HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

DARWIN

Monday, 17 August 1998

OFFICIAL HANSARD REPORT

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE AND FAMILY AND COMMUNITY AFFAIRS

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Mr Forrest (Chair)
Mr Quick (Deputy Chair)

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Mr Jenkins	Mr Allan Morris
Mrs Johnston	Dr Nelson
Mrs De-Anne Kelly	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

DARWIN

Monday, 17 August 1998

Present

Mr Forrest (Chair)

Mr Jenkins — Mr Quick

Mr Allan Morris

Committee met at 8.31 a.m.

Mr Forrest took the chair.

CHAIR—I am the Chairman of the Standing Committee on Family and Community Affairs, and I am pleased to open this 12th day of public hearings of the committee's inquiry into indigenous health as referred by the Minister for Health and Family Services, the Hon. Dr Michael Wooldridge, with the support of the Minister for Aboriginal and Torres Strait Islander Affairs, Senator the Hon. John Herron. This referral was made in June last year.

The committee has been collecting evidence to determine a way in which to coordinate the planning and delivery of health services. We all know the appalling state of Aboriginal health, and I am very pleased to say that there is a determination from our committee—a bipartisan determination in fact—to use this inquiry, even in a progressive way for the immediate future and for the long-term future, to make some real impact and progress on the matter.

Today's hearing in Darwin follows previous hearings in capital cities and selected regional centres, and provides a further opportunity to explore issues with representatives of Territory based organisations and individuals who have made submissions to the inquiry. The committee is keen to gather as much evidence as possible. We have been very pleased with an ongoing progress that seems to have followed our committee. We do not want anybody to be saying, 'Let us wait till they finish their report.' There is some ongoing evolving progress, and we are pleased to see that as well.

ANGUS, Ms Patricia Gweneth, Assistant Secretary, Aboriginal and Community Health Policy, Territory Health Services, 87 Mitchell Street, Darwin, Northern Territory 0800

HEMPEL, Mr Raymond John, Assistant Director, Office of Aboriginal Development, GPO Box 4450, Darwin, Northern Territory 0801

PRINCE, Mrs Jennifer Gail, Deputy Under Treasurer, Northern Territory Treasury, GPO Box 1974, Darwin, Northern Territory 0801

WILLIAMS, Mr Kevin John, Assistant Secretary, Health, Planning and Systems Support, Territory Health Services, 87 Mitchell Street, Darwin, Northern Territory 0800

CHAIR—I welcome witnesses from the Northern Territory government. Before proceeding, I need to point out that, whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives. Any deliberate misleading of the committee might, therefore, be regarded as contempt of the parliament. This process serves to protect witnesses so that they can be fearless, open and straightforward in their evidence to us today.

A comprehensive submission has already been received and has been published as part of the evidence of the inquiry. We would like to proceed to some questions in detail, but you may feel the need to make a brief opening statement on anything that has changed since December when your submission was first made.

Ms Angus—I would like to just make a general opening statement. You will note that there is one significant change since we wrote the submission. Firstly, good morning, and thank you for the opportunity to provide further information to your committee. I would like it on record that the Northern Territory Minister for Health, Family and Children's Services, Denis Burke, sends his apologies for not being able to attend today's hearing. He is in Kalkarinji speaking at the constitutional convention with the council of Aboriginal nations of central Australia.

I would just like to make a few comments which give the context of the Northern Territory government's submission. The most important goal for the Northern Territory is the improvement of Aboriginal health. It is necessary to address the determinants of ill health and not focus on the disease end only. Therefore, it is essential we develop integrated models of care. The Northern Territory government's approach to improving Aboriginal health is based on intersectoral action and collaborative work. Addressing the factors underlying Aboriginal health therefore requires the responsible sectors to work together. From all the points made within our submission, I want to emphasise five

specific issues.

The first is increasing Aboriginal involvement, control and responsibility for health care: to work on strengthening community and individuals' capacity to do this; to support community organisations to control and influence service providers, increase service delivery by Aboriginal organisations and a commitment to the spirit of the framework agreement on Aboriginal health which was signed on 8 April this year. That was not noted in the submission you received in December. This includes participation on the Northern Territory Health Forum, and joint planning approaches.

The second is primary health care and prevention: to implement food and nutrition strategies, especially initiatives such as training for community store managers, promoting healthy foods at community events and employing community based workers to work with families to promote healthy living; undertake comprehensive and regular substance misuse programs; and develop and implement a comprehensive chronic diseases strategy.

The third is environmental health and infrastructure: having adequate and appropriate public health legislation and regulations which include coverage of remote areas—a review of the Northern Territory Public Health Act is currently under way; the development of standards which describe the minimum level of environmental health infrastructure and essential services required to facilitate a healthy environment, addressing basic essential services such as water, sewerage and rubbish disposal and the Commonwealth-state housing bilateral agreement, the Indigenous Housing Authority of the Northern Territory, which pools indigenous housing funds in the Northern Territory.

The fourth is education, training and employment. The link between education and health is well recognised. The Northern Territory government departments are currently working collaboratively on a school-aged child health policy to come up with better ways of improving educational attainment of basics such as literacy and numeracy amongst children in remote and urban areas. Locally employed Aboriginal health staff are vital in providing primary level health care. Opportunities for advancement within the health sector and a range of job opportunities are also important. Initiatives within Territory Health Services include cadetships for a range of degree courses and scholarships for Aboriginal students in medicine and nursing.

The fifth is maximising resources. Outcomes depend on services and services are limited only by resources provided to them. The Northern Territory government believes that it receives inadequate resources from the Commonwealth for tackling Aboriginal health. For example, in the Northern Territory, remote health services and Aboriginal health services generally do not access the MBS and PBS schemes. Thank you.

CHAIR—Just for my benefit, because I need to catch up to speed on how Territory Health Services operates, could you explain how you all fit in in your departments and so forth. Could you explain Kevin's, Jennifer's and Ray's role?

