives going, or had any in the past?

Mr Agius—Health workers are supported to undertake accredited training programs. In fact, health workers attend the Cumberland College training program here in New South Wales. It is an accredited course. They choose to take on either that course or other accredited courses and they are supported to take up those opportunities.

Mrs ELSON—When you say ‘supported’, is that funded?

Mr Agius—Yes, the usual time off, whatever the conditions are. They are certainly encouraged to take that up.

Mrs ELSON—You would not know how many Aboriginal health workers are out there?

Mr Agius—We had about 140 at our conference about three weeks ago but I estimate, because we do not have any accurate figures, it would be in the vicinity of 200 to 250 health workers.

CHAIR—You mentioned earlier a part answer to my next question but the first term of reference that we are addressing is to get a handle on the role the Commonwealth has. You mentioned one in respect of getting some national standards on training. One of the frustrations that we have found is that each state is different. You have already mentioned a community at Dareton just across the river from Mildura, and Merbein, and you have got state border issues and different standards, different rail gauges. It is pretty frustrating for the Commonwealth sometimes—

Mr Agius—It is extremely frustrating.

CHAIR—when it is pretty much the funding agency. Training is a good one but what other roles do you see that the Commonwealth could take a greater lead in?

Mr Agius—I do not know if it is about taking a lead. It is about working with the jurisdictions to work more closely with developing strategies or the allocation of resources. You may have heard that in some areas we actually have an AMS across the road from an area health service. The AMS has been built but we have wards that are closed or buildings that are not being used. The resources that go into buildings could be better used by finding out from the state what is available in the local area. If we have buildings that are not being used, money is going into building something when the Commonwealth could actually talk to us about what might be available in the local area.

Generally, there needs to be more coordination in allocating those resources because, if we are funding an AMS and the Commonwealth is funding an AMS and something goes wrong, there is no joint approach to assist that AMS in addressing those problems. Previously we have done that independently, but what we are trying to do is work out ways of doing that far better than we have in the past.

When an AMS has management problems, or whatever the problems might be, the Commonwealth or New South Wales has attempted to address them in isolation of one another. But we are now talking about how we might do that better. I guess that commences at the national level through allocation of resources.

Mr ALLAN MORRIS—Concerning education and training, we are aware that Austudy and Abstudy preclude any other financial support from state governments, such as scholarships. We are currently canvassing with Queensland whether they have got some suggestions as to how we might overcome that. If we aim to have people educated in remote areas, indigenous or non-indigenous, they are going to need more than your normal

income support to study in somewhere as far away as Sydney or Newcastle or the like. Queensland, for example, has health scholarships which preclude Abstudy.

I have two questions. Firstly, is there any liaison or relationship going on between you and the training providers, like Cumberland or the universities, in terms of establishing traineeships where people actually work in holidays and so on back in regional and remote communities? Secondly, is there any discussion going on between you and the Commonwealth about funding of students to try and ensure we get access to courses, because people living in small towns tend not to get the same marks as people living in the cities? They have got a real problem.

To summarise, firstly, is there any discussion going on between you and training providers in terms of traineeships or access to education? Secondly, is there any discussion between you and the Commonwealth as to a more appropriate scholarship system where students from outlying areas can be funded appropriately to live in places like Sydney, which is impossible for most country people?

Mr Agius—There isn't as far as scholarships are concerned at the moment. There has been some discussion with my counterparts in other jurisdictions and the head of OATSIHS to come up with scholarships. I understand the various allowances, Abstudy and Austudy, do not have provisions for Aboriginal health workers to do their training. However, there are a couple of other sponsorships that we fund with the Commonwealth. One of them is a management training program that is funded by DEETYA, the Commonwealth and the state health department. I am not sure if there is a fourth party but I am aware that they are the three main parties. It is management training with the ACHSE, and there are a number of Aboriginal Medical Service staff at a middle management level who are sponsored to undertake that course. At the same time, we also have public health sponsorship where we have a number of Aboriginal people undertaking environmental health accredited training programs. Again, that is funded by the Commonwealth and the state.

Mr ALLAN MORRIS—In your submission, is that material there? If not, could you give us some material about that?

Mr Agius—Yes. It is not in the submission.

Mr ALLAN MORRIS—We are trying to canvass around looking for angles because we all see education as being pretty critical. The second matter I wanted to raise with you in terms of cooperation is that we see a very high incidence of kidney disease and high dialysis usage. Projections are, in fact, quite dreadful, particularly in some parts of Central Australia. When we ask about water testing and so on, it appears that water testing is mainly for bacterial testing. The cooperation between those kinds of bodies and health management does not seem to be all that strong.

Mr Agius—No.

Mr ALLAN MORRIS—Is there a program taking place with water testing that tests for both bacterial and mineral content, particularly with bore water or other forms of water supplies, in remote and outlying parts of the state? If so, who is actually responsible? Is it the health department, is it local government or somebody else again?

Mr Agius—I really cannot answer who is responsible. There is the environmental health forum which is a major project where we have a number of agencies involved that look at those sorts of environmental health issues. We actually established three pilot projects to look at, in particular, those sorts of issues in three remote communities. Water testing is part of that pilot.

Mr ALLAN MORRIS—Does that testing incorporate mineral testing as well as bacterial testing?

Mr Agius—I am not familiar with that.

Mr ALLAN MORRIS—Could you find that out? We were told in one place that, in fact, they come and test the water but they do not test the minerals. There is a real suspicion about the mineral content. I think the testing body saw itself as testing for bacterial E.coli and things of that nature because minerals were not their game. We are curious as to whether or not that is the case.

Mr Agius—Yes.

Mr ALLAN MORRIS—As I understand it, each area health service in New South Wales is regionalised in the sense of health administration, as Mr Quick was saying. As I understand it, each area of health service is required to have an Aboriginal health program within its regional health strategy. Is that closely monitored or is it simply a lip-service thing?

Mr Agius—It is probably monitored more so recently. We are, again, working with HRC in developing local Aboriginal health plans which the HRC are actually doing at a local level, and we are at the moment developing a state wide strategic plan.

Most of the areas do, in fact, have a specific Aboriginal health strategic plan, and I would say that some of the others, like North Sydney, probably do not have because there is not a need. There are probably a few that have not done it because of that—or do not have a significant population.

Yes, I think it is being more closely monitored now because that process now needs to be linked into—around October is our time frame—our Treasury budget processes, and also with the Commonwealth. It was a requirement of part of the framework agreement.

CHAIR—This question has just occurred to me because of what you have just said

about North Sydney having no need. In those areas where there is, do you encourage the mainstream services to be more culturally relevant in the delivery of their service?

Mr Agius—We are making every effort to make area health services more culturally sensitive to the issues. One way of doing that is employing Aboriginal health staff within those areas. We have Aboriginal health coordinators, which is probably a third tier management level, for coordinating Aboriginal health within a given area of health service. Then we would have a number of Aboriginal hospital liaison staff, health education officers, Aboriginal mental health workers, women child health workers, women's health workers and so on. So we would have workers across each one of those areas. It is the coordinator's responsibility, obviously, to coordinate those activities in a given area.

CHAIR—Is that working in a collaborative sense between the Aboriginal health service and the mainstream service? Are we able to break down some of that?

Mr Agius—It is probably working in some areas. Again, it is at different levels where mainly coordinators in areas are working with AMSs, with the local community, and in some areas it may not exist. But I guess there has been a more concerted effort over the last 12 months to get those arrangements up and going. In fact, the Chief Executive Officer of the AHRC, Sandra Bailey, and I, are currently organising a program to visit each one of the areas to encourage the local players, the area health services and the AMSs, to formalise their local partnerships to work closer together.

CHAIR—How do you measure the effectiveness of all of that, though? To me it seems that, if it is done well, there ought to be some sort of reward, like a carrot, in funding terms, I suppose, to encourage—

Mr Agius—I think the success can be measured by simply getting people to the table to talk. At the moment in some areas that does not exist. In other areas, we now do have people sitting down to talk. The carrot could be collaborative services to the community. Instead of the area services rolling up at the house and providing services and then the AMS rolling up—two or three cars rolling up to provide services—we have one car rolling up with one or two people working together to address the needs of that particular family. So I guess the carrot could be interpreted as that. But simply getting people to the table to talk about more collaborative approaches and efforts would be considered a success in itself.

Mr QUICK—With the Commonwealth abrogating its responsibility in the area of dental health, and with your recent state budget being handed down, what have you put in place to ensure that the dental needs of ordinary non-indigenous Australians are being looked after. More importantly, as a result of our inquiry, what steps have you put in place to try and drag from the very depths, according to the Australian Dental Association, the dental needs of indigenous people in New South Wales?

Mr Agius—The Commonwealth withdrew the Aboriginal dental health program last year. I am not across what the arrangement was before I got here, but I understand that the Commonwealth was funding a number of AMSs to provide dental services. New South Wales Health is in fact funding a number of Aboriginal medical services to provide dental services. The Commonwealth withdrew, and obviously that created a vacuum and problem for the AMSs which no longer had Commonwealth funds. The AMSs and the AHRC then approached the department to secure funding for those dental health programs that the Commonwealth previously funded. As I understand it, some of them either have had to close the doors or have attempted to struggle to provide the same service, hoping that the funds will be made available again. To date, other than New South Wales Health continuing to fund the AMSs which provide dental health services, there is no arrangement to continue.

Mr QUICK—So there is no new money in this state to—

Mr Agius—There is no new money in this state to pick up the dental health program that the Commonwealth withdrew.

Mr QUICK—I would imagine that the dental health program for indigenous people in New South Wales prior to the Commonwealth pulling out was not all that crash-hot anyway?

Mr Agius—Again, this is before my time. We had set up a number of best practice programs; I think there were about four or five at the time. We have managed to fund a few other dental health programs in AMSs. But we are not funding as many as we would like to.

Mr QUICK—Where are those best practice places? Some of us are wandering around Australia in various committees. I am sure we would like to wander in and have a look at what is best practice.

Mr Agius—Okay. From memory, I think there is one in Kempsey and one in Grafton. I do not recall the three others but there are about five.

Mr QUICK—Another partnership I guess we need to talk about is that with state housing authority. Where is the best practice Aboriginal housing policy being implemented? That is another perennial thorn in the side of Aboriginal health—that the houses are not constructed properly. The sewerage connections do not work, the drainage is appalling and whoever has got the contract to construct them does not really care. They are only in it for the money. Have you solved those problems and, if so, where are the best practice housing cooperatives or housing areas in New South Wales?

Mr Agius—I am afraid I cannot answer that one. I could take it on notice and—

Mr QUICK—In the submission, hopefully some mention is made of that. It is

really a vital partnership because we have seen evidence in Central Australia where people are living out on the ground, as they did traditionally, when there are 40 or 50 empty houses.

CHAIR—Just a point on some of those extra questions on notice: please do not let that hold up the submission.

Mr Agius—No. The submission will come—

CHAIR—You could put that in as a supplementary if you want to.

Mr Agius—All right.

Mrs ELSON—I just want to add on to Harry's question about dental health also. We understand that that Commonwealth funding was there for only a short period of time and then to take away waiting lists. Has the New South Wales government plans to increase the funding over the years to ensure that that does not happen again?

Mr Agius—That the Commonwealth withdraws?

Mrs ELSON—Yes. That funding was only promised for a certain amount of time. It was not forever. Does New South Wales, especially in the areas of Aboriginal health, have plans to get money to make sure those services do not deteriorate to that point again? Have they increased their funding? By the sound of what you said, it has not increased.

Mr Agius—I understand that there was an arrangement prior to the Commonwealth withdrawing. In fact, they did that without any consultation with us at all.

Mrs ELSON—But it was not a program—

Mr Agius—As I understand it, it was not.

Mrs ELSON—What actions has the New South Wales government taken there to ensure that those waiting lists do not happen again to the same extent? You might have to take that on notice.

Mr Agius—Yes.

Mrs ELSON—There was another question I particularly want to ask. Many states have put in positions of Aboriginal hospital liaison officers. Many other states have positions of Aboriginal hospital liaison officers. Does New South Wales have the same thing in hospitals to facilitate—

Mr Agius—Yes.

Mrs ELSON—They do. In every hospital or in where there is a need?

Mr Agius—I believe they are in most hospitals. I cannot give you accurate figures, but I understand that they are in most hospitals.

Mrs ELSON—Are these Aboriginal people?

Mr Agius—Yes.

Mr ALLAN MORRIS—I gather there are some concerns where Aboriginal liaison officers are actually located in hospitals. Some of the health service workers located in hospitals cause some discomfort in a cultural sense. The perception is that they are controlled rather than able to act as a genuine interface. There has been a decision made to locate all health workers, et cetera, within the hospital context. I know there has been some debate about it and there are probably some different views in the department.

Mr Agius—Sorry, I am not aware. That is not to say there are not any concerns about HLOs operating in mainstream hospitals. But I am certainly not aware of any concerns that workers have at this stage about their ability or capacity to do their job.

Mr ALLAN MORRIS—If we see health liaison officers as being connected to a family or to a household, if someone is ill, it allows someone to actually go and look at the household. They may pick up other issues and other problems like education for example and hence make use of the networking that is available. It is a medical versus community model question that comes up. If the health worker is seen and controlled as a health worker, then you lose the ancillary community benefits of picking up that there is a child who is not going to school, that there is a preventative health issue or some other issue like domestic violence, which is not visible as a medical problem, but may be very important as a developmental problem.

The benefit of having the contact is lost if the person is perceived and relates only to the health system. The concern that has been coming through is that they are there to extend the medical system in the community rather than provide linkage to the communities.

Mr Agius—A hospital liaison officer is just that. We would need to be careful of that. Hospital liaison officers are not social workers or other workers to do everything else. Hospital liaison officers are to assist Aboriginal patients or families that utilise a hospital to make their experience with the hospital as easy as possible.

Mr ALLAN MORRIS—Let us go further than that. If in fact the people live 200 miles away, there is not much liaison. The hospital experience would be an unpleasant one and often a very damaging one. The hospital does not see it as its problem because its problem is the patient, not the rest of the family.

Mr Agius—Yes.

Mr ALLAN MORRIS—That is not the way Aboriginal communities work.

Mr Agius—That is right.

Mr ALLAN MORRIS—What I am picking up is that we are trying to get the Aboriginal community to change and adapt. Obviously they have not after 200 years and we are still doing it rather than recognising that to help them with their health we need to relate to them in their cultural terms. Whilst the health workers are employed by the hospital per se and therefore are on a hospital budget, we try a medical solution when in fact the impact of the health incident may be as a result of other issues like domestic violence. We treat the symptom not the cause and we fail to recognise a whole of health approach, a whole of body approach or a whole of family approach which I would have thought is good health practice. We do not seem to have quite worked out a way of doing both yet.

Mr Agius—I would have to think about that one.

Mr ALLAN MORRIS—That is okay.

Mr Agius—I understand what you are saying but it would be difficult for those workers to become that sort of worker back in the home. I understand what happens is that, if a family visits, the hospital liaison officer assists that patient and the family—

Mr ALLAN MORRIS—Can I give you an example? Right now I have got a constituent who has to attend dialysis three days a week. The Aboriginal HACC budget has gone; it is not available. The relationship between the Aboriginal HACC services, the hospital services and the other HACC services is very poor. It is incredibly difficult for this woman to go to dialysis; the family has no car. There is no relationship—no connection. The dialysis at a medical centre becomes a question of getting there. Is that someone else's problem? The effect of that on the family and on the health of the woman herself is much worse. It seems to me that we spend a lot of money on dialysis. I am not expecting you to answer this now. This is one of the real challenges we have across the country, quite frankly. It is not in itself a criticism. It is a recognition of a problem being much more than being able to provide a medical service.

CHAIR—You responded by saying that you did not think that was the role of a liaison person, but what needs to be recognised is that a better health outcome can be achieved if the liaison person ensures those support mechanisms occur—not that they do them, but they make sure that they occur and the end result is to get a better health outcome.

Mr Agius—You are right. There are many people in those situations and circumstances. One of the problems is not enough people working within the health

system within that given hospital to provide that sort of service or support that you are talking about. The real issue there may be that we just do not have enough workers in a hospital to provide that support.

Mr ALLAN MORRIS—It may well be. But, perhaps again, when you look at the *Hansard* with hindsight, you might have some ideas you can offer us or some suggestions on how we can do that better in terms of integrating those services in a whole of health or a whole of family approach. I would say whole of family, not simply whole of health.

Mr Chairman, you may not be aware, but in Newcastle the health service is very involved in providing a house adjacent to the hospital for families to come and stay while a family member is in hospital. This is very novel and we hope it will be very effective. That is a recognition of the whole of family approach, which is often needed, not simply a whole of health approach. We are making some progress, but I would be curious to hear if you have got any suggestions as to how we can do it better.

Mr Agius—I think that that probably is a good example because we, with the community in the area, made a significant contribution towards the establishment of that house on hospital grounds. It could be a best practice model for other areas.

CHAIR—We will hear about that tomorrow, will we?

Mr ALLAN MORRIS—You will hear a bit about it, but not as much as I would have liked. It was a bit uncertain but it is now actually going ahead. I guess what I am saying is that they are doing a whole of family approach by having the family close by when a person is in hospital, particularly if they have come from Dubbo or somewhere for intensive surgery. That really has an effect on their health. We are doing that but we are not doing it for someone on dialysis whose family has great difficulty getting her into her treatment and back. In a way we are doing some good things, but we are not recognising that it is wider. Right now with the Minister for Health being the Minister for Aboriginal Affairs as well in New South Wales, you have got an unusual opportunity to try to pioneer.

Mr Agius—As I indicated earlier, I believe that we are working a lot closer with the community here. That is probably a good example of where we did make a significant contribution to do something with the community. We are attempting to do that every day.

Mr QUICK—If someone said, 'What's your highest priority in indigenous health in New South Wales?', what would the answer be, off the top of your head?

Mr Agius—To ensure that the community is involved in identifying what that priority is.

CHAIR—Thank you very much, Mr Agius. We will be really looking forward to the department's submission. We have been waiting for it for a while, so please make sure

that it is not more than a day, as you have said.Take the other questions on notice but respond to them when you can and also as quickly as you can.

[9.34 a.m.]

BAILEY, Ms Sandra, Chief Executive Officer, NSW Aboriginal Health Resource Co-op Ltd, 102 George Street, Redfern, New South Wales 2016

VINCENT, Mr Frank, NSW Aboriginal Health Resource Co-op Ltd, 102 George Street, Redfern, New South Wales 2016

CHAIR—Welcome. I need to point out that, whilst this committee does not formally swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives itself. Any deliberate misleading of the committee, therefore, may be considered as contempt of the parliament. This is a good mechanism as it serves to give witnesses the protection so they can be fearless in the giving of their evidence.

We have just received a formal submission from you. Committee members might want a bit of an opportunity to peruse what you have given us in your submission. While they do that, we can listen and read at the same time. You might like to just make an opening statement about the initiatives of the co-op. We have just heard evidence about the activities of the cooperative, so you need not think that you need to describe it. Please tell us about some of the good things you are doing and some of the things that you feel are not being done well enough. Then we will proceed to some questions.