Ms Angus—Yes. Within the Northern Territory government, Kevin and I work for Territory Health Services. We are both on the department's executive. Kevin is the assistant secretary responsible for health systems and health systems support, which covers the funding policy arrangements, the information areas and acute and specialist policy services for Territory Health Services.

I am responsible for the Aboriginal community health policy direction of Territory Health Services. I do not have direct responsibility for the operations of those policies but it is my responsibility to ensure that we work cooperatively with our operational regional directors to see that the strategies are in place.

Jennifer might want to speak for herself. She is from the treasury department.

Mrs Prince—I am the deputy under-treasurer and have a range of responsibilities in the treasury. The one that is most relevant to this inquiry is the responsibility for intergovernmental financial relations. I am also responsible for the budget areas of the department. That is more of a local focus, but that may also have some interest for you.

Mr Hempel—The Territory's submission refers to intersectoral collaboration and coordination. The Office of Aboriginal Development's role is one of assisting the coordination process and the policy development process. The submission refers to some examples of where this office has assisted in that regard.

CHAIR—I was interested in the minister's public statement. It is undated but it must have been last year, around about November or December.

Ms Angus—Yes, it was.

CHAIR—What I am struggling with is catching up with geography and so forth. There are a number of health services listed in that speech and in your submission as well: Tiwi board, Maningrida and Melville and Bathurst islands. Would you just run us through the strategic locations of those and what stage they are at in terms of progress and so on?

Ms Angus—The Northern Territory's health sector is made up of Territory Health Services and health facilities. They include the small hospitals, two big hospitals and about 70 remote community health centres and urban community health centres in the main towns. There are Aboriginal health services that are predominantly funded by the Commonwealth government but most of them receive some funding support from the Northern Territory as well. They are located in the five major urban towns, and in central Australia there are several in the remote areas.

There are health services in the remote areas that are funded wholly by the Northern Territory government. The reference to the Tiwi health services, which comprises Melville, which is Milikapiti; Garden Point which is Pirlangimbi; and the Tiwi health

service at Nguiu, is a reflection of a new initiative by the Commonwealth to trial some coordinated care opportunities. The Northern Territory took advantage of that and are trialling, together with the Commonwealth and the Tiwi community, a trial within the Tiwis. There is a health board which is now called the Tiwi Health Board to coordinate that trial. There is an Aboriginal coordinated care trial place in the Katherine West area.

CHAIR—So, you have got initiatives that you have initiated and are funding yourselves as a territory and then there are Commonwealth initiatives. Are there any others?

Ms Angus—There are combinations. There are some that receive funding from a range of sources. The Aboriginal health services themselves receive funding from a range of funders. They are the main providers.

CHAIR—It is an interesting situation. Colleagues, have you got any questions that you would like to ask?

Mr QUICK—Yes, I have got heaps of them.

CHAIR—Mr Quick is the deputy chairman, from Tasmania.

Mr QUICK—In the intersectoral approach in 7.4 you mention the link between health and transport. It is obvious when you visit this part of the world as often we have that the upgrading of the road infrastructure is paramount. I know it is great to blame the Commonwealth government because they seem to give the money to the wrong people at the wrong time.

Given that there is an evident link between people's health and the impact of travelling on unsealed roads, is there a 10-year plan, a five-year plan, or any plan, to ensure that roads to places like Kintore, where it is 7½ hours travel along a gravel road, are sealed? Is there a plan by the Northern Territory government to say, 'We're going to seal the road between Alice Springs and Kintore, or the road between Alice Springs and Yuendumu, in the next 10 years'? Is there an intersectoral plan to say, 'We've got this problem; we're going to solve it.' Without blaming anybody and saying, 'We don't have enough money,' is there a plan?

Mr Williams—The funding to remote communities is mixed. A couple of years ago the federal government changed from funding the Northern Territory for what is deemed to be minor and local roads to allocating that to local government councils, consistent with the rest of Australia. Much of the lesser road network out there now is controlled by community councils. There is still a network and roads like those to Kintore and Docker River are maintained by the state. That is primarily discretionary funding and competes with other funding from the state. The Commonwealth, by and large, just funds the national highways as a priority within the Northern Territory and other states.

As in any other state, road funding is competing with other funds for education and health, et cetera. An economic decision is to be made in terms of traffic volumes and the appropriateness of sealing roads. Many of our roads are very, very lightly trafficked but very, very long and still critical to the lifeline. So there is a natural tension there. I think the government, within its means, will continue to maintain as good a standard as is financially viable.

Mr QUICK—I am going to wander all over the place. On the failure to attract GPs to remote communities, we can have the best health system in the world as far as the paperwork goes, but if we have to rely on doctors to go to remote communities—and we heard evidence, I think in Melbourne, of a GP from one of the outer Melbourne suburbs who spends his time in Yuendumu—how do we put in place a really efficient and effective plan to keep the GPs in these rural and remote communities? What do we have to do? If we have this wonderful health plan, strategies, intersectoral approaches, but we do not have the people out there—the experts—we are wasting our time. And what is your government saying to the AMA and the colleges? We have got to have them out there. What do you guys want? Do you need $300,000 a year, or do you need $250,000, or do you set up, through your college and education system, a bonding system to say, like we used to years ago to teachers, 'We'll pay all your fees, your HECS and the like, but you've got to spend two years at these remote communities'?

Ms Angus—They are the sorts of things we are looking at. Whilst it is acknowledged that doctors are an important equation in the health sector, Aboriginal health workers, nurses and allied health workers are as important, so the situation is one of working in with a team of people. It is not as if there is an absence of medical care at the moment in remote areas in so much as we are currently providing a district medical officer service. It is perhaps not as in depth as would be desirable in so much as they have quite a wide area to cover. They go in on a fly-in, and maybe overnight, basis.