Ms Bailey—Thank you. We apologise for our submission being late so you have not had a chance to look at it. I would perhaps speak to some of the sections in the report. First of all, I have enclosed a brief outline in the cover of the report about the AHRC and how we were established following the Aboriginal task force on Aboriginal health in 1982 and 1983. Basically, it recognises that Aboriginal community control is crucial in laying the foundation for a better standard of health care for Aboriginal people.

The role of the AHRC includes advising the ministers for health and Aboriginal affairs at state and federal levels, on Aboriginal health policy, programs and needs. Our membership comprises Aboriginal community controlled health services and Aboriginal community controlled health committees in the process of establishing services. The full membership meets twice a year. The executive is elected annually by the Aboriginal community controlled health services in each of the 12 regions of the state and meets at least quarterly.

The AHRC also has a partnership agreement with the New South Wales Department of Health which has, as one of its guiding principles, the importance of Aboriginal community control, intersectoral collaboration and a partnership approach. We participate in that partnership as equal partners with the department. It is not like a merging of two inherently different groups. It is basically a partnership to bring about the changes needed by two different groups that need to work together.

I can elaborate on that a bit further. Basically, the AHRC acts as a peak body for Aboriginal health in New South Wales and is also an affiliate member of NACCHO, the National Aboriginal Community Controlled Health Organisation. I will leave it at that.

In relation to the report, we have provided a number of headings basically for convenience to show the importance of areas we have discussed. We found that, in responding to yet another inquiry into Aboriginal health, the merits of previous reports should be given due consideration to determine whether their findings have been given due consideration and implemented. Most of the investigations would be by the national Aboriginal health strategy. The effectiveness of given programs and policy in Aboriginal health can be assessed by using this document as a yardstick.

The national Aboriginal health strategy, as you are probably well aware, was the product of an Aboriginal working party which consulted widely with Aboriginal communities throughout the country. It was the first written strategy that was available for governments to implement. Later on in the report we talk about the evaluation of the national Aboriginal health strategy, which foundered for one reason or another. In fact, there were quite a few reasons why the national health strategy had not been implemented.

Bringing it back to New South Wales, we have provided details on the Brereton report, which I mentioned a moment ago. The terms of reference include an investigative function, with reporting responsibilities on the effectiveness of Aboriginal health and measures necessary to ensure greater Aboriginal control over health resources. The report followed an in-depth review and numerous consultations throughout the state and concluded that radical changes were required in the deployment of resources to combat the poor health status of Aboriginal health within its borders. The quote given in the report states:

‘Specifically, the time has come for the devolution of control over Commonwealth funds designated for Aboriginal health within NSW to the growing body of Aboriginal community-controlled health services which have an important role to play in the provision of primary health care for Aborigines . . . [and] an expansion of the stock of resources devoted to the improvement of Aboriginal health in New South Wales . . . ’

So it was a turning point in the sense that it was actually advocating change and that previous funding arrangements needed to be changed to get funds directly to Aboriginal medical services. Frank might want to talk about that after I finish. In addition to that, the Brereton report recommended:

The establishment and maintenance of good health standards among Aborigines will be dependent on the fostering of complimentary social policies including an effective land rights program, a welfare policy that encompasses greater community control and employment and housing policies designed to alleviate poverty.

That was also recognising that Aboriginal health must be seen in its broader sociological context.

A further recommendation of the Brereton report was the establishment of an Aboriginal health resource committee to advise on the decisions in relation to Aboriginal health resources. The report then goes on to discuss what is meant by Aboriginal community controlled health services, so that provides your inquiry with a definition if you do not already have one.

On the next page of our submission we list the members of the AHRC, and on the following pages, from page 5, there is a brief history of health within Aboriginal communities. We have set that out in different periods—the pre-colonial and early colonial period, the federation period and the post-World War II period. We then go on to discuss Aboriginal health within a sociological context.

One definition which we feel is particularly important, and probably underlies the whole issue of Aboriginal health and ill health and lack of wellbeing, is the sociosomatic illness. Our submission states:

'Socio-somatic illness' means those physical ailments, bodily disorders and psychological or mental conditions which impair the health of Aboriginal people and the well-being of Aboriginal communities resulting directly or indirectly from socio-logical disadvantage;

Our submission goes on to state that that disadvantage includes issues such as:

economic deprivation; racism; assimilationist legislation, polices and practices, unemployment; lack of housing; dispossession, alienation from land, forced separation from parents, children, families and communities; and other traumas, which impinge and have impinged upon Aboriginal people since dispossession.

Having put the situation of Aboriginal health in its historical context, and indeed in its sociological context, we go on to discuss the stolen generations, the impact that that has had on Aboriginal health, the inquiry and the importance to the Aboriginal community of the government's response to those recommendations.

We then go on to discuss Aboriginal health and hospitals. Some of the issues which I heard being discussed a moment ago were on the relationship between Aboriginal people and hospitals, the feelings that Aboriginal people have and the experiences that they have had in the health system, and how those impact on their willingness to access those services.

It is important to make the connection there. The very reason that Aboriginal community controlled health services came about was because most Aboriginal people were not accessing mainstream health services. They felt uncomfortable that they were not being given proper treatment and that their presence was not appreciated in some places. Because proper preventative health care was not available, when people were admitted to hospital, their condition was mostly quite grave. The hospital earned the reputation of being a place where people went to die basically. For a lot of those reasons, Aboriginal medical services came around.

There are present day measures to address a lot of those issues, including cultural awareness, training, Aboriginal hospital liaison officers and Aboriginal health workers with Aboriginal medical services. I will talk more about the implementation of the partnership when I talk about planning further on.

We have provided a definition of Aboriginal health on page 10. I am sure you have heard this before during the inquiry. It states:

'**Aboriginal health**' means not just the physical well-being of an individual but refers to the social, economic, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death life.

We have also included a definition on health related services to illustrate the holistic approach that is encompassed within that definition. You will see a heading on page 10 about the necessity for Aboriginal health services. We will provide you with further information under that heading at a later date.

On economic poverty in Aboriginal communities, the national Aboriginal health strategy and the recent University of New South Wales study on poverty demonstrate that Aboriginal people are the most impoverished group of people in the country and that this has a major impact on health of Aboriginal people. The national Aboriginal health strategy and the Royal Commission into Aboriginal Deaths in Custody gave definitive accounts of the interrelationship between poverty, housing, poor health, poor education and so on. I guess the poverty cycle would aptly describe that.

On page 11, we have made a quick list of economic barriers to health services. The first dot point is exclusion from specialist services. I think that actually should be 'difficulty accessing specialist services'. The following dot points cover: isolation—the lack of specialised staff in rural areas; infrequency of visiting specialists to those areas; transportation, a major issue; the denial of bulk billing in certain areas; inadequate funds and incentives for visiting doctors and specialists—I would like to talk about that more in relation to the medical officers award; inadequate or overcrowded housing; unpalatable drinking water and inadequate sewerage systems; nutritional deficiencies,. and so on. A lot of those dot points are economic barriers as well as contributory factors and a number of other things. It all highlights the interrelatedness of most issues.

We have discussed cultural barriers. We wondered how we should put in writing the fact that a lot of Aboriginal people would rather accept the consequences than go to hospital. That is still relevant for a lot of people today.

We then discussed primary, secondary and tertiary health care. We do this with a view to defining or illustrating that Aboriginal community controlled health services are not duplicating services. We make the distinction further down, between primary medical care and primary health care, and that should be clearly distinguished. We talk about primary health care within the context of the Aboriginal community control model and

that it has a lot in common with the World Health Organisation definition which states:

. . . Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's overall health system, of which it is the central function and main focus . . .

Basically, it concerns the important role that Aboriginal community controlled services play within the general health system in terms of preventative health care, primary health care and referrals on to secondary and tertiary health services.

On page 13, we also make a distinction that Aboriginal community controlled health services have been doing for a long time what is now called coordinated care or integrated care and that most Aboriginal medical services that care for patients who have multiple illnesses or co-morbidity—not only their medical condition but also their social and emotional condition—provide services such as counselling, referrals, advocacy and welfare support, to name a few. We have also made a note that the Minister for Health, Dr Wooldridge, mentioned the wider area of health care in a public statement that he is seeking to be delivered by general practitioners throughout Australia, focusing on the quality of health care and not the quantity of health care. On that page, in bold, it says:

The Aboriginal primary health care service since its inception has been providing integrated care and any astute observer of Aboriginal health—

And history—

would have to acknowledge that recent moves to such concepts as **holistic health, co-ordinated care, integrated health care, community health services, health partnerships** and ***non-body parts* approaches to health**, used now widely by the Department of Health, *et al*, have all been direct contributions that the Aboriginal community controlled health sector has made to Australian health.

And to the Australian health system. We also refer to the memorandum of understanding between ATSIC and the Department of Health and Family Services and the fact that that memorandum recognised or acknowledged the indispensable role of Aboriginal health services.

CHAIR—I am sorry to interrupt you. We can incorporate all of your submission in the evidence. It may take you a while if you want to proceed through it page by page. My colleagues are champing at the bit to get to questions, to get right to the bone on issues. You do not need to work through the whole submission. I suggest that, because we have agreed to incorporate it in the record, unless you have some really vital points you need to make, we go to questions.

Ms Bailey—I will move on. I am sorry I took so long. I was trying to lead you through, but I got a bit bogged down. On page 29, there are further specific health issues.

They are in dot points. Because of our time constraints, we were not able to provide a great deal of detail. However, I am happy to talk on any of those issues; I am happy also to answer questions. We will be providing further written information on those issues. We are happy to answer questions.

CHAIR—I was going through them before. We have identified all of them. With the border issues question, we were planning on going to Mildura to get a handle on the debt and the New South Wales-Victoria problem across the river. I do not think there is one issue there on which we have not already uncovered a huge amount of frustration.

Mr QUICK—On page 24, you talk about establishing culturally sensitive and ethically sound privacy and confidentiality protocols for the routine collection of standardised data on Aboriginal and Torres Strait Islander health. That is fine, but what if there is a reluctance on the part of the indigenous people, when they front up at a medical centre, to tick the box? What difference is there between the culturally sensitive and ethically sound privacy and confidentiality protocols that deal with me when I am admitted to the Royal Hobart Hospital? Surely those things are in place. We just need to be a little bit more culturally sensitive.

Ms Bailey—There are two points there. The first is the development of protocols—

Mr QUICK—That are culturally sensitive. I would imagine ethically sound privacy and confidentiality protocols are already established in all hospitals in Australia.

Ms Bailey—Yes, that is true.

Mr QUICK—So the thing is basically culturally sensitive.

Ms Bailey—That is true. Can I just say that the development of those protocols brought together numerous privacy, confidentiality and ethical standards which were already existing and embodied in various pieces of legislation and policy documents within New South Wales and nationally. In relation to culturally sensitive and ethically sound privacy and confidentiality, the NHMRC have guidelines on Aboriginal health research—I think you are probably aware of that. Appended to that document are the ethics in relation to Aboriginal health research. I will get the proper title for you. They actually set out the importance of having culturally appropriate standards. I think that basically relates to those protocols having a cultural application. We do recognise that privacy and confidentiality protocols for routine collection exist and they are also embodied into that document. In relation to culture, there is culturally sensitive information. There is the right of Aboriginal community people to own their information. The other question that you raised was—

Mr QUICK—Can you expand on that: they want to own their own information? We have got a situation where there is a disparity between indigenous and non-indigenous people in health areas—for example, in regard to their life expectancy, there is a

horrendous difference. People expect appropriation of money to deal with the problem and unless we know the bare facts, if the facts are blurred about Aboriginal health, as they have been for the last 150 years, and if no-one is collecting proper data and indigenous people are culturally sensitive about whether they tick the box—for example, in my state people are arguing about Aboriginality—surely, almost in the 21st century, we can come up with some protocols irrespective of whether the people are Lithuanian, Muslim, Aboriginal or 100 per cent Anglo-Saxon. Surely, in this day and age, we can come up with a protocol that everybody agrees with, so that, when people enter a hospital—whether they are a Lebanese refugee or an indigenous person in Wilcannia—there is an understanding to improve the person's health standard. When someone fronts up with a piece of paper with a series of questions, the people will say, 'This is part and parcel of excellent health delivery. I will participate.' How do the indigenous community see their responsibility—whether you are a Redfern Aboriginal, a Wilcannia Aboriginal or an Alice Springs Aboriginal—in getting out and saying, 'Grin and bear it; there are protocols in place, so tick the box'?

Ms Bailey—Could I say something? I think perhaps it is not fair to assume that these protocols are going to prevent information from coming forward. In fact, these protocols will assist the giving of information from the local Aboriginal community level right through to the national level. The protocols that have been developed allow for discretion on the part of the local Aboriginal community controlled health services in relation to what information they give across. The reason for that is that, in the past, there have been people—who have been unaware of cultural situations in communities—who determine data sets and who interpret data when it comes in, without reference to cultural differences and how that information might be interpreted in different ways.

Mr QUICK—As my colleague Allan Morris from Newcastle said, there is the huge problem of the need for dialysis for Aboriginals in Central Australia. I would imagine that they want to get service. Are they going to say, 'We have this huge problem and we don't want anyone else in Australia to know so we will go away and hide the statistics'?

Ms Bailey—We are not about hiding statistics; we are about making the information readily available. The national Aboriginal health strategy recognised the need for data. The Aboriginal community controlled health services recognise the need for data, and the experience of the Aboriginal community has been that data has been misconstrued. Basically, they have had concerns about data being misused or tied to Aboriginal health funding as well.

Mr QUICK—Who has been playing silly twits with the statistics?

Ms Bailey—Basically, that has been the experience in the past with departments. It might not be deliberate, but inappropriate application and interpretation of data that is available has occurred. Might I say also that the statistics that are available are understated and undercounted because of the reluctance of Aboriginal people to report on a lot of

issues. I think that goes to your question about ticking the box about Aboriginality.

Mr QUICK—The shame should be the current system and not the indigenous people. We have been mucking around for 20 years with God knows how many reports. All of us on this committee want to resolve this as we go into the 21st century so that 20 years down the track they are not going to say, 'Well, the Forrest report in 1998 was another report.' We would like to come up with some solutions.

Unless we can get all the definable data out there and unless indigenous people, irrespective of where they are in Australia, say, 'Let us get all the facts out, let us collect all the data and see what money is needed to solve the problem'—not just from one bag of money but from local government, education, health, DOCS or whatever else it is, and through being culturally sensitive in throwing up that big umbrella—

CHAIR—I think Ms Bailey does not understand the nature of your question. We are trying to get at two things. Firstly, why is there resistance from Aboriginal people to actually provide the data and, secondly, there is concern that it is being used in the wrong way. Could we focus on those two?

Ms Bailey—Could I answer those two?

CHAIR—Yes.

Ms Bailey—There are two issues, and I invite Frank to comment as well. Firstly, in regard to the ticking of the box in the health system and identifying as an Aboriginal, there is a reluctance in relation to the collection of that data. Sometimes there is reluctance on the part of the staff to ask the question; sometimes there is reluctance on the part of the Aboriginal person presenting to identify, and they are not going to identify if they are not asked. Under the Aboriginal health information strategy in New South Wales we are working now to address that issue. That is a separate issue.

In terms of the community's involvement, I would like to make two brief points. Firstly, there has been enough research done on Aboriginal people in the last 20 years right now, at this point, to justify much more resourcing to Aboriginal communities.

I do not think it is any secret what the problems are and where they exist and what can be done to address them. However, that is not to say we do not want accurate data; we want accurate, reliable data that is ethically sound. I might add that we know of incidences where, for example, a researcher has gone to a hospital and accessed hospital records, without the consent of those patients, for research, and they have sought to publish a paper on it. They are the issues that we are concerned about.

Mr QUICK—Does that happen with other ethnic groups?

Ms Bailey—I do not know. It probably has, and they should be concerned about

that, because that relates to the very issue of confidentiality.

CHAIR—But if the information is de-identified to individuals—

Mr QUICK—What is the problem?

Ms Bailey—Sorry, this particular incidence I am telling you about was not de-identified information; it was individual hospital records.

Mr ALLAN MORRIS—It is plain wrong.

Ms Bailey—It is absolutely wrong for any group. This all leads to the reluctance of Aboriginal people who, obviously, from an historical legacy, reject intrusion of the system.

Mr ALLAN MORRIS—Can I perhaps pose for you a slight variation on that? One of the complications we are really finding is that there is a real lack of data, even though there has been a lot of research. When we actually go out and start saying, 'What is the quantitative data available,' there is a real absence. Secondly, there is often a massive distortion because the data collected 20 years ago was actually quite different from what is relevant today.

We are finding it very difficult to measure any shift in activity. Even worse than that, I was talking to someone the other day who was telling me that an Aboriginal service, not in New South Wales, said they were too busy to record changes in reporting of scabies and the like following dog treatments because they were too busy. Yet we think there is a very strong linkage. And this is not a health question; it is more of an environment health issue. The peak people who provide that service are not medical people, but the failure to actually measure means that we will not get funding for that service to be continued because there is no evidence that it is actually doing any good.

It is the actual nature and the quality. Someone said to us at a hearing once that you—that is, the Aboriginal community—are the most measured people in the country, and that is probably true. But the fact is you are also the most undermeasured in terms of the conditions that exist as well.

Ms Bailey—Yes. I will add to that and then hand it over to Frank to make some comments. If you look at the chief health officer's report in New South Wales in 1997, and I do not have a copy with me, it sets out a lot of Aboriginal statistics which are appalling. They are compounded by the fact that they are severely understated because data collection in New South Wales at the present time is not good. We are working to address that, but we are insisting that those protocols are culturally sensitive because there is that need and people need to feel secure with it so that they will participate in it.

Mr QUICK—Can I just give you an example? Say that John Howard decided to

reinstate the Commonwealth dental program, just for the indigenous population, and said to you people, 'Here's $10 million for Aboriginal dental health,' which areas in New South Wales would be your highest priority?

Ms Bailey—Everywhere.

Mr QUICK—Is it Grafton, Wilcannia, Kempsey, Wollongong, Newcastle, Wentworth? Have you got those sorts of statistics to say that zero to five dental health needs are worst in this area or that area? They are the sorts of things that people want to know so that, if the money comes down the pipeline, it is funnelled to this spot here. Education has a list of priorities. Has your cooperative got a list of priorities when it comes to dental health?

Ms Bailey—We know the profiles of the Aboriginal health services throughout the state.

Mr QUICK—So you can give me a list of the three top priorities for dental health in your cooperative?

Ms Bailey—I could give you a list of 10.

Mr QUICK—Can you give us some?

Ms Bailey—In fact, it is almost pointless to make a small priority if you are talking about three absolute priorities. When everywhere is in such a disgraceful state, it is an absolute priority everywhere.

Mr JENKINS—Would you want to give us a priority other than dental for communities? If we are talking about giving you the opportunity to have control over the health services—

Mr Vincent—It is also a question of where those dental services are going to be placed. We may well be able to identify that at Wilcannia there is a dental problem, but in Wilcannia there is no AMS and the people are using the hospital, and that is fine. But if you go to a place like Burke, most Aboriginal people do not use the hospital at Burke.

It is also a matter of where you place those services and where it is going to be best utilised to service the Aboriginal population. This is the argument of AMS, that it is fine to say we will put in the services but if you do not have an AMS in that area to provide that service then you will have difficulty with utilisation by Aboriginal people of those services. That is what the partnership is about, it is about trying to address those issues then trying to increase utilisation by Aboriginal people.