Recent discussions and negotiations with the medical fraternity, both with the AMA and the College of General Practitioners, have been about how we can increase that. It is very hard to recruit to remote areas. A lot of these doctors, like any other profession, have families—wives and children. Access to schools and other social life is difficult for the local people who live out there, let alone for these new people coming in. So we do need to look at initiatives of how we can attract them and it might be incentives.

Mr QUICK—Do we say to the federal government, 'Look, we can't get Australians, there are heaps of foreign trained doctors that are willing to come into the system and spend three or four years in God knows where.' I think it is vitally important that we do have doctors in these communities, doing it out of the love of their heart, not just one doctor who is coming up there and spending a couple of years and then disappearing back to the eastern suburbs of Melbourne or Sydney.

So what strategies have you put in place? Do you talk to the federal government,

to Michael Wooldridge, and say, 'Look, it's essential'? I understand the training of Aboriginal health workers, that is fine, but that does not seem to have improved radically the health of Aboriginals in the Northern Territory. We have still got this huge disparity between Anglo-Saxons and the indigenous community.

Mr Williams—It is an important point. The Commonwealth government has just changed the scheme called the Rural Incentive Program to, I think, Australian health work agency, rural agency—

Ms Angus—It is the Remote Work Force Agency.

Mr Williams—Right. That is geared to provide assistance. What is missing for the Northern Territory is that the conditions are more geared to rural areas of Victoria and New South Wales rather than the extremes of our conditions. So there is still a credibility gap and a financial gap in the ability of those programs to apply. As Ms Angus says, there are some healthy liaisons, both with the AMA and the GPs and with the Remote Work Force Agency that we would hope to further dialogue. Certainly things like housing, communications and whole range of social factors come to bear.

Mr ALLAN MORRIS—Could you go further? In your submission you were actually quite critical of the RIP program as being virtually useless to you. On page nine and 10 you say:

It is an inappropriate model of care.

This submission was made some time ago. This is obviously a very strong part of your position, but it does not indicate whether there is an alternative put forward or whether you are currently negotiating an alternative. I accept the criticisms, I think they are very soundly based in terms of your circumstances, but what should the Commonwealth be doing, or yourselves, or whatever?

Mr Williams—At this stage we would like to see the details of the new scheme. This agency has only been in effect for six weeks, as I understand. I think the criticisms of the RIP scheme are sound. There was not a high take-up in the Northern Territory. I guess, if you generalise that, there would not be a high take-up in really remote areas of Australia. I think the objectives of the scheme possibly were not realised. I think dialogue with the Commonwealth to see whether their policy objectives can be achieved through the new design programs is our first starting point. There has been some discussion through the course of negotiation of the Medicare agreement, but that has not led to any particular conclusion.

Mr ALLAN MORRIS—In your submission you raise the question about the Medicare restrictions in terms of educative and other functions and you have just signed a new Medicare agreement—with some extra money. Did that broaden the boundaries to

actually allow the kind of interdisciplinary relationships and preventative care and educative functions that you so obviously support and on which, I think, we would all probably very much agree with you, from what we have heard to date? And, if not, why not?

Mr Williams—The health care agreement as it is—and previously the Medicare agreement, being fairly incorrectly titled, I believe—is really about acute care systems, about hospital funding. The gap in our services at the primary care level in remote areas is about the missing funds that relate to the delivery of MBS and PBS entitlements that the rest of us bear in settled areas.

Mr ALLAN MORRIS—The Medicare agreement could allow funds for interdisciplinary collaboration and cooperation and it could allow funds for preventive medicine if it so chose.

Mr Williams—There are some reasonably minor inducements, looking at stretching the acute care system across into related fields, but to stretch it to the primary care level really is not possible, and in many of those funds the Territory is only a one per cent player.

Mr ALLAN MORRIS—Given that the agreements are new, and it is also a difficult time, I guess, for these things to be discussed, and given therefore that this is out of date with the RIP scheme, I think we would be grateful to get any further advice as to whether or not there are any aspects of the current Medicare agreement which could allow, if you like, some latitude or some development of the kinds of things you are putting forward in your submission. If the gap is a very small one, it is going to be a bit hard on us if you have just signed an agreement that locks you out of doing the things that you wanted to do.

Mrs Prince—I think that the opportunity to negotiate those sorts of agreements is through other programs, other specific purpose or broadbanded programs, rather than through the health care agreement, which is, as Kevin says, predominantly directed towards the acute care services.

Mr ALLAN MORRIS—When you say Medicare provides a disincentive to practise the preventive aspects of primary health care, you are saying Medicare is actually harming you. I am not looking for an answer now. You have the Medicare payments to individuals and you have the Medicare agreements with the states. Quite frankly, philosophically and practically, I do not see any reason why Medicare agreements cannot incorporate educative, preventive and multidisciplinary approaches. Most states do not because most states have their own institutional structures. You do not in the Northern Territory. You have got special problems.

Is there any scope in the new agreement? Are there any openings at all that would

allow the Commonwealth to be more broadbanding in terms of how it approaches the Medicare bulk funding? Secondly, you may have noticed in another report we did that we actually looked at the problems of Medicare payments to people like nurses, at telemedicine and other issues. Is there any scope within the Medicare system to allow those payments to be varied that may be more appropriate to you? I am not asking for an answer now. It is a fairly complex question and the agreement is new. Would it be possible for you to consult with your minister? We, as a committee, have to make recommendations back to the parliament. We are now out of date as it is, given the new agreement. Could we get an update as to where we could actually help support you?

Mr Williams—We would certainly be willing to provide as much information as required. I will make two points, Mr Morris. Within the new health care agreement itself we are hopeful of getting a reasonable share of funds. The government has indicated, at least at the bureaucratic level, support for rolling out some rural health information systems which, aligned with communication systems, will radically improve our capacities to link our remote clinics back into the acute care and other care systems. That has been a bit of a stretch for the health care agreement, but that is a welcome flexibility.

As Mrs Prince says, Medicare benefits are outside of that debate and dialogue, but we are vitally interested in pushing the boundaries of the Medicare benefit system to include telemedicine, remote consulting, to be flexible, to be applicable to our circumstances. There has been a 70 per cent shift in the PBS, the conditions of which still are not finalised under the section 100 schedules. That is important for us and, I suspect, important for your committee because it does start to provide, hopefully, a very easy way of introducing the pharmaceutical benefits scheme in these remote locations. We will be taking up very soon negotiation with the Commonwealth about equal consideration for MBS.

Mr ALLAN MORRIS—If you could forward those to us, I am sure we would find those helpful. This is a vexed question for us here—particularly the pharmaceutical one.

CHAIR—I would be interested in any reactions to the rural incentives program. I come from a part of Australia where it has worked very well but you have said, yourself, that Victoria is not remote Northern Territory. My understanding was that the changes were implemented to try to address some of this. We would need to know very quickly if that is not occurring. I would be interested in your insights. You said six weeks, but I thought it was longer than that.

Mr Williams—That is just from a discussion in Alice Springs last week with the people who set up the office there. I am not entirely sure of that.

CHAIR—I thought it was back in May this year.

Ms Angus—Yes, I think it was a couple of months ago.

Mr ALLAN MORRIS—How many GPs in the Northern Territory are currently here under temporary medical arrangements from overseas?

Ms Angus—I do not have that answer.

Mr ALLAN MORRIS—I am surprised your submission has not mentioned that. I find it particularly offensive that we have all these limitations on medical accreditation and then we actually rely, in so many remote areas, on foreign doctors who are not technically qualified in the sense that they could not practise here normally. It seems to be a terrible indictment of us as a country. Do you have any ideas at all? We have heard that there are quite a few around in remote outlying areas.

Ms Angus—I would have thought there were few; I would not have thought there were a lot. I will take that on notice.

Mr ALLAN MORRIS—Don't get me wrong. I am not questioning these people's ability. I just find it very hypocritical of us as a country when, on one hand, we say, 'You can't be accredited as a doctor, but you can come to work in our remote areas where no-one else will work.'

Ms Angus—Within Territory Health Services I do not know of any that fit that description.

Mr ALLAN MORRIS—Within the Territory?

Ms Angus—Within Territory Health Services, within our agency.

Mr ALLAN MORRIS—No, I meant more as GPs.

Ms Angus—Yes. Even within—

Mr ALLAN MORRIS—We heard that in Alice Springs there were some—

CHAIR—Could you take that one on notice.

Ms Angus—Yes.

Mr QUICK—As I said, I am all over the place. I am interested in your mention of prevention rather than cure. Why has it taken so long to develop food and nutrition strategies when it must have been obvious a long time ago that there is a link between poor nutrition and many of the diseases that the indigenous people are suffering. You mentioned that the Northern Territory is close enough to these kinds of problems to

develop and coordinate the solutions in conjunction with the communities. I think it is mentioned somewhere that we have been looking at this for the last 21 or 22 years. I know that, when I was at school many years ago, the white community understood there was a link between good nutrition and good health.

Why has it taken so long for state governments and territory governments to come to this realisation, that a solution might be something as simple as training for community store managers and perhaps some flexibility in the funding of community stores to provide them with not only good nutritional food but food that is cheap enough to buy, rather than the junk stuff that they currently consume so they end up with diabetes and all the other problems?

Ms Angus—Community stores are not managed by the Northern Territory—

Mr QUICK—Yes, I realise that. You are picking up the tab by having all the dialysis stuff in Alice Springs, and we heard of the problems there. The treasury has to find the money. There might be some lateral intersectoral thinking to say that it would be a hell of a lot cheaper to, say, subsidise some of the community stores, rather than having huge dialysis costs in Alice Springs hospital and having to build new wings of hospitals. Do we have that intersectoral lateral thinking flexibility within the Northern Territory health system?

Ms Angus—Like you, I wonder why lots of things have not happened for Aboriginal health across the country before this. Over the last five years there has been a concentrated effort on working on the community stores. There have been arrangements to work with community store managers. There is currently a curriculum being developed for store managers to undergo training. That has required discussions, consultations and negotiations with the community councils or the store managers who manage those stores. That course is developed as an accredited course through the TAFE sector.

The strategies on working with communities on healthy living and eating healthy foods have not just been about trying to impose a Western lifestyle of healthy living; they have been trying to work in with the community so that there is acceptance and recognition of local food that is healthy as well. Yes, it is critical that we continue to focus on the food and nutrition aspects of it. You rightfully say that it does have a direct impact on not only renal diseases but also the whole range of chronic diseases, which ultimately often end in renal disease such as diabetes or heart disease.

Mr QUICK—Where are these TAFE courses? Are we still at the writing them down stage, or are some of the TAFE colleges in the Northern Territory about to produce their first lot of graduates?

Ms Angus—No. The course has been developed with the Batchelor College. If you are not familiar with Batchelor College, it is a college for Aboriginal students—

predominantly for adults. It is an institution that provides courses from certificate level through to diploma. We have not yet had a group of store managers go through. I understand it is about to get off the ground within the next two to three months.

Mr QUICK—Is it expected that indigenous people, basically, will be the largest number of people going through this? Do we still have the Anglo-Saxon store managers who come in? We are all well aware of the trouble that there is in some communities with white store managers. I am trying to link that aspect and my perception that educational opportunities for indigenous people to get into those sorts of courses are minimal. I understand that in Katherine no indigenous person has ever graduated from year 10. We can put these courses in place, but how do we link, intersectorally—which is a wonderful word—the indigenous people who should have control of all this with the education system and with the health system to ensure that, hopefully, we can give it back to the indigenous people? Then they can have ownership of it and it can actually work.