Back on that other point, in regards to data, what we have tried to do in our report is give you a historical view of why Aboriginal people have not used mainstream services.

It is because mainstream services were part of the whole removal of children process. All these institutions in New South Wales were part of the removal of children process. The racist attitude of people in those institutions has caused Aboriginal people to be reluctant to use those services. When people can get away with not identifying, they will not identify.

Mr QUICK—You mention here a hospital in the 1960s. Has that hospital changed its attitude? Has the administration of those hospitals been more culturally sensitive, or is it still a problem.

Mr Vincent—At Kempsey they have changed. That is because the AMS there is working in partnership with the local area health service and the local hospital to address those issues. It is changing. However, because of past practices a lot of people still have a lot of mistrust and misgivings about those institutions. I do not think in one generation you are going to turn that around.

Mr ALLAN MORRIS—Mr Vincent, I should point out that we have had a lot of evidence about that problem. My colleagues and I have not discussed it formally but certainly we are very sympathetic and very supportive of Aboriginal control of medical services, although we have not done a vote on it. We have had a lot of evidence of that, and even the AMA evidence was very strongly supportive of Aboriginal control of medical services. We are not wishing to impose on you in data collection some mainstream kind of mythology but it is done more so to try to understand the nature of the problem. That is our difficulty.

CHAIR—The frustration we have is that without the absence of data we are unable to prove the point that this particular initiative delivered and that therefore that is a good model to recommend it. If it is not backed up by good data, we cannot recommend it. That is the frustration that we are expressing. If the treatment of pet dogs or scabies is successful, or if the treatment of sexually transmitted disease got a good result, we need to be able to show it and we need to be able to show it quickly. Anecdotally we see that when the issue has been owned by the community itself it could be delivered, but we cannot prove it scientifically because we do not have the data. That is the frustration we are expressing.

Mr JENKINS—Your submission is only suggesting that you want to be involved in the process.

Mr ALLAN MORRIS—We have no problem with that.

Mr JENKINS—We are not too divergent. You are acknowledging the importance and suggesting to us some of the integral elements that would be required in achieving that.

Mr Vincent—That is what we are trying to say. We are not saying that we are

opposed to data collection or the use of it, all that we are saying is that we want to have some input in that data collection and the safeguards as defined in the ethical barriers and how that data then gets used. We are not really arguing the point here.

CHAIR—We are just trying to get to the bones of why it does not happen.

Mr QUICK—I am really worried that if there are 17,350 indigenous children under the age of five who are in need of dental health, that that is kept away because someone does not want to share that because that is an embarrassment. For God's sake let's deal with the 17,350 kids and provide them with dental health because in the long term the cost is going to be enormous if we do not get the resources in at the early stage. Let's get all the hoary old details out and then we can argue the case.

Mr ALLAN MORRIS—I guess we should be a bit frank. We have had a bit of evidence suggesting that in some communities there is some sensitivity vis a vis other communities. We have had evidence that some community elders think that the incidence of STDs in their community is embarrassingly high and therefore they do not want it known. They believe the incidence in other communities is lower and therefore it is a failure on their part. So the confidentiality of it is in some cases to protect their perceived reputation. We picked that viewpoint up in our travels. We are concerned that that viewpoint may override the greater benefit. Not having the data may make them worse off than—

Ms Bailey—Because our communities are smaller, and even if information is aggregated on a regional level, it is still not necessarily de-identified. It comes back to ordinary, mainstream principles of confidentiality as well as cultural considerations.

Mr QUICK—Conversely, we heard evidence from Aboriginal communities in Alice Springs who said, 'Look, we've got this problem with petrol sniffing. We are the worst in Australia for petrol sniffing. Therefore, we decided to do something about it and here are the strategies we put in place, and we are succeeding.' The incidence has gone down. Basically you have a cohort of people of a certain age but there is not anybody else joining in. That's great, but before they said, 'We are embarrassed and we don't want to share it.'

Can I move on to another issue, the issue of local government and partnerships. Earlier we were talking about the treatment of indigenous people by hospitals. Local government has got a terrible record around Australia of indifference and insensitivity. Is this mentioned anywhere in your report? I have not had a chance to have a close look.

Ms Bailey—We did talk about local government, although it is just a brief reference. I might say two things in relation to that. Firstly, the local Aboriginal health plan that the AHRC is developing under the partnership agreement is a result of consultations with Aboriginal communities. We are developing plans which take account of all existing services, the gaps in services, the performance of those services and

allocation and utilisation of resources, and we are trying to mesh all of those services so that they are utilised to the best advantage of everybody concerned. Local government will be involved at that level.

Secondly, in New South Wales there is an Aboriginal health, environmental and infrastructure project. That has been a joint project of the Department of Aboriginal Affairs and the Department of Health in New South Wales. That has also been addressing issues with local governments. Other than their role in relation to Aboriginal health, I think it is more within the realm of the New South Wales Aboriginal Land Council and regional and local land councils who have a lot of dealings with those issues. But in relation to health obligations, that is how we will be working with them.

Mr QUICK—Can you give us examples of best practice with local government through your cooperatives? Which local government areas are doing the right thing? If we happened to be visiting as a committee, we could go along and say, 'Council A is doing a fantastic job.'

Ms Bailey—I do not think I could—

Mr Vincent—I do not think we could point to one.

Ms Bailey—We do not work a lot with them but some of our member organisations may be working with them.

Mr QUICK—Is it easier to think of ones that are not doing the right thing? I do not want you to necessarily name them.

Ms Bailey—I could not give you a specific example.

Mr Vincent—The best body to give you examples would either be the Department of Aboriginal Affairs in New South Wales or the New South Wales Aboriginal Land Council who, as Sandra said, have a closer working relationship with those bodies than we do.

Mr QUICK—We hear the issue of housing brought up. Surely in this day and age we could construct an atypical house that would deal with all the concerns of indigenous people to reflect their cultural needs and aspirations. It is obviously not a three-bedroom, brick veneer house. Is there anywhere in New South Wales that we can visit to see an example of housing that is adequate, where the sewerage works and it is ideal for the needs of the community? Or are we still guessing?

Mr Vincent—I think there are attempts to address those needs. Because Aboriginal medical services and the AHRC are not particularly involved in any discussions or any decisions that are made about housing—

Mr QUICK—But you are talking about a holistic approach to health. If you live in a house that is built on a slab that is below the water table, the holistic approach to health goes out the window. We saw evidence when visiting Central Australia of water lying around and there were dogs, inappropriate sewerage and rubbish collection and the like.

Ms Bailey—That has probably been one of our biggest tasks. ATSIC has the environmental health budget and we are trying to work under the framework agreement between the Commonwealth and the states. We are trying to work jointly and ATSIC is on that forum. I think some of the issues, as you rightly say, relate to poor design of houses. Faulty workmanship and probably out-and-out bad practice on the part of some builders and contractors in their work in Aboriginal communities have contributed greatly to poor health. There are places where there have been less than the specified requirements for building, like the slabs on houses and the number of people utilising the sewerage system in that area. This comes to our attention in relation to the environmental health and infrastructure project.

I cannot recall the exact details, but some houses were being built recently where the builders had just put shelves in the kitchen and no cupboards. The whole issue of design for Aboriginal housing needs to be looked at closely. Some things have been done by the Centre for Appropriate Technology in Central Australia on housing design. There needs to be more of that.

The other thing is the cost arguments and the economic rationalism of that design. I have seen communities where the community starts off with a plan. Then one department comes along and says, 'Here's your plan; here's your five stages of development.' They arrange the houses in a way that would maximise harmony and good living conditions. Then the next department comes along and says, 'You've got money for two houses; you'd better put them close to where the power lines and the sewerage are.' Then more funding is available and, before you know it, you have houses closely located. You have a sewerage system that is overloaded because there is no planning for sewerage for future growth in Aboriginal communities and all those issues. I will not go on with that because I think it is well documented.

Mr QUICK—But surely that goes back to the question about local government involvement? I know that, if I want to put an extension on my place or alter the drainage, the council inspectors are there in a flash trying to justify their existence with the local government authority. Do local governments not give a toss about it?

Ms Bailey—Speaking from personal experience, local governments have been involved in building and development applications. They should be involved in provision of roads, water supply, garbage collection and so forth.

One of the major issues contributing to the poor design of houses, and also town planning in communities, is the fact that there are all the economic arguments about where

you locate houses, how much you can get if you want two houses out of one budget—they have to be so many squares in area—and all those issues. A lot of communities do not have access to expertise.

Mr ALLAN MORRIS—I think what you were saying earlier was spot on with what we have been hearing. Tell us what you would recommend, if you were us, to overcome that kind of problem so there was better coordination? We are trying to find ideas, answers and suggestions as to how we can address those issues. We have found location of housing, the environmental health issues, the testing of water and the whole coordination process seem to be a real weakness.

Ms Bailey—The New South Wales Aboriginal environmental health and infrastructure program has sought to do that. It is into the third year of its life span. I think it is a major task. I do not think there are any easy answers, but I do think that the community has to be listened to and they have to be give access to appropriate expertise. I know of a community that has just put a water supply in for their community and they have been ripped off by the contractor. The system that was supposed to go in did not go in. They are having trouble finding their way through the maze of departments and layers of authority and who makes the decisions and so forth and what they can do about it. That is an issue we are taking up.

Mr ALLAN MORRIS—We do not have the state submission yet, so we have not seen what they are doing formally. You are suggesting that the Aboriginal environmental health and infrastructure project is an effective program. That is one we should look at closely.

Ms Bailey—No, I am saying that that project has a committee and that committee is quite large. We have been trying to address the issues of coordination. I do not think it has met for a while. Some work is still being done. I am just endorsing that it is very difficult because there are so many players, funding agencies, architects, engineers and building inspectors.

Mr ALLAN MORRIS—Yes, I think we agree. That is what we see. You will get a copy of this *Hansard*. If you want to offer some further suggestions as to what you think of that program and how it could be improved or whether or not it has been given enough weight, a supplementary note might be helpful. We are looking for constructive ideas to try and bridge some of these chasms. They really are chasms within states and between states and federal, and between departments. It is just enormous.

Mrs ELSON—As Harry said before, we have been doing these inquiries over the last 20 years and we have not come up with much and we really need that data. The New South Wales government this morning told us they were working with you to start this off.

Ms Bailey—Yes, that is what they said.

Mrs ELSON—I cannot see the picture of how the New South Wales government and you are going to collect this data that we need so importantly to come down with some findings and extra funding.

Ms Bailey—Sorry, what was the question?

Mrs ELSON—I am at a loss to find out how you are going to get these figures because this morning the New South Wales government said they are working with you to try to get this data together.

Ms Bailey—That is right.

Mrs ELSON—This is the first attempt at it, by the sounds of it. But I have not picked up from you this morning how this is going to be done. You said it is starting and you cannot give us any—

Ms Bailey—Yes, I can actually. The Aboriginal health information strategy is a six-point strategy. The first point was the development of an Aboriginal health information agreement. It is actually a memorandum of understanding which is attached to some guidelines. That sets out roles and responsibilities, and addresses concerns in relation to privacy and confidentiality, which I have already covered. The second point of that is to address the whole reporting and identification issues that Mr Quick raised. We are also working towards establishment of a database of Aboriginal health.

Mrs ELSON—And 'we' is?

Ms Bailey—The health services will collect data from our health services and the Department of Health will improve their data collection procedures.

Mrs ELSON—How long would this procedure take, do you think?

Ms Bailey—I could not give you an exact time, but we are working towards it.

Mr Vincent—I think there is an initiative by the current Commonwealth government to fund AMSs for data systems; that is, already an initiative has been undertaken. I guess it is just a matter of the devolution of funding for those services that want to take on the initiative of data collection. In New South Wales, all of our AMSs are supportive of that initiative.

Ms Bailey—A lot is happening now that was not happening, say, two years ago or one year ago.

Mrs ELSON—That is all I was trying to determine—whether anything has actually changed.

Ms Bailey—It is not going to be an overnight thing, but I think we have covered a lot of ground. Also, that health information agreement has partnership endorsement, which makes it all the more workable.

Mr QUICK—Am I right in believing that six states and two territories will develop their own strategies, or is there a suggestion that perhaps the New South Wales protocols are going to be effective right across Australia? My big worry is that if we wait for the six states and the two territories to sit down and develop a strategy—

Ms Bailey—Just to clarify that, at the national level there are data protocols in place which have been adopted by NACCHO and there is improved reporting on data. That is all taking place now and being developed. At the state level, we have the health information agreement. So those national data protocols are intended to have national application.

Mr QUICK—So by the year 2000 hopefully things will be in place and whatever recommendations this committee makes in the way of X, Y and Z hopefully we can get into it?

Ms Bailey—Yes. But I would still like to emphasise that I think we have enough reports and statistics that give us shocking enough statistics now to start to act in some areas. I know that leaves the finer detail which needs monitoring and evaluation through data, but the justification is there for more resources now.

Mr ALLAN MORRIS—We agree with that. We just want to know how to direct them.

CHAIR—I thank the representatives from the cooperative for their time today. We will take your submission and digest it some more and perhaps we might have some further questions. Thank you very much for your time and effort today.

[10.40 a.m.]

BARTLETT, Dr William Bennett, Public Health Consultant, PlanHealth Pty Ltd, 31 Buttenshaw Drive, Coledale, New South Wales 2515

CHAIR—Welcome. Before proceeding I need to point out that, whilst this committee does not formally swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the House of Representatives itself. Therefore, any deliberate misleading of the committee might be considered as a contempt of the parliament, but this has the advantage of offering to witnesses the capacity to be fearless in what they tell us.

We have a submission from PlanHealth which has already been published as part of the formal volumes associated with the inquiry. It was submitted in October last year and things might have moved on a bit since your submission. You might like to highlight a few points and then I will proceed to questions from committee members.

Dr Bartlett—I suppose I have been a bit influenced by hearing the tail end of the previous evidence in relation to data. I think one of the difficulties in the way Aboriginal health is treated compared to non-Aboriginal health is that in non-Aboriginal health there is an expectation that basic health care services are actually there and in place when that is not in place for many Aboriginal communities. The issue about data is, I would say, that the fundamental data that is needed is already there—it is the sickest population in Australia—and the responsibility of the Commonwealth government particularly ought be to ensure that health services are put in place. I think that is a failure of the Commonwealth.

The barriers to that happening have been, from the 1979 House of Representatives inquiry into Aboriginal health right through, this identification of the differences between the state and federal jurisdictions and, I think, local government jurisdictions as well. Yet the Commonwealth government has not had the political will or capacity to actually use its authority, given that it holds the money bags and has some constitutional rights, as I understand it, to in fact bring recalcitrant states and local government to heel about what I would argue are not indigenous rights but human rights.

What I have tried to do in this submission is to present some sort of framework for moving in that direction which needs some understanding of what the actual poor health status of Aboriginal people is about. Part of the previous year's practice has been to think in terms of, 'Well, housing is an issue. We should be able to fix up housing.' But, of course, people live in houses and if people do not have the means to maintain housing, if there is a lot of substance abuse in a community where the housing technology, if you like, the health hardware, gets damaged, then that does not help those problems. So things like housing can become much of a hazard much though it may improve health.

The holistic approach to health that Aboriginal people talk about is actually

recognising that a lot of these things interact. Health services themselves do not produce many good health outcomes. You can immunise people, you can do some things about ischaemic heart disease, which I do not believe Aboriginal people have access to at the moment—across the board, at least—but when it comes down to a lot of the young adult mortality rate particularly we are talking about things that there are no medical interventions for. These things actually are to do with community cohesiveness. They relate to the histories of these communities and they have some implications for how health services are delivered.

I know that the community control health sector has been arguing for some years that some core functions of primary health care should be identified.There were some attempts to get that included in the framework agreements but, unfortunately, that was not successful. I do not really know the ins and outs of the reasons for that. I think that is really what we need to get back to, recognising that there are some core functions in primary health care, which include the provision of basic sickness services and the delivery of medically driven public health measures like immunisations.

There needs to be proper support for primary health care, which includes things like the capacity to have in-service training support for management and those sorts of things, which small stand-alone community health services often do not have the capacity to maintain. There needs to be a recognition that there are these other dynamics required for actually turning around health strategies which may relate to nutritional issues, such as store policy in some communities. It may relate to trying to address the youth suicide rate and things like that which require community action to have any chance of success.

Data collection ought to be understood in terms of: what is it useful for? When it comes to the first core function, which is the provision of basic medical and public health services, we do not need a lot more data to know that that has to be delivered. It is time we got on with the job. In terms of the support, I think that is also part of what government responsibility ought to be.

The third part is where there needs to be support for Aboriginal people themselves to begin to document the impacts of their programs in what I would describe as a participatory evaluative type process. I think that is where you are going to get data about whether the scabies program for the dogs impacted on the kids or not.

I suppose I am advocating that there needs to be some better clarity about health services and the need for that. A lot of the other issues are a matter of intersectoral relationships, which I also think the Commonwealth is in the best position to have some impact on, given that it holds the moneybags.

CHAIR—I was interested in the early part of your submission where you identified the spiritual connection. My perception is that, of all the things we have seen, this is very difficult to demonstrate in any scientific way, other than in an anecdotal sense. The idea is that, if people feel good about themselves, they are going to be a more

motivated and more conscious community and all the rest of it. Can you help us by pointing us towards a scientific way to demonstrate that assertion? You know what I mean about that, obviously, because you have referred to it in your submission.

Dr Bartlett—I think it is hard to demonstrate these things in scientific ways. Science is not always the best tool for looking at these things. It is possible to get some understanding by comparing communities. Central Australia has been my main experience. When you look at the best things that are going on in Central Australia, particularly in the eastern area, these are in communities that were not subjected to forced settlements like the government settlements or the missions. They tend to be more self-motivated and more autonomous in their behaviour.

I am not saying they do not have health problems, but I certainly think there is a dynamic in some of those communities that is quite different from the remnants at least of those settlements more on the western side of Alice Springs, where I think the petrol sniffing is. I was interested in your comment that you have information that petrol sniffing is on the decline. It is the reverse of information that I have got in recent times. It is those communities where petrol sniffing tends to be the worst.

The histories of people relate to how self-active they are in terms of their own lives. Self-determination is an issue that is multilevelled. It does operate at a national people to people level, but it also clearly has a family and community level to it. I do not know whether that helps, but I think that those histories have or have not robbed people of certain independence. I am not sure—

CHAIR—I am surprised that you cannot answer me. I would be desperate to find something more than just anecdotal comment that this is a key. If there is a comparison to be made, we would be interested for some data that does that—for instance, that shows a community and its outcomes compared to one that is grossly different. We do not have that information. I think you have heard that frustration from other witnesses we have spoken to already this morning. You cannot demonstrate to the satisfaction of the bureaucracies the way they operate: what gets better outcomes and what does not? I will leave it at that; I am not surprised that you cannot answer me. From my point of view, without trying to steer the committee, this is something that is important to get a resolution on.

Dr Bartlett—The anxiety that I have about your anxiety is that, when you look back over the last 20 or 30 years, there is a real tendency for central government bureaucracies—and I do not just mean the Commonwealth; it applies just as much to state and territory governments—to look for models. Models are fine. They can be stimulating and I am all in favour of people documenting their experience. But, when it comes to imposing models, you often find that they do not work because of this sort of nebulous area that you are referring to—spirituality. I do not know what spirituality is in any real way, but I have learnt to respect the fact that it is something that is deeply important to people and their health. It is not just important to Aboriginal people but to everybody.