We hear from Sydney, Melbourne, Brisbane—the big five cities of Australia—that we have been pouring billions and billions of dollars in here for God knows how long. Are we honestly in the position where we can say, 'We have a lot of these things in place; give us five years and the problems will start to resolve themselves'? Is that a realistic expectation, or are we still putting in place knee-jerk reactions such as, 'Okay, we need to train the community store managers, but the Aboriginals are not going to get involved so it is not going to really solve the problem'? I am sorry to be all over the place.

Ms Angus—I have to get the comment in about Katherine, for a start. There have actually been several people who have gone past year 10 in Katherine, me included. Unfortunately, yes, the majority of store managers in the Northern Territory, and probably in Australia, in the remote communities, are non-Aboriginal people.

The idea of training for store managers is not just to focus on those store managers; it is about working with the local community councils and having Aboriginal people involved in the training courses as well. I totally agree: there is no point training the visitors who are just there for the short stay. So the focus is about working with the local communities and the people they want to be trained in that area. It is also about working with the local nutrition workers and health workers who may be interested in doing community stores management.

With regard to the community store managers, we have had discussions with the two major land councils, the Central Land Council and the Northern Land Council, about what is the best way of going about achieving long-term benefits, not just the benefits for the current store managers.

CHAIR—We have seen a lot of different models for the store itself. Some are owned by communities; some are owned by an outfit out of town, for profit, which is a real worry. What is the best model for the Northern Territory communities, or are they all

different here as well?

Ms Angus—I think they are all different. I have my own personal view, but I think the best model is the model that the community wants to engage in. If they want to have a community store that is for profit, in order to make money, that is that community's choice. There are some communities which view the community store as part of the health precinct and believe that it is about promoting good health. Their emphasis on profit may not be as strong as that of the enterprising business person who comes in, because they do focus on healthy food, food demonstrations, selling local foods or promoting local foods.

I think the best model is the one that the community engages in. We do need—when I say 'we', I am not talking about Territory Health Services on its own—to support communities in not being 'taken' by outsiders coming in, be they community store managers or other visitors to their community, such as town clerks.

CHAIR—So it is still very much left up to the communities themselves to decide, or are they encouraged to make the decision that is the right one? How does it work?

Ms Angus—No, I think it is about encouraging; it is about informing, sharing information and working with them. This is what the community store managers' training is about; it is about working with the communities, but working with the other important and relevant organisations that have influence and impact on communities. They are the local health services, whether they are Territory Health Services or community council run or community health board run, or the land councils. Discussions have taken place not only with them, but with transport and works about access for foods, and with the food suppliers.

I understand that the major suppliers of food to community stores are the smaller grocers, the independent grocers, rather than the bigger outfits like Woolworths and Coles. A problem in remote communities with regard to having access to good food is the cost factor which, again, we do not control, but we have been working with the independent grocers and suppliers to see what can be done to have fresh food, especially fresh fruit and vegetables, at reasonable prices.

Mr QUICK—This is probably a generalisation, but most health systems tend to be hospital driven. Your communities, as Mr Morris has mentioned—probably here and in remote areas of Western Australia—need to have that flexibility. The person in charge of nutrition in the Northern Territory Health Department, I would imagine, would not be all that highly ranked in the bureaucratic pecking order, but in lots of ways he or she would need to have input into a whole range of interdepartmental agencies to say, 'Look, this is really important'. It goes back to my previous statement: it is great to wait until we get the dialysis machine; we need to expand services in Alice Springs hospital and build a new wing. If we could somehow get back to that basic provision of adequate food and a

nutritional program that was accepted by the indigenous community, the cost would be astronomically less at that basic point.

Are there any best practice communities where things are actually working, so that you can say that when we come back again we could see how community X have set up a hydroponic system so that they can grow food irrespective of what the weather is like, and how they have a community store manager who is linking with the Aboriginal health workers and the local doctor to say, 'We can immunise the kids, and that is great; but we also need to have nutritious food'? Is there a community approaching a situation where we can say, 'This is best practice, and other communities need to go and have a look at what they are doing'?

Ms Angus—I think there are many communities within the Northern Territory that are wanting to do that and are trying to do that.

Mr QUICK—What is stopping them?

Ms Angus—There are some that are perhaps doing it more progressively. You might have heard about the Minjilang project at Croker Island, where the community took over the direction of what happened in the store. The community members themselves, led by a very senior health worker, recognised that their community was spending more on, and eating more, fats, sugars and unhealthy foods. They recognised that and took over, and the store now has a healthy approach. That one still manages well, as far as I am aware.

The Nguiu community, in taking over their own health board, are demonstrating good practice. I do not know if you would call it 'best' practice, but it is at least 'good' practice in their approach to the community store. For the first time in the history of Tiwi grand final football, the food that was handed out at the last grand final by the local community members, supported by the food nutrition unit of Territory Health Services, was carrot sticks, celery and fruit. Before, it generally would have been pies, pasties et cetera. That community has taken control of the store. They are working on ways they can get cheaper food in their store. I think that community is showing it is taking up initiatives.

Mr QUICK—As a government, what are you doing to say, 'That is fantastic. Here is an extra $100,000 for you to expand the system'? What longitudinal studies is the Northern Territory Health Department putting in place so that you can say that, at the end of 10 years, the incidence of X, Y and Z has gone down to billyo and it is fantastic? We need to be able to say to Kintore and Yuendumu and the other places, 'This is what they did. Here is the blueprint. We will fly people in and help you set these things up.' There are two questions here: what incentives are there, and what longitudinal studies have you put in place to see if it really does work?

Ms Angus—The types of incentives that are being offered and are in place are small. They range from granting small amounts of, say, $5,000 for health promotion things, if communities want them, to employing nutrition workers to help work with communities. The small incentive programs I talk about are health promotion incentive programs, where communities can ask for small amounts of money for whatever they want to run. Some of them have arranged for a health promotion activity.