It seems to me that one of the ways of getting around to the sort of need that central government seems to have for models is to get down to regions where you actually get closer to the local realities. An example of this is the healthy Aboriginal life team. I am not sure whether you are familiar with HALT, which was operating in Central Australia in the early to mid-1980s. It used dot paintings and things like that as a way of trying to deal with petrol sniffing particularly. Their focus was supporting traditional family and kinship relationships. There was actually a private company that was involved with that program and I think there were inevitabilities about the sustainability of ongoing funding to a non-Aboriginal private company for that sort of program. But there was one Aboriginal person involved in that program. The community from which he came was where the program actually worked. The Menzies School of Health Research did an evaluation of this project. In the other communities where it was tried, it did not work. It illustrates the problem of thinking that maybe the essence of the model is having a local person of status involved in the program. If you do not have that, it does not work and that puts a different slant on the general way that there has been a search for models that work.

Dr NELSON—I have two questions, Dr Bartlett. You have worked for eight years at the Central Australia Aboriginal Medical Congress and you also worked in Redfern and numerous other places. Could you perhaps give us a description of what life is like in trying to deliver health care to people in each of those different environments? Aboriginal people in Redfern using the service there presumably have different needs from those you looked after in Central Australia. Is there a different approach that ought to be applied to the problem? I presume that is consistent with what you were just talking about. I have also got something else that I want to ask you about in your submission.

Dr Bartlett—I worked as a volunteer at Redfern for a very short period of time a long time ago. So, whilst I have been back there a few times, I think there are other urban centres I would be more familiar with currently.

I do not think there are huge differences, but there were some very significant ones, between the rural and remote situation and the urban situation. One is that in urban situations usually the health infrastructure, the environmental infrastructure, is more or less in place. There are houses, there are sewers, and there is a major water supply. So the problems with those sorts of things tend not to be such an issue in the urban areas, although poor quality housing can be an issue.

There is also the reality for urban people that the issue for them in terms of access to health services is often feeling intimidated by the mainstream, and that is where Aboriginal controlled health services are quite important in the urban setting. But once they have made that contact the full range of health care facilities are available in Sydney. There is not a problem in accessing them, whereas in the remote areas you have got much more significant problems about remoteness.

In Alice Springs, a CAT scan was only put in the hospital after the Royal

Commission into Aboriginal Deaths in Custody. Until then people did not get CAT scans unless they went to Adelaide. That is still an issue. There is a whole lot of medical technology that just is not available in Alice Springs.

I referred before to the problems with ischaemic heart disease. There are a lot of young Aboriginal men dropping dead of myocardial infarctions who have not been diagnosed as having ischaemic heart disease. I think that shows assistance problems these days. A lot of these deaths, I would suspect, should be preventable.

So you have the remoteness, and you have the general lack of resources that operates in remote communities compared to a place like Sydney. I suppose there are some other issues like languages and those sorts of things, but they may be a strength of the bush in many ways.

Dr NELSON—On page 10 of your submission you said:

The other historic influence on health is the welfare system that has robbed many Aborigines of their autonomy as a people. By welfare I do not mean the social security entitlements—although there are problems with whole communities being largely dependent on such payments which were designed as a safety net. Rather I mean the institutionalisation of people—

At the moment you can open a newspaper or turn on a radio or television in any part of the country on any day of the week and hear people, or you hear Mrs Hanson herself and those who subscribe to those sorts of views, promoting what is becoming a popular mythology—that a lot of money is spent and provided to Aboriginal people but they suffer poor health and all sorts of other deprivations through choice. There seems to be a significant section of the Australian community who feel that the reason why we see obesity in some communities and malnutrition amongst children in others is that money that is provided in terms of individual payments is spent on alcohol, gambling, fast food, tobacco and other things which contribute substantially to the ill health which we are then trying to address.

I am not for one minute suggesting I subscribe to these views but, as politicians, as people trying to both lead and represent public opinion, it is a very difficult thing. Do you feel that we are likely to make progress, certainly substantial progress, in improving health for Aboriginal people if we continue to provide financial assistance in the way that we currently do? Apart from perinatal mortality, there seems to have been negligible improvement to the health of indigenous Australians over the last 20 years. And there is some evidence in areas in the Cape and certainly in the Torres Strait that perhaps we are going backwards. Would you like to comment on that?

Dr Bartlett—There is a problem with the communities being economically dependent on welfare—there is no question about that—but it is very difficult to know where you go to address that.

Dr NELSON—At Kowanyama, for example, we were told that.

Dr Bartlett—I think the CDP, which probably would be politically unpalatable to the mainstream in Australia, has been embraced with vigour by a lot of Aboriginal communities. It is basically work for the dole but they have seen that as a way of getting people active and doing useful things in communities, et cetera. I think the economic marginalisation is a major issue which is easier to see ways through with some communities than with others.

You talk about people who are poor spending money on tobacco and alcohol. That is the classic behaviour of people in poverty. It is not Aboriginal people specifically. Wherever you go in the world where there is a lot of poverty, whether it is in Russia and their vodka or the old gin drinkers in London, part of the behaviour of people caught in poverty is that they consume what they have got for now. It is not the fundamental cause, surely, of their poverty. So I find it hard to know how to address that.

I think that there is a problem, particularly in a lot of rural areas. I was in Roebourne for a few months a few years ago and the tourist bus route goes straight through the town. On the left-hand side is the park and on the right-hand side is the pub, so everybody who goes on the tour through the Pilbara, through Roebourne, comes back with stories about the blackfellows in Roebourne being drunk and what not. However, hidden away in the back blocks of the town is the community itself, who are not drunk. There is this image problem.

We have this extraordinary situation that the majority of non-Aboriginal Australians have virtually no relationship with Aboriginal Australia, so they construct reality from these distant observations when they are on holidays in the bush or something. You can see where some of the attitudes come from, but it is not taking into account the fact that more Aboriginal people do not drink at all, proportionally, than non-Aboriginal people. Most white fellows, probably 95 per cent, drink alcohol to some extent, whereas probably something like 40 to 50 per cent of Aboriginal people in some places do not drink alcohol at all. That sort of stuff is never put in balance and so you do not need many out of control drunks to cause a lot of disruption, to be very visible publicly, et cetera.

I do not know whether I have answered your question. I do not know how to deal with this phenomenon at all. I think it is a major issue for Aboriginal health, but I can see that there has been a change. Many people are now walking with their heads high, being proud to be Aboriginal, where once they were trying to fade away into the background. That is not a healthy state of mind, to be denying who you are, and that is really a common situation now in a lot of bush communities.

CHAIR—In your submission you made that comment about the percentage of drinkers. I have made a reference against it. That is more than just an anecdotal opinion of yours. Can you substantiate that statement about the proportion of Aboriginals who do not drink alcohol?

Dr Bartlett—Yes, that has been well documented. The Menzies School of Health Research has done a number of studies that have shown that. I think Carol Watson in the late 1980s established that

Dr NELSON—On average about 34 per cent of indigenous people are non-drinkers whereas 16 per cent of non-indigenous Australians are non-drinkers of alcohol.

Mrs ELSON—I want to add to what Brendan said about the nutrition problem that is within the Aboriginal community, especially in remote areas. Can you see a way to solve that problem?

Dr Bartlett—I think some food subsidies would help. Food is so expensive in those bush communities, and you are dealing with really poor people who have no economic activity to speak of. Where there are cattle, that is eaten with bush tucker, which reduces the ability for people to practise more traditional economic activities through hunting and gathering. Store food is outrageously expensive.

Mrs ELSON—We were talking to a group of Aboriginals in Alice Springs who said that they do not want to bush hunt any more for their food. Especially the young women are likely to give their children chips and coke.

Dr Bartlett—That is what they are—they are generalisations.

Mrs ELSON—That is what they told us.

Dr Bartlett—I think there is a pattern of young people, like everywhere, tending to want to leave bush communities and go into the big smoke, whether it be Alice Springs or Sydney or wherever, and often, in that period, people are more likely to drink, et cetera. There seems to be a pattern that once people have reached the age of 40, if they get that far, there is a tendency for them to go back to a more sober lifestyle. Often it is those people that are the main strengths of, say, the out-stations and maintaining them. Often you find that those people are looking after their kids' kids whilst their kids are still into that dazzling lifestyle in the fast lane.

It is difficult to predict whether those sorts of patterns will continue generation after generation, but it does seem to be a pattern at the moment, which I do not think we should be surprised at. As I say, young people, whether they are in Papua New Guinea or Bathurst, find rural life somewhat boring and want to get into something more exciting and risk taking. One thing we need to recognise is that that age group is also an age group that gets its kicks out of taking risks.

Mrs ELSON—Thank you.

Mr QUICK—Turning to the education and training of the current staff—Aboriginal health workers and people who have progressed further rungs up the ladder—

and also the recruitment and provision of training nationally to have a nationally accredited Aboriginal health worker regime, how do you see that operating given state and territorial regimes where they want to do their own thing, and DEETYA, or whatever it is called these days, has got a responsibility for the whole of Australia?

Dr Bartlett—I think it is a bit of a dog's breakfast in many ways, partly because, if you are looking at medical practitioners, there is some sort of commonality between the courses that lead to registration as a medical practitioner, whether you go to Sydney University or Melbourne or wherever, whereas with health workers there are fundamentally different functions between the states.

In the Northern Territory, there is an Aboriginal health worker registration board, and they are clinicians. They are trained to diagnose and treat common conditions in the community. That is not the situation in any of the other states. My understanding is that in other states they are not allowed to actually give vaccinations, to give injections.

CHAIR—So some are cultural—

Dr Bartlett—Brokers?

CHAIR—Yes, rather than clinicians.

Dr Bartlett—Yes.

CHAIR—We are a bit unsure as to what is the best model. You need a bit of both, don't you?

Dr Bartlett—Most health workers in the Territory do come from the community; they do have that community knowledge and a degree of cultural knowledge as well. That comes with being Aboriginal and being from that community. The status question is sometimes a little bit trickier. Certainly the health workers in the Territory are very strong on maintaining a clinical function. And I think it has been an important role they have pursued over the years in terms of their relationship to the community and whatnot. There are some significant barriers to that model being taken up in the other states because of the professional jealousies that exist, which I guess Brendan would know about.

CHAIR—I think we all know about them.

Dr Bartlett—It is a fairly big ask. Also, there is a different tradition with health workers in New South Wales and Victoria and whatnot. I would imagine that the existing health worker work force in New South Wales would resist being turned into clinicians. It may not be so important to have one model again. It may be quite satisfactory in the more popular states, where there is better access anyway to nurses and doctors, to have less reliance on health workers as clinicians.

Mr QUICK—In a place like Wilcannia, what sort of model do they have?

Dr Bartlett—They fall down the hole, don't they? Maybe it has re-expanded its borders.

Mr QUICK—As we heard evidence, Aboriginal groups wander across two or three state and territory boundaries. The Pitjantjatjara can be in Western Australia for six months and in the Northern Territory or South Australia for the other six months. So how do we put in place the Northern Territory model, if it works best, irrespective of where you live in Australia, and the New South Wales model or the Tasmanian model or whatever it is as well, so that you have some gradation? How do we link it into the education system, because we have heard evidence that no Aboriginal child has ever completed year 12 in Katherine. And no doubt they have Aboriginal health problems. If you want to get into the system and work your way through, you can't. So how do we link both of those systems to have a model that works effectively to deliver health to people, irrespective of where they live in Australia?

Dr Bartlett—As I said earlier, I think the Commonwealth has a role to actually take a fairly tough line with the states. I think there should be flexibility to enable Aboriginal people at Wilcannia to take on a role of providing clinical services for basic problems where they cannot get health service staff otherwise. There are big areas of Western Australia that are in a similar situation.

I understand that in a lot of those communities there is a clinical role being played, but it is not sanctioned. If there was to be some litigation or something like that, who knows what would happen. I think in those areas that the clinical role is very important.

When you look at the education system overall, there are some major problems. If you look at what are the determinants, in some countries overseas like Sri Lanka, for instance, there has been what they call the low road to health where life expectancies similar to Europe have been achieved without that economic development. There are a number of things that are said to be responsible for that. Firstly, there is the education level of women; secondly, there is the autonomy of women, and these two tend to go together sometimes; thirdly, there is access to health services and, fourthly, there is some sort of vision about achieving something.

When you look at the education levels in the Territory for Aboriginal people, it is a major problem. But that is a long-term problem that needs to be addressed. In the short term you have the needs of primary health care, which are not well met at the moment by the current educational situation with health workers. Batchelor College, which has the main running for providing qualified health workers at a certificate or diploma level, do not consider the community need for health workers in their selection of students. There are communities that have no health workers. Batchelor have come around to talk to them and they have put in three or four people—filled in the forms—but they do not hear anything because they do not match up as do some of their other students who are more

likely to be based in the more urban areas in the Territory.

There is a sort of mismatch going on between the educational parameters of the competencies and accredited courses, credit providers and all that system versus the day to day need to have Aboriginal health workers in place doing a job for their community. I do not think it is contradictory, but I think people have tended to dig trenches about it. For example, in the Territory you can get registered as a health worker through the old basic skills requirement in the act. It does not require much stretching of the imagination for the registration board; it is actually still there in the act. People can achieve that through a very simple assessment to make sure they have got the skills and then they can get registered along with the students who have successfully negotiated the Batchelor course or whatever.

Mr QUICK—On page 5 of your submission you say that regional management support is important so that those in the community can concentrate on community issues. Then you talk about the areas that lend themselves to regional approaches, such as recruitment of staff, financial management, industrial relations and workers' health and safety. However, if we speak to some indigenous people we find they still want to gain control and there is a reluctance to have a regional approach. They seem to think their needs are not being met. But you are talking about provision and training of staff and the fact that you have actually got someone there rather than having no-one there. How do we go about it?

Dr Bartlett—I am not talking here about these regional supports having any control whatsoever. They are simply regional resources. That means that, instead of a small community having to start from scratch to develop a recruitment policy, there is a sort of draft recruitment policy that can be plucked off the shelf and that they can change however they want. Similarly, with going through all of the things you are meant to do with recruitment, like police checks and things like that—which sometimes do not get done and sometimes inappropriate people get employed in these services and rip them off—we are not suggesting that these regional supports are actually going to decide who gets employed.

A good example of the history of this in the Territory was when Kintore was established. The Territory health services tended to take the attitude: you have got your own health service; we will have nothing to do with you. People would get evacuated—these were not emergency evacuations—from Kintore by air for investigations at the hospital and then sit at the airport because no-one would pick them up. They would say that is Kintore's responsibility. Kintore, with a small community and a small health service, had no resources to run a transport service in Alice Springs. That used to be the attitude: if that is the way you want to go, it is all yours. That set up a lot of communities, if not for failure then certainly for more difficulty than they needed to have. What I am really suggesting is that the Territory health services need to redefine their role to provide support for the provision of health care to the population rather than to compete in delivering it, which has been the model. That has created all sorts of conflict and tensions

between the community controlled sector and the government sector.

Mr QUICK—You have obviously had lots of experience working with local government or not working with them. Have you seen some good models of local government involvement in provision of basic services which in the long run see benefit for indigenous health outcomes?

Dr Bartlett—No. My main experience was in Alice Springs. The Tangatjira Council tended to take responsibility for things like garbage collection and things like that. With bush communities they all have their own local community government councils which are more or less resourced to do some of these functions. Some do it well; some do it poorly. I think that the local government story might be different if you looked at Katherine. I am familiar with a range of stories about local government in Western Australia not taking any responsibility at all.

But in Alice Springs there has at times been some sort of competition. The local town council would have liked to take over the responsibility for garbage collection from Tangatjira Council. The argument against that has always been that it is less likely to employ local Aboriginal people from the town camps. So you would not get those spins-off from the Tangatjira Council doing it. But I think local governments are really critical because a lot of the basic services that we take for granted do tend to be a local government responsibility in lots of jurisdictions.

Mr JENKINS—There is a cycle of grief, anger and despair and elements of that that come from when non-indigenous people arrived on the island continent. In the modern context, we are grappling with a reconciliation process. Non-indigenous Australia are grappling with the way we admit to the actions of the past and whether there is the need to even say the word 'sorry'. What effect does that really have on indigenous Australia? Some of these elements of reconciliation and everything—are they necessary first steps in trying to break the cycle or to be part of the breaking of a cycle?

Dr Bartlett—I think reconciliation is a really important process. I have my own conflicts at times about whether it is really most important for us white fellows or how important it is for Aboriginal people. It is really tempting to take a line that says, 'All of that stuff is all very well but let us get on with fixing up health and education,' which has tended to be the Howard government's policy. The problem is that tends to assume that fixing up health means that you can virtually stomp on people's dignity and still have a healthy outcome—and I do not think that is true.

So I think my concern is that somehow the attitudes of non-Aboriginal Australia have to actually celebrate indigenous Australia in a way that allows indigenous Australians to be proud. It comes back to some very basic things about self-image, pride, self-respect—those sorts of things. My sense is that, since the 1970s, there has been more of that developing until the last two or three years when it just seems to have, in a crazy way, have gone off the rails. Just the effect of Aboriginal people being a focus of this

national debate I think has a negative effect on people's outlook.

You hear stories about more actual verbal or sometimes maybe physical violence towards Aboriginal people. I would not be surprised if that is true. But I think, more importantly, it is just the sort of cringing response that the current very public debates are likely to have. That is a real contradiction between saying we are going to fix up health and at the same time not being able to find a way of addressing that sort of problem. So I think reconciliation is really very important.

Mr JENKINS—The other thing is that you and others have highlighted that indigenous Australians' sense of dignity and pride is the indicator of their health and wellbeing that we should be achieving, both as individuals and collectively as communities. I understand that. The problem would be how we would ever be able to measure that.

I am not going to get too hung up on my inability to think of a model to measure that aspect. To achieve that we have a sense of other things in the level of sickness that is within indigenous Australia. We can measure those things. Perhaps the way that we improve that is to go back and set targets that would hold everybody—indigenous and non-indigenous Australia, state, federal, local governments, communities too—and just work together to achieve those. Do you think that we are in a position to be able to identify some of those things? They might be about not just the sickness or wellness of people, but ratios of Aboriginal health workers and those types of targets? Would we be in a position to set those steps towards achieving an ultimate goal?

Dr Bartlett—I think those sorts of targets you are hopefully referring to certainly are a big step forward to the targets that say to reduce diabetes by 25 per cent in five years. That tends to put all the onus on the health service to produce outcomes, rather than a more sophisticated analysis of the system that is required just to achieve the appropriate delivery of health care, let alone all the other things. You would have to make sure that your targets were appropriate. One of my little passions is how to develop some performance indicators of government, because clearly government does have a role. The community has a role. It seems to me that, with Aboriginal affairs generally being under a greater accountability microscope than anyone else, there has almost been a fetish with producing data that justifies bureaucratic decisions, rather than real data that is genuinely reflective of community development. I would like to see some performance indicators that measure government success.

The other thing quite extraordinary is that the data that is most fundamental is the demographic data. Looking at it regionally: where are people, what sort of movement do they have, how many people are on out-stations, what sort of access to health services do they have? That was done only last year for Central Australia. I know there are some discussions between the Territory health service and OATSIHS to do a similar process in the Top End, but I suspect that some of that basic information is not available. So how can you plan health services?

The development of health services has followed a colonial path in a sense. They started off in Darwin, then they got a doctor in Alice Springs. They still have not got a doctor at Yuendumu.

Mr ALLAN MORRIS—They are working on it.

Dr Bartlett—They are working on it. But in the meantime a lot of people over the last 20 years have moved away from those big communities and the service delivery to those people is almost nil in most situations. Just getting a picture of that would help to then start to measure the sort of access to health care people had in 1997, when you ask in the year 2000, 'What sort of access do people have now?' That becomes a performance measure of the health care system to provide that.

The worry I have always had about simply putting the onus on the health services is, firstly, the that data you get is very mixed because your population base is not adequate to make any conclusions about health status. All you are talking about is who has access to service, not a population group. Secondly, you are only looking at the better served sections of the community anyway. That is the problem with primary health care data. Unless you can illustrate access by and large to primary health care for everybody, your information from primary health care is always going to be a bit skew-whiff.

Mr JENKINS—There are indicators of, say, environmental health. What impressed me when Nganampa gave us the briefing was their talk about housing. They had a fairly simple way of looking at whether housing was efficient.

Mr ALLAN MORRIS—And working.

Mr JENKINS—Yes, and working—the whole thing of clean water in, waste water out. There was a third one. I am hoping the chair, as an engineer, would remind me of that. The point was that that is the way that they were looking at it. Then everything else flowed from that to make sure that it was working as a healthy environment for people to live in. I was attracted by simple targets to aim for. The other aspect is that you then allow the local communities to adopt the models. It may be that they borrow off others, but there are sufficient differences that they have to develop their own.

Dr Bartlett—I think what Nganampa have done is fantastic and it does provide a way forward to think about the housing question. But their success is related to the fact that the Pitjantjatjara lands are under the control of that community, so they run land management—

Mr ALLAN MORRIS—All the services?

Dr Bartlett—All the services, exactly. As soon as you go into the Territory, you often have different jurisdictions again.

Mr ALLAN MORRIS—Right in the middle?

Dr Bartlett—Yes. You have that intersectoral problem that has not been easy to deal with. I am agreeing, but I think that it needs to be in that context that not everyone has the sort of control over their whole of life stuff that the Pitjantjatjara mob have. I still think that the notions of health hardware and making sure that the material is good form a very important model.

I heard what Sandra Bailey was saying about shonky contractors. There is no doubt about that being a big part of the infrastructure problem in all the communities. I would think that the army would do better, but is that sustainable? There are a whole lot of other questions about what that infrastructure will be like in five years. We often do not think about it in terms of technology and what is easy to maintain. If you put in a solar powered pump system for the bore, it sounds fantastic, and no doubt all the environmentalists pat the decision makers on the back. They break down and people in the community cannot fix them, whereas all those old blokes out there know how to fix the old windmills, which are also environmentally friendly. I think that those things are often not considered when some of those decisions are made about infrastructure.

Mr ALLAN MORRIS—Dr Bartlett, I firstly point out that we have been told that, in areas where Aboriginal people have been trained a health workers or social workers, they are classed as second-class professionals. There seems to be some evidence of that discrimination. I note your comments on page 9 about education and training and Batchelor College and the Territory health service. We picked up similar information when we were talking to people over there. Given your background and experience in working and education and being a member of some colleges, you have been through the system. I know that you have done a lot of work so far, and it is very impressive work you have done, so I do not want to be ungrateful. We are desperately looking for some ideas as to how we can encourage governments, institutions and departments to rethink how they approach the training of people from remote and outlying communities, and how they develop education programs and access to courses. Academic standards are nowhere near the level you find in Sydney or Melbourne. So we want to know about access to courses, appropriate training to keep relationships going, where they come from, and appropriate training regimes which may take longer and be of a different nature to some degree but still give the same professional standards.

It seems to me that whenever we go anywhere we run up against this barrier constantly. You make some comments which are very pertinent, but you do not offer us any solutions. I am really trying to ask the professionals because they are the ones who may be able to offer some ideas, but you are saying that what is happening is inappropriate. You are a professional, so perhaps you can tell us what the academics and what the department should be doing that may be workable, given your experience with Aboriginal communities.

Dr Bartlett—It seems to me that you have two issues. You have the basic

education issues for Aboriginal people. I am no expert on that, but I think it is really important to their health status in the long run. I think that Aboriginal people, like everyone else, should have the opportunity to develop their career paths. I think it ought to be rigorous and all that sort of stuff. I do not believe in patronising Aboriginal people to push them through, which I am sure happens sometimes, which ends up, no doubt, with some of the comments you have referred to about them being second rate. I think there is a big danger in pushing people through. I am all in favour of rigorous formal qualifications.

Whether the education system is adequate or not, I can only say that I think not enough kids are getting the opportunities to become literate. I would have to say, on that basis, that it is not adequate. Sometimes I think it is top heavy. Somehow you do not have that basic plank of education in place. You have all these other accredited tertiary courses in place but no-one gets up there.

You also have the reality now that the delivery of health services, policing services, substance abuse services, et cetera, must involve Aboriginal people. There have to be ways to strengthen people who are doing it, anyway. Often we are talking about the stalwarts in the community who are community leaders in their own right and have a high status so they are going to be playing these roles anyway. We need to provide them with the support to better do that job. By putting in too many barriers about literacy and accredited training we can actually disadvantage some of the most powerful people in those communities at the moment.

Let the education system address those other issues, but maybe the health sector should be given some latitude in addressing the immediate problems. I would argue that OATSIHS has a responsibility to look at the educational and training needs within the services that they are funding. I understand at the moment they are saying that that is not their job, that it is DEET's job, so there is some flick passing going on.

Mr ALLAN MORRIS—After today, when you look at the *Hansard* and read the questions and comments about where we are coming from, if you have any ideas, you might like to drop us a line further to that. That is perhaps one of the areas that is the most vexed for us because it is so intersectoral—there are so many different sectors and players involved. Our capacity to actually probe that area is really quite difficult.

I think the final remark you made about OATSIHS is one we have heard before. The difficulty for us is that training needs to be rigorous, for sure, but you cannot take a person of a low academic standard, say, from a country town and put them into a course, because they will bomb out in their first six months—they will not cope. Maybe the courses still have to be rigorous, but not necessarily of the same regime or in the same methodology, but courses that are more appropriate and may take longer to get through. It may be that courses need to be stretched to allow the picking up of literacy and academic skills that were not available at the primary stages of education.

Dr Bartlett—I have worked with people who have had very poor literacy. It seems to me that the way they learn is to observe and they do. Being a health worker is often a very hands-on, practical thing. My experience is that some of those health workers have been highly skilled but they will never negotiate their way through that—

Mr ALLAN MORRIS—Through level 3. I am with you there.

Dr Bartlett—So I think the health sector has the capacity, with a bit of support such as an educator or two, to provide training for those people. It is not just literacy; it is the fact that a lot of these people do not particularly like leaving their community and, if they do, they end up in trouble. So, to provide local hands-on training, there is already the capacity for those health workers that do that to get registered in the Territory, because it is still on that basic skills concept.

Mr ALLAN MORRIS—That can be done by competency based training or competency based performance, and we have had submissions about that. I am quite supportive of that, and I agree with you on that. That is at one level now.

Dr Bartlett—Yes, at one level.

Mr ALLAN MORRIS—But eventually we need to have people who are fully qualified nurses. It is not simply for their own medical and health services; it is also for their own sense of equality as people in society that they actually have professional careers at another level, but they will never get past that primary educational level unless some courses recognise the entry points.

Access to courses and the course regimes are designed for private school students out of Sydney. That is what justifies the medical faculty at Sydney University, and we all understand that. Unless you go to a private school in Sydney, you are not going to make it all that well in medicine necessarily, apart from anything else.

I suppose the question is this: how do we get professionals and academics to recognise that vast gulf that is there? Perhaps after today you might have a ponder about that and see if you can think of any words that we can use to help encourage them to understand that it is not impossible.

Dr Bartlett—One thing that would help, once you start looking at medicine and that sort of thing, is that I think there is a tendency for there to be very poor recognition of primary health care itself, or rural medicine, as having some skills. I know there have been divisions in the College of General Practitioners and whatnot about some of these issues. There is a tendency for people to think that, because they have the professorship or whatever in the universities, that they then are experts. I would suggest that a lot of these people do not actually have the expertise about rural medicine or Aboriginal health, and maybe they should seek to get a few people in who do have experience.

CHAIR—We will wrap it up there. Dr Bartlett, as someone whose time is valuable to him, we appreciate your effort in making a submission and your evidence today. I note you have been around a bit. You have been down to Wentworth as a GP, down in my part of the world. We wish you well with your master's studies. I meant to ask you how you were proceeding with those.

Thank you very much for your time and, again, if you think there is anything you want to add, send us a letter and we will put further information in *Hansard*. Thanks again.

Dr Bartlett—Thank you.

[11.44 a.m.]

HAMMER, Dr Herbert Irving, President, Australian Dental Association, 75 Lithgow Street, St Leonards, New South Wales 2065

CHAIR—Welcome, Dr Hammer. There are a few formalities before we proceed. We need to point out that, whilst this committee does not formally swear its witnesses, these are legal proceedings of the parliament and warrant the same respect as proceedings in the House of Representatives itself. Therefore, any deliberate misleading of the committee can be regarded as a contempt of the parliament. This serves to offer the protection for witnesses to be fearless in what they tell us, so we will be interested to hear from you.

You have already made a submission to us, although it was nearly 12 months ago. Things may have changed and you might like to bring us up to date on that. Your submission has already been published as part of the inquiry we are conducting. There is no need for you to revisit that, but we are interested in any brief insights that you can offer.

You would be interested to know that we have asked on all of our outreach visits to on-site facilities and Aboriginal health services: what dental health service is being provided? From some we have had good responses. From others we have seen heaps of capital investment but no dentist. We would be interested in you bringing all of your perspectives together on that.

Briefly, it is your turn now, but be aware that members get a bit toey and want to hop in with questions. So do not take too long. We will then get to the bone with some questions, if you like.

Dr Hammer—I certainly will not take long, because we have a thorough and comprehensive submission which really does not have to be greatly fleshed out. I was a little bit nervous, but, fortunately, I see a couple of people—a fellow Tasmanian and a former fellow Tasmanian—on the committee, and I feel a bit better about that.

CHAIR—I might point out to my colleagues that Dr Hammer has done his research. He knows about the chairman being an engineer; he knows about economists and medical doctors and school teachers. So he knows about us.

Dr Hammer—We did our research, Mr Chairman.Basically, our submission to your committee came about as a result of the Senate community affairs reference committee into public dental health services. We submitted a rather shotgun approach to them, whereas in your committee we submitted a rifle submission to target one specific component. The Senate committee took on board a number of our recommendations. One that is pertinent to this committee is that they said that it was desirable for the Commonwealth to fund, implement and develop specially targeted programs to attack the

difficult problems of underprivileged and needy Australians, and among these were indigenous Australians. This is, of course, what this committee is all about.

You all probably watch on television the Aboriginal people and do not notice. But we look at these beautiful little Aboriginal children at eight or nine with their lovely smiles and big pearly white teeth—they just look gorgeous—and we notice that, when they get to be teenagers, they end up with high caries rates and the development of periodontal disease as a result of lack of fluoridated water in most of the communities, poor oral hygiene, very little dental health education and high fermentable carbohydrate diet. All of these things predispose to these components. When they get to be your age, which is relatively young, I might say, looking at the committee, they are dental cripples in many respects.

It concerns us that there is not more being done. We have determined that, first of all, the extent of the problem is difficult to get a grip on. Of the dentists practising in Australia, 93 per cent are members of our association, which is a pretty darn good delineation of membership. We have meetings with our state branches and our constituents, and universally the members who are mostly salaried members in this regard, who deal with Aboriginal patients, have great concerns about the resources and the inability to attack the problem properly.

We do not have specific figures that we can lay before you, but we do know that we have a couple of organisations that are very capable of providing these. They are the Dental Health Research Unit at the University of Adelaide, Professor John Spencer's organisation, and the Queensland University and the Queensland health group, who have the expertise to obtain these figures for us. We would certainly like to promulgate these and be able to do a study on this, but it again requires federal funding.

You know, it is sort of useless to do all this research and find out where the problem lies, unless behind it there is going to be adequate funding to do the treatment and to develop the treatment programs. That is where we find that there is a lack of will. Actually, since the demise of the Commonwealth dental health program, very little funding has gone into the dental profession. I do not say that as a criticism—actually, I do—but that has gone and we do not try to politic on that.

Our colleagues also tell us that, unless these programs are developed in cooperation and with the assistance of the local communities, they do not work. You just cannot inflict treatment upon Aboriginal groups and say, 'Big Brother decides this is for you.' It is somewhat different from what we can implement among many of our other patients.

Where does the money come from? It seems to me that everybody who is looking for money says, 'We got the Federation Fund—an inexhaustible supply of funds.' Even in the paper this morning, I noticed that they wanted to tear down this attractive building that is blocking out the Opera House and they wanted to use the Federation Fund. Frankly, we see no other source of funds that could implement a desirable program.

There is not, in the Department of Health and Family Resources, any dental expertise any more. We had some at one time, but in a restriction of funding our dental expertise has diminished. However, we have a fine organisation, the Australian Dental Association, which has the ability to bring together the various components of the states. They would be implementing the treatment program and, together with any other bodies who have expertise, they would implement a summit type of thing. We have a facility here in Sydney and we do this from time to time for our own needs, for various special interest groups. Given the funding, I think we would get an excellent outcome. We would certainly make every effort to cooperate with government should the funding be available.

I have one final aside; a little interesting story. We found, a few years ago, an Aboriginal dentist in Canberra who was funding Aboriginal dental students out of his own pocket. We thought that was a very fine thing to do. In recent years, the Australian Dental Association has funded two Aboriginal scholarship students, not with vast sums of money, but to show them that we would like to encourage them. We have had a little difficult time because the educational system available to Aboriginal students, in many respects, is somewhat limited. We have had to get students who had to repeat courses, who had lower passes and failures, but suddenly we found gold this year. Two Aboriginal students have just shown up out of nowhere—it happened to be in New South Wales, incidentally—with distinctions, credits and wonderful academic records. We have given them this year's scholarship.

It would be just delightful if we could find an increasing number of Aboriginal dental students and generate more Aboriginal practitioners. It is difficult. To us, it would be another advantageous factor, if we could somehow improve the number of Aboriginal students in dentistry, certainly long term—and this is all long term. We do not have a magic cure. That is my submission: I do not have any secret formula.

CHAIR—Are you saying that, in the whole of Australia, we only have one Aboriginal dentist?

Dr Hammer—I do not know, but that is all that we could find in our membership. There may be others, but we do not take notations as to whether people are Aboriginal, Polish or whatever. To my mind, and to my knowledge, we have one Aboriginal dentist that I am aware of in the Australian Dental Association.

CHAIR—And now two students.

Dr Hammer—Do not take that as gospel, but that is the figure I have.

CHAIR—We will go to questions. Mr Jenkins, do you have any?

Mr JENKINS—The submission is pretty self-sufficient, and we have been over the need for the basis of the epidemiological studies. When you talk of setting up an expert body to plan programs, do you recognise the need for the involvement of the local

communities themselves in the implementation of any programs?

Dr Hammer—There has to be, in the implementation; but in development I query that idea. I would like to see somebody who has the ability to determine things and who has worked with Aboriginal groups. If you get too many people involved in implementing a thing, the whole system falls down. At some level, though, certainly you have to. I am not much of an expert. I would be inclined to suggest that, whoever implements this program—and our executive director is a very competent person in developing these things—at that stage we could decide who would be invited and who would participate.

Mr JENKINS—Should this be a program that is driven by the Commonwealth government directly?

Dr Hammer—Funded by the Commonwealth government. There is no expertise in the Commonwealth government to drive anything any more. We would have to do it through the state health departments, through the dental departments and through the Australian Dental Association. We do not have any federal expertise in dentistry any more.

CHAIR—With your idea about the Federation Fund, I cannot realistically see an allocation coming out of that. I hear you issuing a challenge. You are saying, 'Where are our priorities?' You are talking about monuments and edifices when there are real needs. That is what you are really saying.

Dr Hammer—That is what I am really saying. Thank you: that is why you are the chairman.

Mr QUICK—With regard to overseas experience, we often hear that, for example, with the health problems of the North American Indians, they seem to be a few years down the track. Are you aware of any programs that the American government, in conjunction with the American Indians, has implemented in this area?

Dr Hammer—They have a very sophisticated system. Incidentally, I brought back from the United States, about seven or eight years ago, a simple little fluoridation kit that is developed for small Aboriginal water supplies—in this case, native American type—where fluoridation could be delivered to small communities safely, successfully and simply. The engineering has been developed and it has been installed in American Indian reservations, where they have small groups that are mobile. I never heard back about it again. It is an interesting concept, and that is the sort of thing that has been developed over there.

Their public health service has had far more significant development. As you would be aware, they have a lot more money over there, as they have a larger population of indigenous native Americans. We could not copy their system because they place so much more money into their federal government system. The Indians come under the

auspices of the federal government, whereas for Aboriginals here, in many respects, their delivery care is predicated on state health systems and state dental services, rather than the Commonwealth, which really does not have a comparable system.

Mr QUICK—In your association's dealings with state governments, do you deal with local governments? A lot of the issues you are talking about—for example, the provision of adequate water supplies—rests with local government, in lots of cases, as the final delivery arm of the state government agency. The simple provision of fluoridated water in regional communities, for example, in this state does. Does your association liaise with state and local government?

Dr Hammer—Not at the local level. Our state gives support to the state associations. Just like any other organisation, the states are king, so to speak. If we started influencing and interfering too much at state level, we would lose our ability to support the state association. We have to be a source of information and a source of coordination, but we do not involve ourselves, as an Australian Dental Association, beyond the state level—and then only as a advisory organisation. To answer your question, no.

CHAIR—It is not simple: there is World War III in Victoria at the moment, around Bendigo, over fluoridating the water. It is not an easy debate. You obviously have a position: I can tell that by your submission and your remarks.

Dr Hammer—A strong position, yes.

CHAIR—It is not an easy debate in mainstream Australia, let alone in some of the other areas.

Dr Hammer—Queensland, for example, is largely unfluoridated. They had a big campaign in Queensland to try to obtain fluoridation of the water supply—a move which was defeated, incidentally. As a federal association, we gave all the support we could to the Queensland Dental Association, but we certainly did not in any way interfere with their battle and with their submissions, because it would be probably inappropriate for us to inflict our federal standing on the state's rights.

Mr QUICK—So, with Queensland's huge Aboriginal population, how do we resolve this issue?

Dr Hammer—I wish we could tell.

Mr QUICK—Do we say to the Aboriginal communities, 'You fluoridate your water; it doesn't matter what is happening in Cairns or Mount Isa. All the Aboriginal communities have got fluoridated water', so that hopefully there will be some change in their dental programs?

Dr Hammer—Queensland is a very difficult problem to attack. I have no answer

to that, with all due respects to Queensland.

CHAIR—I will give the next question to our Queenslander, Mrs Elson, if you like.