With regard to what longitudinal study we might have in place, there is a program that commenced in 1993 called Strong Women Strong Babies Strong Culture. We used the baseline data that we had at that time on infant and maternal health. The data on infants is about mean birth weight and, for maternal health, it is about first attendance to antenatal care and the health of antenatal mothers. That program has been in place since then. We are now using data from the commencement of that program and will follow it through to see whether that program is having the effects that we believe it is: a recent evaluation has shown that there has been an increase in the mean birth weight of newborns, a decrease in the incidence of underweight babies and an increase in early attendance at antenatal classes. The focus of that program is on community participation, being run by local community workers, either part-time or full-time. The thrust of it is about early antenatal care and good food nutrition habits.

Mr QUICK—How comprehensive is that evaluation?

Ms Angus—It was done by an independent evaluator from the Menzies School of Health Research. I can arrange to have a copy of it available.

Mr QUICK—So it has been in place for almost five years now. Going back to Mr Morris's idea, we are a Commonwealth parliamentary committee and we have to make recommendations. As a result of that evaluation, do you have recommendations that you would like to put to us to say, 'This program needs additional funding because it has been proven that there have been massive cultural swings and, if we had some more money, we could put this in place, replicate it, expand it and link it with educational health training for our Aboriginal health workers'? Are you at that stage?

Ms Angus—Yes, we are. Within this new Northern Territory government budget, there was a budget for expansion, because of the program's impact and success. Communities are wanting it, and so it is expanding to more communities. I strongly support the characteristics of that program, not for the Northern Territory alone but for any communities across Australia that want it. I know that there has been some interest in it from the remote areas of Western Australia. The Kimberley health workers have invited the program people to come over and talk to them, and the Pilbara area in WA has wanted information about that program. I do not know whether their programs are identical to that one or similar to it but I would strongly support them getting extra funds and support—and the same with Queensland.

Mr ALLAN MORRIS—In your submission you note that, by 2006 or 2007, you are going to have 662 people on dialysis. Anywhere else, that would be seen as an epidemic. If we have a drug epidemic or a plague, or if some other disease of enormous magnitude happens, people treat that as a national emergency. It seems to me that you have a national disaster happening here, and that it is being treated as just another part of the health system.

Has there been any discussion with the Commonwealth or with other states to actually recognise the peculiar nature of this crisis? It will destroy your budget, but it appears that almost no attention is being given to the fact that people are living in remote areas, areas which are hard to service. It seems to be something that you just have to pick up and spend your money on. The figure you quote is $34 million. I have heard somewhere else that the cost for each dialysis patient is $150,00 per year. If that is the case, it is more than $34 million. Is there any attempt at all to put that on the national agenda as a national emergency?

Ms Angus—Yes; there have been lots of discussions with the Commonwealth on the preventative program, tackling the dialysis problem.

Mr ALLAN MORRIS—I will come to that second. The first part is that you are saying in your submission that, by 2006 or 2007, there will be 662 people on dialysis at a cost of $34 million, but I suspect that the costs are probably double that. Your current health budget is $168 million, from recollection. So 20 per cent of your current health budget, on your estimation, is going to be taken up by dialysis alone. It seems to me that, if any other part of the country has an earthquake or a flood, or if something of that nature happens which affects as many people as that, we treat it as a national disaster. We do not apply all the norms and say, 'It is just a minor hiccup in the health system.' I just do not understand why, as a country, we have not recognised that. There are other areas of Aboriginal health which are similar, but this is by far the most dramatic.

Mr Williams—We would agree with a lot of the things you have said, Mr Morris. I guess the long time to resolve the health care agreement has been a distraction at our level and at the political level. It is certainly the Territory's desire to attract the Commonwealth to join us in wholesale investment in Aboriginal health, and that is very much on the personal agenda of people sitting around the table here today. We would hope that this would be an important year for doing that.

There are some facts surrounding this situation, though. The problem with renal disease and other chronic diseases has not appeared overnight; it has been embedded in our history. Certainly, the department is looking at smart and cost-effective ways of dealing with it. It will be very complex in terms of whether you treat people in acute care settings or whether you invest more on the intervention side. It will be very complex in terms of all the lifestyle and infrastructure investments relating to good health. Certainly, the Territory has been saying for some time that this is a national issue, and we would

hope to attract definite Commonwealth interest in investing at this particular time.

Mr ALLAN MORRIS—Again, I am trying to suggest that this is not just a national 'issue' but a national disaster. I come from a community of 450,000; if we suddenly discovered that 600 of those people were going to have a particular condition of this nature, with that kind of expense, we would be screaming. Obviously this is not a health problem; this is a disaster problem. An earthquake causes a lot of health problems, but it is actually treated as a disaster. A flood creates health problems of all kinds, but we treat it as a disaster.

Absorbing the dialysis problem within the overall health framework and trying to be intelligent and clever about it is noble of you, but it seems to miss the point that, in the community, the problem is neither recognised nor understood. I have been in federal parliament for quite some years and I have never heard of this before—and, let me tell you, nor have most of my colleagues. There is very little awareness of it.

The figure we were told in Alice Springs, by the way—Ms Angus, you might recall this—was 400, but it may have been for a shorter time frame. It may have been for 2004 or 2005. Your figures of 662 by 2006 or 2007 mean that we cannot sit back and simply say, 'We'll put a bit of extra money into the health budget.' The problem has to be taken out of the health budget. The whole thing with the drug offensive was taking the problem out and treating it as a national emergency. What is happening now with drugs, as minimal as it might be, is at least recognising it as having a significance of its own, and so it is treated as something which is really quite special and not within the normal funding guidelines or normal government parameters.

Are your ministers talking to the government about that, on a Chief Minister to Prime Minister basis? Or is it simply being done by you yourselves and your own bureaucrats? Are you guys soldiering on, trying to cope by yourselves with this tragedy coming at us?

Mrs Prince—Mr Morris, it is fair to say that the argument about the increasing level of renal disease is being taken forward by people in the Northern Territory with the Commonwealth and with other national bodies at every level, but I should stress that it is not only a matter of renal disease: other chronic diseases are a problem, but renal is the first one. Certainly, it has been addressed at the Chief Minister and Prime Minister level, and at health ministry levels.

As far as the institutional arrangements go for funding of states and territories, we have certainly made a major case to the Commonwealth Grants Commission for differentiating the Northern Territory in respect of the emerging needs of renal disease. I do not know if you have had much evidence about the interrelationship between Commonwealth Grants Commission approaches to funding between jurisdictions.

Mr ALLAN MORRIS—No, we have not; and it is not in there either, and so I presume we would like some information about that, Mr Chairman. If that is one of the angles for doing it, then by all means let us hear more about it, please.

Mrs Prince—It is certainly important for renal disease; but also, when Trish Angus started, she was talking about the relationship of Commonwealth direct funding of health services and those that the Territory funds. The Commonwealth Grants Commission has some influence on those arrangements as well. But, as far as the funding of renal disease goes, the interjurisdictional arrangements would provide for that to be assessed through differential hospital needs assessments in each state.

The Commonwealth Grants Commission does that on a DRG basis. We have asked them to look at the DRG which covers renal disease and to make a specific assessment for the Northern Territory. You will see from the figures that already we have a rate about 50 times that of the states, and it is growing rapidly. Unfortunately, the commission looks at things in the past, and so we have a catch-up issue. The problem with the commission's assessment is that it is dealing with what is pretty much a fixed pool, and so—

Mr ALLAN MORRIS—So someone loses.

Mrs Prince—If the Northern Territory's needs were met then other states would not—

Mr ALLAN MORRIS—So you still need to have an approach of saying this is a national disaster or a national emergency, and not simply just part of our health system. In terms of DRGs and the work being done to develop the national DRGs, how will they take into account the remoteness, severity and the peculiarity of some of the health conditions in the Northern Territory?

Mrs Prince—They do not at the moment. As you know, they are only a hospital based system. There is work afoot to expand that.

Mr ALLAN MORRIS—We expect we will be moving more and more towards national DRG type systems.

Mrs Prince—That is right. Interestingly, with the cost of treating renal disease and because we have so many of them, I think that is an area where we are as efficient as the rest of Australia, which is not something that is the case in other areas because our level of DRGs is relatively small compared with others. We do not have economies of scale, as we have in renal DRGs. On average, the cost of a DRG in the Northern Territory, in respect of an Aboriginal patient who has a particular DRG, has been assessed to be about 40 per cent higher than a non-Aboriginal patient. That is because those people are sicker.

Mr ALLAN MORRIS—They are remote.

Mrs Prince—They are also remote and they need to be in hospital longer. They are often accompanied by boarders who stay in the hospital.

Mr ALLAN MORRIS—Could I take another line. I notice in your submission that you talk about—perhaps in response to our first term of reference about national approaches—an anticentralist view. It seems to me that a lot of people in remote communities think that Darwin is very centralist. On the question of Aboriginal or community control, which you do refer to and you do accommodate to some degree, I suppose most of the submissions we have had to date from around the country, including the from AMA and a number of other bodies, have long argued that Aboriginal control and community ownership, if you like, of the solutions is more likely to lead to community ownership of the problems. Yet the Northern Territory seems to be one of the most centralised of the health systems in terms of lack of community control or community management.

In fact, I recall when we were at Yuendumu—and we have not been to enough areas to have a strong enough view on this, to be honest, at this stage—the clinical sister there, who was very good, by the way, was appointed without any consultation with the local community and was, therefore, a source of discontent, despite the fact that she was very good. It was the methodology and the lack of ownership of the process.

There does not appear in here to be any attempt at all to devolve in any way. You are looking for devolution yourselves from Canberra, and a lot of your communities are looking for devolution for themselves and their own health and other parts of their problems. Is there any move that way amongst yourselves? Is there any spirit of recognition that the vast bulk of evidence around is that we will do better when communities have more say over their health? Is there anything at all?

Ms Angus—That approach has been around for some time within the Northern Territory. I guess its application—

Mr ALLAN MORRIS—Have you moved on?

Ms Angus—Yes, but its application may not have been as vigorous right across as we would all have hoped it could be. I am sorry about that incidence at Yuendumu. That is not the way the practice was supposed to operate when we were recruiting to remote areas. There is a set protocol for recruiting Territory Health Services staff to remote areas and that does include consultation with the local Aboriginal staff. There is a protocol that says they must be on the interview and selection panel.

Mr ALLAN MORRIS—We are surprised and disappointed that in talking to—and I do not want to put Yuendumu under too much of a spotlight—the various state departments there was not a structure on the ground to ensure they actually integrated. You talk in your submission of holistic approaches and so on, and yet you get to

communities and find that they all report back to Alice or to Darwin. The police, education, clinical sister and, I think, public works all have their own streams running in and on-the-ground cooperation is purely coincidental with the goodwill of the people involved, with some restrictions because they are still answerable to their own lines of command up the wire.

Ms Angus—There are local coordinating committees at each of the regional centres, coordinating the Northern Territory government agencies.

Mr ALLAN MORRIS—We do not see that in the submission. Would it be possible to get some documentation as to just how it would work and what level of authority they would have? If that is all being overridden by Darwin or Alice, then you can coordinate but you cannot have any autonomy to cooperate. Collaboration, cooperation and ownership with communities seem to be critical. I will just give you one example that was quite stark to us. I suppose I have told it a dozen times; it was in a different state.

CHAIR—In a different state.

Mr ALLAN MORRIS—We were at two schools about 400 kilometres apart. At one school we were told the attendance rate was about 30 or 40 per cent and we thought that was really terrible. And it was; it was dreadful. We went to the next one and the attendance rate was over 90 per cent and we said, 'How on earth did you achieve it?' The headmaster said, 'This is the first year we have not had a conscript. All of our teachers are here because they want to be here. Every teacher here, for the first time ever, wants to be at this school and the kids know it and therefore they want to be there.' I think there is a really important message there. If the people who work in your communities are conscripted and reportable and on career paths, it means they do well there and move on.