Mrs ELSON—Being an advocate for disadvantaged groups for many years with the public dental health system in Queensland, I am interested to hear what your theory is on this. I found that, when the Commonwealth put in some money to try to get rid of waiting lists, the public system in Queensland went even slower. They thought that, by going slower, they would get more funds and so they were seeing something like five patients a day. I am probably an advocate of the other way, and I want your opinion of using a voucher system for people in disadvantaged areas to go to private dentists, rather than using the public dental system. Have you looked at that as an association?

Dr Hammer—We have looked at that as an association and we have decided to butt out of the various arguments that are put forth by various states. Queensland actually is an example of a fairly good public health system. They are quite an effective organisation, we feel.

Mrs ELSON—I do not. Working at first hand with disadvantaged groups, I know they are not.

Dr Hammer—Again, you see, this is an overview: it is not the infantry view in the trenches. They utilised all of their funds in the Commonwealth dental health program to implement improved public service dentistry, whereas some of the states—for example, Tasmania—utilised their funding for private implementation. I do not want to buy into the Queensland argument, because I feel that that is their problem and that they will solve it as best they can. But we are here to help, as they say.

Mrs ELSON—So what is your opinion on voucher systems?

Dr Hammer—I would rather not comment.

Mrs ELSON—Okay.

Dr NELSON—Dr Hammer, I have got a series of questions I would like to ask you. Firstly, have you and your association met with the current Minister for Health to discuss this proposal or, indeed, the previous one?

Dr Hammer—Which current minister?

Dr NELSON—Dr Wooldridge, the federal minister.

Dr Hammer—The current minister is almost unapproachable as far as we are concerned, as far as dental problems go. We have made several approaches in the past, attempting to see him, and we even have difficulty making appointments with his

parliamentary secretary. From a practical standpoint, we have made attempts to see him at his office—and I will probably be blackballed from the party or something after this—but he has been most unapproachable as far as the Australian Dental Association is concerned.

Dr NELSON—Thank you. In my previous life I had a role not dissimilar to your own. About one-quarter of the ear, nose and throat surgeons in Australia were prepared to provide services to Aboriginal communities in remote and rural areas. Have you canvassed your membership to establish how many dentists might be prepared to perhaps travel to remote, and particularly Aboriginal communities, to provide both services and education to health workers who are on the ground floor?

Dr Hammer—That is a wonderful suggestion. We have had support—not from the top, but groundswell support from people criticising us for not implementing programs—to send our practitioners voluntarily into these areas. I am quite confident that a program of this sort would meet with considerable success; but, again, we have difficulty implementing this without the support of the federal government. If that support were forthcoming, I think we could do something.

Dr NELSON—If the Commonwealth were prepared to provide infrastructure funding to enable your members to travel to these areas—and I would think there would be not only Aboriginal but also non-Aboriginal people who would be in need of care—are you confident that there would be a significant number of your members who would be prepared to participate?

Dr Hammer—I think there would be a large number. Incidentally, last year I attended a meeting of the Asia-Pacific Dental Federation in Sri Lanka. Surprisingly, we came across a group of Australian dentists whom we had never heard of before who were from Perth and who travelled every year and spent three weeks in Sri Lanka, donating their services to treating children because they felt that that was an altruistic thing to do. I think these people are saints. That type of person exists in the profession in Australia and, given the opportunity and the availability of infrastructure and support, I am quite confident that there would certainly be the probability of significant numbers prepared to participate. I cannot commit to anything at this stage, but the idea is just great.

Dr NELSON—It is rather ironic that doctors are the same: they are very happy to provide voluntarily their services in the developing world, which is very worthy, but they are not quite so enthusiastic about going to Central Australia. In the medical area for Aboriginal people, there is a very distinct and important role for Aboriginal health workers. Do you feel that Aboriginal health workers could be trained to provide at least basic dental hygiene and perhaps even emergency dental treatment? We have visited services throughout the country that have what I would consider to be first class dental facilities, but they are empty: no-one is in the chair; the patients are waiting to be seen, and there is no-one there to provide services. Not only is there a need for dentists but there is also a need for those who could provide primary dental health care. Do you feel that you would have members prepared to participate in the training of Aboriginal health

workers and perhaps nursing staff in that regard?

Dr Hammer—You sure know how to put hard questions, Dr Nelson. That has been a bone of contention in the profession. It is on a state-by-state basis. There is some strong prejudice among various states. Really, the dental boards control these regulations and also control the training, to a certain degree, and the registration of the people who are allowed to do this. In Queensland right now, with the utilisation of hygienists—who are preventive auxiliaries—there is a bit of concern because the dental board has a restriction on the number of hygienists who can be overseen by each dentist; whereas the health department would like to have more hygienists but they do not have the dental manpower to oversee these people in a tighter, more restricted environment. It is on a state-by-state basis.

We really have no control over the restrictions in the state. But there are pilot programs. For example, in Tasmania there is a pilot program to train auxiliaries to treat adult patients. There is a strong feeling in the dental profession that it is not supported, but dentists are, for example, discussing an intern type of program, though I do not want to call it that—

Dr NELSON—That was my next question, actually.

Dr Hammer—It is a postgraduate training period required by all dentists and, at that time, there would be a possibility of them being sent to back areas which are lacking in dental manpower. Again, funding by the federal government would be required for this. Certainly that would be a great help in getting dental manpower into these areas that do not have it. As you say, it is a big problem: getting medical and dental manpower into the restricted areas, Aboriginal areas, is not easy.

Dr NELSON—Were there to be an internship program, not only would it elevate the standards, I presume, of dental graduates and play an important educational role, it would be a way of providing services for low income, regionalised and remote people who perhaps, both in the public and private sectors, currently do not have access to those sorts of services. It is a personal view, but I think the Commonwealth ought to be prepared to finance that and the Australian Dental Association ought to be prepared to support it for lots of reasons.

Dr Hammer—Brendan Nelson for minister for health.

Dr NELSON—That is the kiss of death!

Mr ALLAN MORRIS—Minister for finance—that is the more important position.

CHAIR—We have some visits this afternoon and we are going to run out of time if we do not move on. We thank Dr Hammer.

Dr Hammer—Thank you for listening and allowing me to present my case.

CHAIR—You do not speak like a Taswegian.

Dr NELSON—He makes sense.

[12.14 p.m.]

HERBERT, Reverend Harry James, Executive Director, Uniting Church Board for Social Responsibility, PO Box A2178, Sydney South, New South Wales 1235

SMITH, Reverend Brian Lewis, National Secretary, Uniting Church in Australia Frontier Services, PO Box A2266, Sydney South, New South Wales 1235

CHAIR—Welcome. I point out that this committee does not formally swear its witnesses, but you need to understand that these are formal proceedings and therefore legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives. Therefore, any deliberate misleading of the committee would be considered as a contempt of the parliament. This is a process, though, that offers witnesses the capacity to be fearless in what they tell us.

We have a submission from your organisation which is dated September last year. It has already been published as part of the substantial volume of evidence collected so far by the inquiry. You might like to make a brief opening statement in respect of the submission and bring us up to date with any changes to it since September last year. But be aware that committee members like to get straight to the bone with questions, so if you could be brief about your opening statement, we will get to the concerns that you have and try and get some formal evidence on the record.

Rev. Herbert—Thank you. I will say a few words and then Brian Smith will also, as our two roles are somewhat different. As I think is clear, our board does not have hands-on experience in the issue of Aboriginal health; however, as you would appreciate, the Uniting Church has a long association with Aboriginal people and it regards this, as you have indicated you yourself regard it, as a most serious issue for our country. We particularly wanted to appear here to indicate the seriousness with which we regard the issue of dealing with problems of Aboriginal health. I would just like to emphasise some of the points that the New South Wales synod were making in the submission that we made to you.

We would urge the committee to learn from the past. Many times in these exercises people do not consider what has gone before them. I say that with respect. We would suggest, for example, that in your inquiries you ought to look at the Toomelah report, which was done quite some time ago, and consider some of the issues as to why, with so much knowledge and understanding and identification of the problems, very little actually occurred, so that we do not have simply a repeat of that cycle again.

Also, we would refer to relevant sections of the report on Aboriginal deaths in custody—again, issues which have not been implemented—and the report of the Social Justice Commissioner of the Human Rights and Equal Opportunity Commission. Our church in New South Wales committed itself several years ago each year to study closely the report of the Social Justice Commissioner and to publicise it among the members of

the church in order to help all the members of the Uniting Church to understand the important underlying issues that affect the Aboriginal community.

It seems clear to us that it is not knowledge of situations or knowledge of causes or necessary strategies and tactics that need always to be discovered, but that it is the will of the political processes to implement what we know that is the key factor in dealing with issues of Aboriginal health. Also, we would urge the committee to use this inquiry to set the lead for state and territory governments in looking at the implementation, for example, of parts of the Royal Commission into Aboriginal Deaths in Custody in terms of outcomes for Aboriginal people. We have itemised some of those in our written submission.

We would also urge the committee to understand Aboriginal health issues from a human rights perspective rather than from a charitable perspective. We believe that Aboriginal citizens are entitled to the same rights as other citizens of this nation and that they should not have their health issues addressed in a charitable way or a pro bono fashion, but that they ought to be addressed in the way we would address any other health problem in the Australian community. We would point to article 12 of the International Covenant on Economic, Social and Cultural Rights which says:

The States Parties to the present Covenant—

which includes Australia—

recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

While we regard Aboriginal health from a perspective other than a right, I do not think we will progress very far.

The committee should learn, we hope, from the inadequacy of the process of implementation reports with regard to, for example, the Royal Commission into Aboriginal Deaths in Custody. With future reports on Aboriginal health—and we hope this will occur with your report—you should regard what is done by bureaucrats and others as inputs and strategies, and differentiate that from outcomes; and the outcomes should clearly be what Aboriginal people wish to have as outcomes, not what other people impose on them as outcomes. Also, it is very important for those who implement any health policy for Aboriginal people to understand the context and the reasons which give rise to that policy.

The findings of the Social Justice Commissioner require that the committee urge the government to adopt a radically different approach in future to funding, planning and delivery of health care and related services. We would urge you to give attention to his report—you may have already done this. His second report identified certain steps which we think are very important. He said:

New policy should be based on an understanding of Indigenous forms of knowledge and decision-

making and come from a perspective which does not further undermine a community-based Indigenous view of health matters.

We think the implications of that are: a significant strengthening of the network of indigenous health workers and Aboriginal medical services; encouraging the development of whole of community strategy or plans based on critical debate and analysis at the community level; drastic increases in Commonwealth funds for development of that community structure; and mechanisms for tying the provision of appropriate and accessible health related services by the states and territories to accountable outcomes. I feel somewhat humble that here we are sitting in Sydney with me making these comments only to urge you that, at the end of the day, you need to improve the situation by finding out what Aboriginal people want, rather than listening to other people, even ourselves.

The findings on housing in the Social Justice Commissioner's fourth report lead to the conclusion that the committee should seek radical changes in the way that services are delivered. Again, this needs to be focused on community participation, remembering always that the reason Aboriginal health is of such an appallingly low standard in Australia is that they are the most disadvantaged culture group in this nation and that poor health standards are always related to poor income levels and disadvantaged people. It is the same in the white population: the poorest health standards among white people are also to be found among the poorest and most disadvantaged white people. Because Aborigines fall to the bottom of the scale continually, it is not surprising that health standards are so poor. In a way, you are addressing a symptom of a wider problem. Thank you for the opportunity to make those comments. I hope that our views will be considered.

CHAIR—Am I right in assuming that Reverend Smith represents the coalface, the frontier end, if you like?

Rev. Smith—To a degree.

CHAIR—Over to you, briefly, please—I can feel the sense of frustration already from colleagues; they want to get into it.

Rev. Smith—Very briefly, Frontier Services is the successor in the Uniting Church to the Australian Inland Mission of the Presbyterian Church and the Federal Methodist Inland Mission of the Methodist Church. Part of our work involves ministers who work in remote areas.

Early this year our minister in Jabiru, George Woodward, on 27 January buried an Aboriginal man in his 40s who died of a heart attack. On 1 February, he buried a woman in her early 30s who died of a stroke. On the same day he buried a young baby, four months old, who died of cot death. These are all Aboriginal people. On 15 February, he buried an Aboriginal woman in her late 30s who died of violence which she had suffered years ago and had left her incapable of caring for herself. On the same day, he buried an Aboriginal man in his late 30s who had died of kidney failure. On 4 March, he buried an

Aboriginal woman in her early 30s who died of a heart attack. And on 23 March, he buried an old Aboriginal woman in her 70s who died of natural causes.

This is in a community in Kakadu of 300 to 400 Aboriginal people. I venture to suggest that if that rate of death had occurred in any community that was not as remote and was not Aboriginal, if it had occurred in Canberra or Sydney or anywhere else, we would be mobilising every pastoral carer, every counsellor and every psychologist we could find to help the community overcome that sort of trauma.

These traumas exist consistently in Aboriginal communities across this country. The community as a whole fails to recognise that these deaths, the grief and this rate of mortality cause further trauma amongst Aboriginal people. That is my first point, that if we are going to address the health of Aboriginal people, then we need to recognise the reality of ongoing trauma in many Aboriginal communities and the impact of that trauma on their health.

The terms of reference of the inquiry talk of:

the extent to which social and cultural factors and location, influence health

I feel that we have covered up some of the realities of the situation of Aboriginal communities. We have talked about missions, and lately we have talked about communities. But many of these Aboriginal communities are groups of people who have been moved from their own land, away from the situation that they knew as home and where they were comfortable, into close proximity with other groups with whom traditionally they may have had difficult relationships, or have had nothing to do with them. Traditional taboos have been broken down.

Four years ago an anthropologist on Cape York made it clear to me when she said, ‘These are like long-term refugee camps.’ I think we need to take the viewpoint and the understanding that was articulated there very seriously and recognise again this factor in the trauma that so many Aboriginal people face. Until these issues are addressed widely, many other health issues will simply be symptoms.

When we talk about their need for improved education and for medical practitioners, we need to recognise that in remote areas when somebody talks to an Aboriginal person in English, they may be talking to a person in their fourth or fifth language. We have not been very good at taking account of Aboriginal language, and we certainly do not encourage too many people, who serve within Aboriginal communities, to learn the language. Yet the intellectual constructs of a people are found in their language. How can we engage Aboriginal people in what their needs are, and encourage them to find their own solutions for moving out of their situation, unless those who deliver services are prepared to stay long enough to learn the language?

The patrol padre who took those funerals, when I told him I was coming here and

that I was going to tell that account, said, 'The people here are so disempowered that they don't care about their health.' These are the people who receive the royalties from the Ranger uranium mine, although they do not get that much in the pocket, I have to say.

Mr QUICK—What about life on Mornington Island? Is it any better there? One would assume that at Ernabella the Pitjantjatjara associated tribes would have stayed there with the Uniting Church and the Presbyterian Church.

Rev. Smith—The Nganampa Health in the Pitjantjatjara lands do a great job. I believe that the impact of the Aboriginal controlled health service has made a great difference there. I do not personally know much about Mornington Island.

Mr QUICK—That was a part of the Uniting Church mission.

Rev. Smith—Yes, but I am saying that at the present time, as far as I know, it is not significantly different from anywhere else.

Mr QUICK—Is Aurukun pretty bad?

Rev. Smith—Very bad, as I understand it.

Mr QUICK—Were those people relocated?

Rev. Herbert—Aurukun is a famous and sorry story, yes.

Rev. Smith—All missions were about relocation. They involved the best of intentions, but what I am saying in referring to missions is that we have to recognise that what was being set up there were refugee camps. People were moved, relocated from their own situation, to another situation. Because we call them missions, or more latterly communities, we actually obscure the reality of that situation. If we called them what they were we might have a greater understanding of some of the health needs that emerge.

Mr QUICK—In your recommendations on pages 6 and 7, there are lots of urgings. We welcome the urgings, but I would like to see some more concrete recommendations from the Uniting Church, breaking it down into more specific recommendations such as, 'This will be set up and adequately funded.'

Rev. Smith—If one wanted to do that, then in relation to what I have said about trauma, I believe that this country needs to first of all fund the beginnings of the understanding of mental health for Aboriginal people.

Mr QUICK—You mention here:

a significant strengthening of the network of Indigenous health workers and Aboriginal medical services and facilitating their aggregation into regional structures.

That sounds like something that a public servant in Canberra has written, no disrespect to you people. I would like to see bums on seats and moneys allocated to say this is the way to do it. That is the series of words, but out at Kakadu or Aurukun or Ernabella or wherever it might be, what does that mean for that community? When they read that they say it is white man's words.

Rev. Herbert—The overall point we are trying to make is that we cannot sit here and tell you, and you cannot sit there and tell Aboriginal people, how to run their health system.

Mr QUICK—There is a belief amongst this committee that we would like finally to resolve this issue of Aboriginal health in Australia, after pussyfooting around for 20 years, and there is a bipartisan approach to that resolve. We would like to come up with a series of recommendations, as this committee did with the management and treatment of breast cancer. As a result of that report there were bodies set up, there was money allocated, and women in Australia who suffered from breast cancer saw that there was a definite improvement in the management and treatment of that disease.

I know that this is probably the most complex issue that this committee has ever been faced with, but as a result of touring around and speaking to everybody and anybody, we are determined to come up with a series of recommendations. If we manage to get into power next time, then whoever the Minister for Health and Aboriginal Affairs is we expect him or her to take those recommendations on board and implement them. That is how serious we are. It is not just a series of well constructed phrases and sentences. When we go back to Kintore and Yuendumu in five years time we expect to see the matter has been resolved.

CHAIR—It is up to us to write the recommendations; we are determined we are going to do it. We are just after some insight. I have to say that, when I read your submission, it did not gel with me. I do not actually believe, as naive as I am, there is an absence of goodwill. I do not care what colour of government there has been; there has been enormous effort and an enormous amount of money spent, but it just has not been spent in the right way or the consultation was not done properly. I do not actually believe there is no sense of goodwill.Your submission tends to say that politics has been played. That may be true. It always happens, sadly, but I believe there is a real sense of goodwill. It is a matter of channelling it.

Rev. Herbert—If there is one thing the Uniting Church has learned in its relations with Aboriginal people on a wide number of fronts it is that you can never do for them what they need to do for themselves. You must go through the tedious and difficult process of their finding the solutions and your resourcing them. That is why I said before to complete your report. It is so important to look at what other people have done and examine why is it that those things never reached achievement, why is it that if there is all this goodwill, which I do not deny, that we still have this appalling situation in Australia? Otherwise you will just repeat what went on in the past.

Dr NELSON—Reverend Smith made the point, without saying it specifically, that whilst there is goodwill there is not political will. If this happened overnight—and that description, as you know, you can apply to any one of a hundred or two hundred Aboriginal communities throughout Australia—we would declare a state of emergency, the federal government would take complete control of the situation and we would be out there doing everything we possibly could to stop it. We have governments going to the barricades over quite worthy causes where people are suffering injury, ill-health and death.

CHAIR—Like HIV.

Dr NELSON—Yes that is right—a lesser number of people actually.

Rev. Smith—You have picked up my point there. If I may just respond to your question. I accept the lack of specific recommendations in the report that I have written to you, but I am heartened to hear this is a bipartisan committee with a bipartisan approach because that was one of the recommendations that I had. If health is simply subject to partisan pressures and changes, party political changes of the normal political process, then you have not got the time to do what you intend to do. Other committees have sought to do this. I actually fear the sort of phraseology used in terms of 'We are going to fix it this time—it is really here.' It took us 200 years plus to get into this position; it will take a long time and a lot of long-term political will to get out of it. One of my recommendations will be, 'For goodness sake, on this issue get your act together politically and create a long-term bipartisan strategy that both major parties will agree to that is negotiated with Aboriginal people and have the political will to put the resources in,' and to look at the long term because these things that I am talking about are not going to be fixed in a five-year cycle or even a 10-year cycle. They took a long time to get here.

In terms of another specific recommendation in relation to the impact of trauma: Pat Swan in a paper presented in August 1988 to the mental health status of the nation conference of the Australian National Association for Mental Health said that today there is no framework by which Aboriginal mental health problems can be usefully understood. Without this framework, appropriate programs cannot be developed. Without this framework, services that are accessible and acceptable and are Aboriginal will never become available and the mental distress of those people will remain as it is today, largely unrecognised and untreated. We need a framework whereby mental health issues and the impact of trauma can be understood and engaged because, as Dr Nelson said, if what I had described had happened here, the whole community would be immobilised. We do not even have a framework for engaging it and yet it happens all the time in remote Aboriginal communities.

If I had another concrete recommendation—and this does get political, but I think this issue is very political in the sense of the word 'political'—it would be that the root cause of most Aboriginal health problems in Australia today is the invasion of Aboriginal land and its subsequent consequences. One of the problems we face in our society, and perhaps the deepest ethical issue that we face today, is how we live as a society that was

founded by the colonial process. Part of that problem is where we draw the line in terms of the continual invasion of Aboriginal people and give people the space to engage with us in a way that will determine their own directions.

Health is a good example of this continual invasion. What happens now when there are military exercises in the north of Australia? We have a wonderful PR exercise where the military go in—and you see it on the television screens—and 'fix up' the health of an Aboriginal community: the continual invasion of Aboriginal lands. In terms of concrete recommendations, one of the things I talked about was the need to give high priority to the submissions of Aboriginal controlled health services. There must be an engagement that gives the people concerned a genuine space in which to find the answers to their own issues.

Mr QUICK—Should we develop an Aboriginal health charter, like we did with the United Nations Declaration on the Rights of the Child and all the other bits and pieces that we sign up to ad nauseam?

CHAIR—Just another document, Harry.

Rev. Smith—Only if you are prepared to put it in.

Mr QUICK—We talk about basic services, but some communities do not have a decent road, there is no sewerage, there is no adequate water supply, yet you expect to impose a health regime that emanates from Canberra, Sydney, Melbourne, Brisbane or Adelaide.

Rev. Smith—That is just what we are saying: you have to address the basic political issues which form the context in which health problems arise—the basic political issues. You cannot take health and housing and extract them from the total political context in which Aboriginal people live and exist.

Mr QUICK—How do we drag the states into the party?

Rev. Herbert—Not to mention local government.

Mr QUICK—That is right. That is the avenue I have been pushing all day. Local government, in lots of cases, is absolutely hopeless.

CHAIR—Our inquiry's last term of reference is:

the extent to which past structures for the delivery of health care services have contributed to the poor health status of Aboriginal and Torres Strait Islander people.

We resolved we would not make a scapegoat of that. It is easy to say, 'It is their fault. They have not done this or that.'

Mr QUICK—No, I am not apportioning blame.

CHAIR—Local government would mount a case that they have been disempowered, because their funding source is the Grants Commission. I would like to see the committee take a more positive view in our final report. We ought to use these people here today. We have positive people to help us write the report, and I think they have done that in their submission. Frankly, I do not know whether we ought to hear any more evidence. We could probably sit down now. We have the prospect of an election coming, and the whole thing will get deferred. We have a resolve here. We want to write something—

Rev. Herbert—What consultation has the committee had with Aboriginal people? No doubt you have had extensive consultation?

CHAIR—Absolutely, and we have spent a lot of time on the ground with them, too.

Rev. Herbert—I think that is the important thing. That is what we are saying, 'Don't listen to us, listen to the people.'

Mrs ELSON—That is what I wanted to add, too; it is a fact that we have been out on the ground. I have been involved with Aboriginal people since I was small, but the thing that this committee knows—and I am quite sure my colleagues will agree with me here—is that we do have a large problem within the Aboriginal community: there is a bureaucracy within the Aboriginal community, too. There is also the problem of a number of different cultures out there that talk different languages—and they do not communicate with each other. We can put as much money as we like here, but it is not filtering through to the end because of this bureaucracy. You can blame it on governments all you like, but I think out there also is a big problem.

The Aboriginal people do not like or trust white people. It is as simple as that. They have been told—the group that I have mixed with for many years will speak to me—by so many different elders and groups, 'Do not talk to or trust the white man and do not do what the white man tells you.' We have probably built that up over the years; I am not saying it is their fault. I am just saying that is the problem that I see out there, too, that the Aboriginal people do have to take control of the situation and help the ones that are really suffering out there. It breaks my heart to see a group that have and a larger group that have not. The have group will not let us look after the others and communicate with them, yet they will not take responsibility for them either. That is how I see the problem. We are not just sitting here listening to people like you. We are actually getting out and speaking with the Aboriginal people.

Rev. Smith—I think the reason Aboriginal parents may tell their children, 'Don't trust white people,' is from their experience. Again, it is up to us to start acting in a way that can be trusted and that is one of the reasons why I say a long-term bipartisan

approach is absolutely essential, because we keep saying, 'We are going to do this.' I have been in this job now seven years and I have seen in that brief period of time a remarkable number of health ministers and changes in the title of the department that services them. From time to time Aboriginals hear, 'We are going to do this,' and then the political process changes and somebody else comes and says something different, 'We're going to do something else.' Why should Aboriginal people trust us on health issues, if that is the way government relates to them? There must be a long-term bipartisan approach.

Mrs ELSON—They are equally as frustrated with their own people—not just with white people—not doing the right thing by them.

Rev. Smith—I recognise that, but at the moment I am talking to the people in government.

Mrs ELSON—What do you recommend to the committee, a quick fix then, as far as trust of white people and breaking down those barriers?

Rev. Smith—There is no quick fix. I think that I have said it twice already, be long term and be consistent. Be bipartisan, that is only way to go.

Mr ALLAN MORRIS—Could I perhaps come from another angle. You reinforce the fact that various inquiries have found that substantial funds are required and relatively small amounts are given. I think you mentioned that in a couple of places and we understand that. But, in the community at large, there is a perception that there are huge amounts of money being wasted—and I think we have just heard it now from committee members. One of the conundrums that we have is the perception that there are huge amounts of money being wasted on Aboriginal health and it is getting no better and, therefore, it is either being cheated or being ripped off—or there is something funny going on—when what you are really saying, and what you are repeating from other reports, is that the amounts required are really quite substantial and the amounts being given are actually relatively small. There is conflict between those two perceptions.

Rev. Herbert—Maybe what your committee has to give some thought to is that you are not going to solve all of the problems all at once. In many areas of social welfare, one of the ways in which big problems are approached is by attacking them with some centres of excellence, some particular pilots where you really do show, in certain particular areas, how the thing ought to be done without trying to do that across everywhere all at once. That is more achievable financially and also it sets a standard which, later on, when people see how successful it is, they can follow.

Mr ALLAN MORRIS—That is a thought.

Rev. Herbert—I think that, attempting to achieve with all the necessary resources everything at once, you do have a political problem. I can recognise that.

Mr ALLAN MORRIS—Either way we have a political problem and that is why we are trying to be bipartisan. We do not want to waste our time. What I was trying to address was the community perception problem. Unless that gets addressed in some form in terms of community understanding and attitudes, the funds will not be made available anyhow. It does not matter who controls them, they still will not be made available. You will see governments cutting Aboriginal funding rather than increasing it. You are active in the wider community outside the Aboriginal community. Have you found ways to explain to your own people the kinds of funds that are required and the problems that are there?

Rev. Smith—With respect, I think the governments are probably better placed than anybody else in terms of addressing the perceptions of people within the community. You are the experts in that area in many ways.

Mr ALLAN MORRIS—I hate to disappoint you. If you look at your own inquiry and look at how much money was given out, then go back and look at the statements made when that money was announced, whichever government that was would have projected that this was a wonderful, huge amount and how grateful you should be. In fact, the money was probably a tenth or a fifth of what was actually required.

Rev. Smith—But if I can continue, one of the reasons why the perception is so poor is that people are not aware of some of the situations that you and we are now aware of. That can be made known. We do not like, as a community, to let that be made known because internationally it does not do our image any good. But if there was a degree of honesty, I believe that there is enough decency in most Australian people to say, 'Yes, we must do something about this.'

Mr QUICK—The only side we see on the media is the worst case scenario. Why should we not see the best practice? Can you give us half a dozen or even two or three examples of these pilots that we need to emulate? There must be some out there somewhere, surely to goodness.

Rev. Herbert—You people would know that better than we would.

Mr QUICK—But you are a church that covers the length and breadth of Australia. You have had a long history of dealing with the Aboriginal community over the last 80 years. You must know of some areas where indigenous health is working well.

Rev. Herbert—We, as a church, changed our relationship with Aboriginal people a number of years ago and we no longer have that relationship with them. We no longer control. We gave it back to them.

Mr QUICK—But you must be aware that town A or place B—

Rev. Herbert—No, I am not personally aware. I was making that comment to say

that, rather than attacking a whole issue el globo, sometimes it is easier to concentrate on certain aspects of it and to build up expertise which can be then copied in other places.

Rev. Smith—I go back to what I said before: go back to the Aboriginal health services and they will have those stories that you are looking for. Go back to the Aboriginal controlled services that are functioning on the ground and see where there are best practices. But, please, do not ignore what I was saying before in relation to letting the community know the realities.

Mr QUICK—But what happens in one of the states of Australia on Saturday could change the whole tenor of what we are on about, God forbid.

Rev. Herbert—Indeed. That is why it is so difficult and why it has failed in the past.

Mr QUICK—That is right.

Rev. Herbert—There is racism in Australia and we do well to note that. It is no good pretending.

Mr JENKINS—I think that that gets to the problem that this committee faces. I think Mr Quick has illustrated the will of those on the committee who have followed this inquiry where we would really like to achieve things, whether that is in the frustration of 'Let's do it tomorrow' or in the longer term. As we set out to put down recommendations, we can resolve that. But one of the things that you have illustrated today coming before us is that there is a level hovering over the whole question of indigenous health which really goes to a wider relationship between non-indigenous people and indigenous people.

I understand it is very important for us to resolve those matters, but I do not know whether we could get that same sort of bipartisan political will over those issues. That is an even longer term thing. We then have the conundrum between trying to change attitudes over the bigger issues and whether we describe it, as you do, on the basis of invasion—that the communities could be described as refugee camps and things like that. To me, it would take an even longer term to get people around to perhaps accepting that, if that is the way we want it to be portrayed. That is one of the things that the committee has to come to terms with. Whilst we understand that that longer term attitude has to be there, we have to start somewhere and that is probably why we are trying to hold the committee together, to have a bipartisan effort on that.

Rev. Smith—I think that is terribly important because I believe that, until we address the overarching things, there is a sense in which we play around with the symptoms. As you well know, if you just pour money on symptoms without addressing underlying causes, in the end the symptoms are still there and you say, 'Oh, my goodness, what did we do? All this money went in there and nothing happened.'

You are absolutely right about the time line for some of the larger issues—how do we live ethically in a post-colonial society?—but unless there is a beginning, with an acknowledgment of a long time line, nothing happens. Unless, as a committee, you can grapple with that and at least create a beginning, even if it is only setting up some other structure that can continue to wrestle with that, there will be another committee sitting here in 20 years time asking the same questions and finding the overall political issue still too hard to address. Somebody somewhere has to make a beginning, and you can do that.

Mr JENKINS—Can you help us by saying how, as a church, you dealt with these issues, because you were involved in past practices—I do not say that as an accuser, but the point is that—

Rev. Herbert—Some of them were not too good.

Mr JENKINS—You have had to come to grips with that, as a very important institution within Australian society, so what steps have you taken to try to contribute to this wider community understanding?

Mr ALLAN MORRIS—Within your own community, how did you actually deal with it?

Mr JENKINS—Not only within your own community, as the institution, your church, but also by expressing your concern about past practices to the wider community.

Rev. Herbert—All the churches, not just our church, realise that the relationship between Aboriginal people and white people cannot be a paternalistic one, that it has to be an equal relationship. When the churches gave their ownership of mission stations back to Aboriginal people many years ago, that was a recognition that we had to have a different relationship.

We have had a very strong policy in the Uniting Church never to speak on behalf of Aboriginal people, which is why we cannot come here today and say, 'This is how you solve Aboriginal health.' I think that is where my good friend Father Brennan got himself into hot water over the 10-point plan, when he tried to act as a negotiator on behalf of Aboriginal people. The Uniting Church will not do that. Aboriginal people must speak for themselves.

Mr ALLAN MORRIS—Are your congregations as one on this?

Rev. Herbert—No, of course not.

Mr ALLAN MORRIS—How did you set about persuading them?

Rev. Herbert—We have not persuaded all of them, as yet.

Rev. Smith—Can I talk from the experience of Frontier Services, from what I know. As I said earlier, Frontier Services' predecessors were the Australian Inland Mission and the Federal Methodist Inland Mission. If you look back at the history of those organisations, there is a sense in which you could say—particularly with the Australian Inland Mission—that their inception was about the consolidation of the invasion of Aboriginal lands. It was about making the bush a place—

Mr ALLAN MORRIS—About civilising them.

Rev. Smith—where women and children could feel safe. Those are the sorts of things that are in the documents from earlier this century on the formation of the Australian Inland Mission. One of the important things for us in making change to our approach to Aboriginal people has been to just recognise that. We are coming to very religious grounds now, but confession is good. It is good to recognise, to accept the realities that were—not necessarily beating ourselves around the head by being overly judgmental but recognising that we were a part and that we contributed in certain ways. I suppose it has been the same for the church in relation to the impact of the removal of children: we have recognised involvement and its impact.

The next step we took was to ask, 'How can we do things differently?' There are two ways that we can do things differently: we can do things differently on the ground, but we can also do things differently where decisions are made. Over a period of six years the committee that provides the governance for Frontier Services moved from a committee that was totally non-Aboriginal to a committee that is now composed equally of Aboriginal and non-Aboriginal people. We have Aboriginal people participating in the important decisions. That then starts to impact on the way we deliver services and, indeed, on what services we deliver. We can talk only from our own experience.

Dr NELSON—When the Reverend Peter Wales from Anglican All Saints Church in Charleville came out and questioned the wisdom of his bishop on native title, I rang him—I suspect he will be there for a while now—and he sent me a letter. Amongst other things, he said that the first duty of love is to listen. It is not my place, obviously, to tell you what your job is, but he is so right that the job we all have is to try to understand how another person feels and that his job is to try to bring people, often with competing if not conflicting experiences and agendas, to a mutual understanding of how the other feels.

It just seems to me that the vast majority of Australians are not racist. Mrs Elson was more or less reminding me that what Australians do get upset about is a lack of egalitarianism, although she did not say that—basically, people being perceived, rightly or wrongly, as getting more or less than another. If we are going to make progress here, it just seems that Australians need to see the problem. They need to understand it; they need to have a feeling for it.

I noticed that a previous submission from the Dental Association quoted the current health minister, Dr Wooldridge, when he said, 'Let's hope we never see another health

minister traipsing around through Aboriginal communities for the television crew and telling people how bad it is.' I hope we do, because the more that Australians see this the more we might see a political will. As I realise, you are not here to be lectured to me, but I just thought I would make that point.

Rev. Herbert—We have given you a bit of a lecture! Maybe we should see the minister for Aboriginal affairs or the minister for health traipsing through a few communities where it really is done well and where it is organised. That is what we ought to see a bit more of.

CHAIR—That is what we have been trying to do, actually.

Rev. Herbert—As Brian said, you cannot separate health from employment. People's sense of participation in life and all of those issues is linked.

CHAIR—We need to wrap it up there but, because I am the chairman, the final say is my prerogative. It seems to me we will not get through this whole issue, as Australians, if we come at it with some sense of guilt. We have to come at it with a genuine sense of wanting to change. I have seen the torture that the Uniting Church went through about the John Flynn memorial: we have to give the stone back. My perception is that that has been driven by their sense of guilt rather than by the tribute that it ought to be to someone who pioneered health care services in outback Australia.

That is just a comment from me, but I see the politicisation destroying any progress we have made. I have said to committee members from all sides that, if we let Aboriginal health become as politicised as the native title issue became, we may as well give up now. Where we will end up, we do not know yet, but we thank you very much for the time and effort you have taken and the recommendations that you have urged us to make.

Rev. Herbert—Thank you for taking the time to listen to what we had to say.

Rev. Smith—Thank you.

[1.05 p.m.]

KNIGHT, Dr John, Medical Director, Australian Kidney Foundation, GPO Box 9993, Adelaide 5001

CHAIR—Welcome. Before proceeding I need to point out that whilst this committee does not formally swear its witnesses, these are legal proceedings of the parliament and warrant the same respect as does the House of Representatives itself, which means any misleading of the committee can be regarded as a contempt of the parliament. It also offers you an opportunity to be fearless as a result of having the protection of parliamentary privilege.

We have a submission from your organisation which is dated last year. You may want to bring us up to date on any changes by making a brief opening statement. Please do not feel the need to read your whole statement. We have had it for a while and we have read through it. Be aware that my committee members get anxious to get to the bone quickly, so they will want to ask questions. So after a brief opening statement we will have some questions.

Dr Knight—The submission that you have, which is dated 25 September 1997, was written by me and by Dr Wendy Hoy. I take it that you will be talking to Wendy, or you have been talking to her, in Darwin separately.

The Australian Kidney Foundation has a partnership with Dr Hoy and is funding research and intervention into renal disease in Aboriginal people at the Menzies School of Health Research in Darwin. It represents our biggest investment from our rather modest research budget and it represents the Australian Kidney Foundation's absolute commitment to this problem, which we see as the number one kidney problem in Australia today.

My submission outlines the very dramatic increase in renal disease which has been seen in the few years in the Northern Territory. It outlines some possible causes, it outlines the cost, and then it sets forward a plan of action. The cost, which is on page 61 of the book, I have put at $40,000 per annum for each dialysis patient. However, I have a letter here from Wendy, dated 27 May 1998, with her estimate of costs, which is more inclusive. It includes the costs of transporting patients to Darwin and putting them up, because many patients come in from remote areas. She estimates it is more like $75,000 per annum. So you are dealing with a medical problem that is currently costing $10 million to $12 million per annum, and it is increasing exponentially.

There are a couple of things that have happened since Wendy and I wrote this submission. The first is a medical advance. There have been articles published both in the *Lancet* and the *British Medical Journal* just this year showing that for the first time we have an effective means of halting the progression of renal failure. I know that Dr Nelson knows what I mean by that, but let me say to other members of the committee what I mean by that.

I should say, parenthetically, that I speak as a kidney specialist. I work for the Australian Kidney Foundation, but I also work as a specialist in children's kidney diseases at the Children's Hospital here in Sydney. Up until now, throughout my professional career, once a person had kidney disease that disease would go on to destroy the kidney completely over a period of months, or sometimes years, and there was nothing we could do to stop that. All that we could do would be to watch them, keep them safe and then put them on dialysis, or look for a kidney transplant for them. One of the holy grails of kidney medicine has been to look for some way to try to stop kidney diseases. To cure would be better, but to stop them would be very, very nice.

This series of articles that have appeared show that the use of a drug called ACE blocker or ACE inhibitor, which has been used for some time now for high blood pressure, will specifically stop and stabilise kidney failure at a particular level. If you have lost 60, 70 or 80 per cent of your kidney function, you can often stabilise a patient at 60, 70 or 80 per cent instead of watching them progress on to 100 per cent and needing dialysis.

This is now proven beyond reasonable doubt in very large multi-centre studies with many thousands of patients. The particular study I am referring to is known as the Gissen study. It comes from Italy and was published in the *Lancet* and the *British Medical Journal* this year. Interestingly, this is exactly the same class of drug that Wendy has been using on Tiwi Islanders to try to halt and stabilise the renal disease, particularly in Tiwi Islanders, but also throughout the Northern Territory.

The first advance I wanted to report to you was that this breakthrough is really the major breakthrough of my professional lifetime. The management of renal disease has changed the outlook for this situation because now, instead of watching, we can act.

The second thing I wanted to say to you is that this second document I brought with me today is Wendy's report on the first 12 months of her study of using this drug to try to stabilise renal failure in Tiwi Islanders. It shows quite dramatically that she has been able to stabilise the disease, arrest the progression and keep the people she is treating—it is a group of about 200 people—at the same level of renal failure, rather than watch them progress rapidly towards dialysis. I think it is a nice juxtaposition of facts that hard data is coming out in medical literature at the same time as Wendy's data, which by its nature is much more limited and local data, showing exactly the same thing. So the message I have for you is that while it is a terrible situation we do now have some means of intervening.

The third and final thing I would say to you that has changed since I wrote this with Wendy is that she is now receiving requests from Aboriginal controlled health services throughout the Northern Territory and throughout the northern half of Western Australia asking her to visit those communities to institute the same sort of surveillance and intervention measures that she has been undertaking so successfully on Bathurst and Melville Islands. That's great. It is great because she has been invited, as I am sure you have been told many times in this inquiry, by Aboriginal controlled health services. It is

great that she now has something to offer—not only surveillance in early detection but actually a preventive program which looks as if it is going to work.

If I was updating the submission now I would say that there is a glimmer of optimism in this terrible situation. If the resources were available it would be feasible and appropriate—I would argue essential—to extend the model that Wendy has established amongst the Tiwi Islanders to other Aboriginal communities throughout the Northern Territory, or to wherever we find Aboriginal people who are suffering from this form of progressive, devastating kidney disease. That will do for an opening remark, and I hope that brings members of the committee up to date on what has happened since the submission was written.

Dr NELSON—Dr Knight, what reaction have you had from the Office of Aboriginal and Torres Strait Islander Health, from the minister or the government, as a result of the work, or have you had none at all?

Dr Knight—The AKF, to my knowledge, has had no reaction from any of those bodies.

Dr NELSON—Have you sought to try to get some assistance to extend the program?

Dr Knight—The funding for the program at the Menzies School for Health Research at the moment is from the Australian Kidney Foundation, from Servier, the pharmaceutical company that makes the drug that is being used, and from the NHMRC. Wendy has a senior fellowship. Her salary is paid by a senior fellowship from the NHMRC. I am not aware of any specific funding which is available over and above that. But I am not in touch with the most recent information. I would need to take that message on notice, go back to the Menzies School and see what other funds have been made available.

Dr NELSON—As you say, it is exciting, but it is now a question of finding our way through the bureaucratic maze to get it supported, funded and operating.

Mr QUICK—Have you any idea how much money would be required? Are we talking tens of millions of dollars, long term?

Dr Knight—I have actually been talking to Wendy Hoy about this in the last day or so. She believes that, for half a million dollars per annum, she could put together a task force, comprised mainly of nurse educators and Aboriginal health educators with doctors as backup, largely at the end of the telephone but also structuring the program, which could visit communities, set up the program, teach local people how to implement detection and treatment.

Detection is really very simple. You sit down all of the adult members of the

community. You test their urine for protein. You take their blood pressure. You look at their body mass index or how fat or how tall they are and you can build up a risk profile of those people who have early kidney disease. Sometimes you would want to do a blood test as well if their blood pressure is up or if they have got protein in their urine.

For those people most at risk, you then start on this treatment. You monitor their progress and you watch their blood pressure come back towards normal. You watch the amount of protein in their urine come down. It is not conceptually difficult or complicated. It is not high tech. That is the figure that she mentioned to me. For half a million dollars per annum, she thinks she could put together a task force that will make a real difference in this area and, as you say, potentially save a lot of money.

Mrs ELSON—I want to ask a question in regard to page 60 of your submission on that table of incidence of new cases of end-stage renal failure. Those figures jump enormously between 1992 and 1996. Is that because of a lack of data beforehand or an increase of incidence of kidney failure in that 1993 to 1996 period?

Dr Knight—I think that is an absolutely key question and this is where we need a lot more research. My take on it is that this is a new disease, that it is not a question of inadequate ascertainment or even worse that people are just not being offered treatment. We know quite a lot about the health status of Aboriginal people in the Northern Territory in the 1940s and 1950s through the mission native surveys of health. We also know quite a lot about their bodies through the old photographs that were taken and that are on display in Alice Springs and elsewhere. These were lean people in the 1940s and 1950s who had very little in the way of renal disease. There is now a huge problem with obesity and hypertension and it seems to be in that context together with maternal malnutrition that the renal disease develops.

The professional view is that this is what is called a transitional disease, a disease that occurs when western lifestyles hit people who have been used to more nomadic, hunter gatherer style of existence. You certainly get the fast foods, the high sugar foods, the high fat foods, the obesity and the high blood pressure as traditional lifestyles are disrupted. You also get, in many cases, severe maternal malnutrition which can affect the developing kidney. Those sort of situations are really quite recent in their onset as far as we can determine.

The reason I can speak so confidently is that the ANZDATA registry, which is the national registry of all dialysis and transplant patients, has been collecting data on every single person with end-stage renal failure in Australia since 1966. So we have 30 years of figures and they are really very complete and accurate figures.

Mr QUICK—State health departments tend to be monolithic and very slow to respond with something as positive as this. We were up in Alice Springs a month or so ago talking to the health department there about their projected planning to cater for this obvious problem. They have probably allocated money five or 10 years down the track. Is

your organisation in discussion with state health ministers to say, 'Look, hang on a second, rather than expend hundreds of thousands or millions of dollars in Alice Springs building a new wing to cater for this, for which there might not be a need, perhaps some of the money might be allocated to that half a million dollars to set up the roving team'?

Dr Knight—The Australian Kidney Foundation is a charity whose main purpose is to raise money for medical research into kidney disease. While we do see ourselves as having an advocacy role, which is why I am here today, we have not in the past had the resources to get in amongst it with state governments to say, 'How about this?' or 'How about that?' I think this is something that the AKF should be doing much more in the future than it has done in the past.

There has been a huge under-resourcing of renal services, particularly in the Northern Territory. When I was up there at the end of last year, there were around 100 people on dialysis. In Sydney or in Melbourne, a dialysis population that size would have maybe four or five kidney specialists to look after them. In Darwin there is one, and he started work 15 months ago. Prior to that, there were none. They were served by someone coming intermittently from Adelaide. In this city, to have 100 people on dialysis and one kidney specialist would be a disgrace.

Listening to the remarks earlier about, 'Aren't we spending too much money?' staggered me. The lack of resources by any reasonable standard of any western country is quite extraordinary.

Mr ALLAN MORRIS—Why don't you say that publicly a bit more often?

Dr Knight—I am saying it here now.

Mr QUICK—In comparison with other indigenous races, is this the worst case scenario? What is happening with the North American Indians and the Maoris?

Dr Knight—Similar problems are being seen in other transitional lifestyle groups, particularly the ones you mentioned, the Maoris and the North American Indians. This has been subject to quite a bit of Internet discussion among kidney specialists in the last few months. It is being seen mainly in the western countries that have the data collection facilities to really pick this up and work on it. There is a concern that, as other countries develop and get more affluent lifestyles, it is going to be much more common.

Mr JENKINS—Can I get the picture about the overlap requirement for expanding dialysis, plus the more recent developments: how much does it arrest the need?

Dr Knight—It is too early to say, because this data is literally months old rather than years old. It seems to me that there is no doubt that we can slow and stabilise. But I think there will still be people going into renal failure and needing dialysis. I think the numbers will still be increasing. I think we are looking at a three-year to five-year time

frame before we see that graph, hopefully, taper off and steady or even out.

Mr JENKINS—On the evidence that we were shown at Alice Springs, the graph was exponential. It was dreadful.

Dr Knight—Yes. If we started these interventions right across the Northern Territory today, we would be looking at a three-year to five-year time frame before the curve flattened out.

Mr JENKINS—When you say 'a transitional change in lifestyle', we would have to go to the lifestyle problems as well?

Dr Knight—Yes; not everything is known about what causes this. The point I make in the submission is that there is a lot of money needed just to research to try to understand it a bit better. Wendy is there on her own with three or four PhD students. She could easily do with three or four times as many staff as she has now in order to speed up the pace of the research into the basic mechanisms of the disease.

The data that she has produced, and that has been produced elsewhere in similar communities, does suggest that lifestyle is crucial—diet, exercise, blood pressure—in type 2 diabetes and particularly child and infant nutrition and maternal nutrition.

One of the most dramatic findings that Wendy has published is the relationship between low birth weight and renal disease. If you are a tiny little baby, 2.25 kilograms at birth, you are much more likely to need dialysis at the age of 40 than if you are a proper size, proper weight term baby.

Mr JENKINS—It is the other edge of the improvement in infant mortality rates.

Dr Knight—Yes, I think feeding pregnant women properly would be a huge advance.

Mr ALLAN MORRIS—Perhaps you might advise subsequent to today about the kind of nature research that is required. It seems to me that the lifestyle one is very generic and that there has to be a biological ingredient in there somewhere. I am not sure that is happening. I think as a committee we would be really interested in following up the need for more research. Perhaps you could particularise—and perhaps Ms Hoy may be able to when we talk to her—as to the kind of research or the nature of it? Perhaps you could answer that with a note?

Dr Knight—Yes. There is a temptation to think this is genetic, that Aboriginal people are somehow different from us and are more predisposed to kidney disease. To me the evidence does not really point in that direction because, firstly, it is so recent. Their gene pool has not changed for hundreds of thousands of years and yet this epidemic of renal failure is really only five to 10 years old. That points to an environmental influence,

rather than a genetic influence. Secondly, there is the link with birth weight and with maternal nutrition. If a healthy Aboriginal baby is born into a healthy middle-class Aboriginal family, we do not see these problems.

One of the bits of research that I am involved with here in Sydney is to try and survey different Aboriginal communities, both urban and rural, and look at the children in particular—being a children's kidney specialist—to see whether the same renal disease is there in those populations as they are seeing in the more remote populations. The hypothesis I will be testing is that it is actually very rare in urban communities and that the more you get out into the outback and the bush the more common it is. That, again, I think points to a lifestyle and environmental influence rather than a genetic influence.

Mr ALLAN MORRIS—I was not particularly suggesting genetic. What I was trying to suggest was that low birth weight and high renal failure are symptoms and there has to be a biological factor that actually makes it happen. We do not seem to know what physically and biologically is causing it and I would have thought that we needed to understand that better. Perhaps Ms Hoy may be able to help us particularise that kind of research, rather than us just saying we need more research, because I think if we say that I doubt much will happen.

The other point I wanted to raise with you is that in our travelling around talking to people in communities we notice that there is quite a lot of water testing programs. When we ask, the testing seems to be mainly for E. coli and bacterial testing. There appears to be very little testing for mineral content, particularly of bore water. Amongst ourselves we were curious about mineral content and a continued use of bore water and whether bore water content may well be changing, as it seems to be in a place like Bangladesh, for example. Firstly, is that a possible influence? Secondly, are you aware of any testing going on for that?

Dr Knight—To me, as a kidney specialist, that would be fairly implausible as a cause of this. I am not aware of any testing. A much more important issue is access to adequate drinking water. Kidney stones and bladder stones are very, very common, particularly in children from the deserts. I think that relates to just not having enough water to drink that is readily available, rather than to any particular content of the water. But those stones are soft and they are fairly easily dissolvable. Looking at the epidemiology of this as hard as I can, I do not think the stone story is involved in the renal failure story; I think is a separate issue. I do not think water quality is a key issue. Water availability is an issue for stone disease but not, I think, for renal failure. I think it comes back to nutrition and lifestyles.

Mr ALLAN MORRIS—In other words, we do not actually know?

Dr Knight—You are quite right—we do not actually know. In terms of more research, there are two sorts of medical research, aren't there? There is investigator driven research, where you have to put in an application to the NHMRC and you have a 27 per

cent chance of funding and it tends to go to the big institutes, like the Hall institute or the Gardiner. The full-time career molecular biology bench researchers can always put up a better case than someone out in the field in the bush getting their hands dirty. At the moment, most people interested in this area are having to struggle for funding to compete in that environment for investigator driven research funding through the NHMRC mechanisms.

But there is another sort of research funding, isn't there, which is targeted research where governments invest particular amounts of money into particular problems, not only for altruistic reasons but because they can see the cost?

Mr ALLAN MORRIS—Yes.

Dr Knight—It seems to me that there has not been enough of that sort of funding available for this problem. But I am not enough of a student of the bureaucratic process to know how one goes about unlocking that sort of funding.

Mr ALLAN MORRIS—But if you could perhaps tell us the kind of research channels that are deficient, we may be able to try and persuade parliament or governments that there is an obligation to actually fund that research. Our submissions tend to be very generalised about the kidney problems, the epidemiological and statistical rather than the actual biological problems. So perhaps when you are talking with Ms Hoy you might raise the twin strands: one is what she is doing, which obviously needs to be extended, but the second is that we need to understand the 'what'.

Dr Knight—I guess in writing submissions to a committee of this nature one tends to speak—

Mr ALLAN MORRIS—You have done very well.

Dr Knight—in big picture perspectives, but I would have no difficulty, given a little notice, in putting together a very detailed research proposal with the Australian Kidney Foundation and the Menzies school, with specific projects, the pay-off for each one, the cost of each one and how they would fit into an overall picture. There are things to be done, like looking at the kidneys under the microscope, measuring them carefully and seeing whether they look different. There are samples to be done in randomised control trials where you just take a group of people and treat them in different ways and compare the outcomes. There are natural history studies to be done across other communities in Australia, because although we know a lot about the Tiwi islanders, thanks to Wendy Hoy, we know virtually nothing about the situation in Western Australia, Queensland, New South Wales—

Mr ALLAN MORRIS—We are not experts, but if we knew there was a project that was going to help address this issue and it was available for application for funding, I would think we would be supportive of that concept. We would not be able to judge its

merits medically. Mr Chairman—

CHAIR—Form a subcommittee.

Mr ALLAN MORRIS—would you agree with that? I guess I want to encourage Dr Knight to do that little bit of work, not a finely detailed submission but perhaps an outline or something similar that we might be able to—

Dr Knight—Certainly, given a little notice, I could, with the Menzies school and the Australian Kidney Foundation, put together an outline of what needs to be done.

Mr ALLAN MORRIS—I am sure we would appreciate that.

Dr Knight—The other professional body that I think would need to be involved would be the Australian and New Zealand Society of Nephrology, which is the professional grouping of all the kidney specialists in the country. There are about 380 kidney specialists across Australia and they are the ones with the expertise to make sure that the quality is there that you are talking about. I am a member of that group as well.

Mr ALLAN MORRIS—We would appreciate anything that would help us take this a little further.

Dr Knight—What would be the process from that point on, if I prepared a document like that?

CHAIR—You could submit a document in ongoing evidence, in a similar way to what you have already submitted, then we would—

Mr ALLAN MORRIS—We seek follow-up material because often these discussions do bring out things. We will not be reporting in the next month or six weeks or so, and we have a question about elections sitting up there—

Dr Knight—But what would happen to it then?

CHAIR—It is not an application—we are not in a position to do that—but we would want to be able to say in our report, 'Here are a few good examples.' I do not envisage you would need a comprehensive submission but we would make it part of the

report: here is a program that has been suggested for half a million dollars per annum and this is what it would deliver. If you had a good feel for the potential outcomes we would use them as examples of what could be done. What normally happens after that is that government has to respond to our report.

Mr ALLAN MORRIS—The departments would actually look at the evidence we have had, look at the *Hansard* and look at the submissions, and the minister would have

to then resolve whether or not the government agreed with that recommendation.

Mr QUICK—Also, when we get the department back in and ask them questions as a result of hearing witnesses all round Australia, we say to them, 'What is your departmental policy on following this up?' and 'Why not?'—those sorts of things.

Dr NELSON—It might be a waste of your time and effort—in fact, it would be—to put in a detailed submission for a research project. What is perhaps more relevant to what we are doing is: how is research of Aboriginal disease financed; how do people such as yourselves suffer in the NHMRC financing process; and what recommendations ought this committee, in the context of Aboriginal health, make to the government in terms of re-ordering the way in which research is financed?

The government is currently being pressured in other areas to actually bundle up all the money that is made available for research, whether it is in mental health or general practice and so on, put it under one single umbrella and have people apply for medical research only on the basis of the scientific veracity of the proposal. Those who are putting those sorts of arguments forward are trying to stop the politicisation of certain diseases. For understandable reasons the research community are anxious to see that politicians do not pluck diseases out and say, 'We will fund research into Aboriginal renal disease even though the quality of research might be inferior to a whole lot of other things that are not being funded.' So I suggest perhaps something along those lines might be more relevant to what we are actually doing than a detailed proposal.

Dr Knight—I understand what you are saying.

Mr ALLAN MORRIS—I agree with what you are saying there, but I would take the point of view that, from what we saw and heard in Alice Springs, we are facing a massive epidemic of kidney failure that we can see coming and we are actually ignoring it. I see it as being like AIDS or any other epidemic: we should be treating it as an epidemic. So I would suggest we try and do both. Dr Knight, we are only suggesting an outline of the kind of program. We sat and watched the health people in the Northern Territory tell us that virtually their whole budget will be wiped out by dialysis in about five years time. Knowing that, if we do not address that particularly—I know there are other health issues that Aboriginals have that also need research, but your particular one is—

Dr Knight—I am not opposed to investigator driven research. I have benefited from it often enough and it is crucial to the intellectual life of the country to have people doing curiosity driven research. But I think there is also an argument when a disease is costing an absolute fortune to have the same sort of R&D budget that a business might have in terms of tackling the problem.

Mr ALLAN MORRIS—Perhaps you can do both and we can then sort it out.

Dr Knight—They are different sorts of research; we probably need a different name for it.

CHAIR—Thank you, Dr Knight, for your time and effort. I realise you have probably got some needy patients at the hospital, and it is good of you to take the time to put this evidence before us. The task is back on us now as a committee to make recommendations based on what you have told us. Thank you very much. We will look forward to getting any submission onwards from here.

Mr ALLAN MORRIS—Or any other matters you might think you can help us with.

Resolved (on motion by **Mrs Elson**):

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

Committee adjourned at 1.36 p.m.