I am a regionalist.I find that regional managers spend less money than they need to and get promoted to Sydney, leaving behind an underspent budget and being heroes. It happens all over Australia because of our structures. Here, more than anywhere else, the implications of that are so much more serious than anywhere else in the country. Coordination is not enough. It needs to be community ownership, real collaboration and some real autonomies for the communities or the officers working in them on your behalf or the government's behalf.

Ms Angus—Can I just quickly answer the question on intergovernmental coordinating? There has been good progress in the essential services area where the agencies responsible for that have actually got an agreement that they coordinate their activities at the remote area level. Those agencies deal with power, water, housing, health services and environmental health infrastructure.

Can I just answer the question then about devolution to Aboriginal communities? That is the way the Northern Territory government is going. I think, in previous times, it

might not have been well recognised across the country that there are different models of community control.

Mr ALLAN MORRIS—Yes, we agree.

Ms Angus—In the Top End, probably more than in central Australia, there are at least 19 Aboriginal community councils that run their own health services. They are devolved to those communities to run. Certainly the direction that we are now moving into in our new planning cycle is for increasing the numbers of health services that are devolved to Aboriginal health services or new groups such as the Tiwi Health Board or the Katherine West Health Board.

Mr ALLAN MORRIS—I made that long statement partly on purpose in the hope that you would take the *Hansard* and actually ask the other departments that are involved for their comment as well. I think it is unfortunate in a way that your department was singled out and you are the ones who always have to front and carry the can, if you like. I am going to ask if you could refer those comments when *Hansard* comes to you and particularly ask if there could be a whole-of-government approach to that kind of issue and that kind of question. I sympathise with your situation as officials who are answering for other departments when in fact it would be nice to have them here at the same time to ask them how we can make this more effective.

Ms Angus—I can say that the Northern Territory government is currently looking at a process to improve that and formalise it more. Ray might want to speak to it, but there is an interdepartmental group called the standing working group on Aboriginal matters; we are now looking at what its main function is. The Office of Aboriginal Development has a coordinating role for that issue.

Mr ALLAN MORRIS—If you can assist.

Mr Hempel—The coordination arrangements in Aboriginal affairs is very extensive in the Northern Territory. I take your point with some of the examples that you have mentioned: I would suggest that in many cases they are rather isolated. There are a number of different government agencies, including the Commonwealth and ATSIC, who operate in this area. All of them come from different directions and different funding streams—you have already referred to the different funding streams that operate in the health area. They, to a large extent, come from the Commonwealth.

The Territory has in place in each regional centre comprehensive coordination arrangements, which include all relevant Commonwealth and Northern Territory agencies that work in the field of Aboriginal affairs. The communities that you are referring to in the Northern Territory—the vast majority of the larger communities, at any rate—have their own local government structures incorporated under the Northern Territory local government legislation. They are treated much the same as you would treat a municipal

authority like Darwin or anywhere else in the country. They have, and it is their right to have, their own say about how they might operate their particular community affairs. It really is not for a lot of government agencies to interfere too much in that although there is a lot of advice available. In other words, it is a very complex thing to do.

Structures do exist. There is a considerable effort that goes into maintenance of coordination arrangements. There are some examples in the paper that the Territory provided. You have requested further information in that regard that we will provide to you. The paper refers to the interlinked issues that make up the whole of the health and housing issues in the Northern Territory and in particular in Aboriginal affairs.

Somebody before mentioned housing; we could refer to the Commonwealth's HIPP program, the National Aboriginal Health Strategy programs in housing, the provision of housing and infrastructure which relates to environmental health and relates to all sorts of other things as well. It is like the proverbial balloon; you pinch one bit of it and the other side of it bursts out. There is a considerable amount of effort going into, at the moment in the Northern Territory, properly coordinated housing programs and related infrastructure programs. There is a series of massive projects operating in the Northern Territory at the moment. Also, we have the Indigenous Housing Authority in the Northern Territory which we also refer to in the submission. It includes all relevant Northern Territory and Commonwealth agencies and is designed to properly coordinate the provision of Aboriginal housing and infrastructure. All of this is related to health.

Mr ALLAN MORRIS—Thank you.

CHAIR—I have a question on community care trials. I know they have only been operating here in the Northern Territory since about December last year. Even if you cannot answer it now I would be very keen to get some feedback on progress there. As a committee we see this as one way to get through the difficulty with PBS and MBS—trying to get that money into the community. If you have got a reaction to put on the *Hansard* record now it would be helpful. If you need more time to make a submission we would like to know how progress is being achieved on those.

Ms Angus—We can give you further, more detailed information, but initial feedback is that in the Tiwis it is not without all of its small teething problems, but there are bigger goals at stake and it is worth pursuing. The Tiwi Health Board is very strong and functioning very well. As I explained, they have taken up the healthy lifestyle initiatives themselves. There is signing up of community members onto the program, that is, getting them registered with the Health Insurance Commission; that is working well. I think we have progressed a fair way in doing that.

The Commonwealth coordinates and chairs a monitoring group, which meets monthly, that monitors quite closely the activities of that. The monitoring group consists of the local Commonwealth office, the Tiwi health board and Territory Health Services.

We meet regularly to iron out any problems. Kevin referred to the health information system that is in place. There has been extensive training for the local health staff—which includes health workers, nurses and doctors—on using this health information system that, amongst its features, is a health care plan for coordinating the care.

The trials at Katherine West have only gone live in so much as we are starting to sign up the community members to the program. Both health boards have done this. Tiwi is just that more advanced at the moment because of a timing issue. The health board members have undergone training. The Katherine West Health Board is currently going through an intensive training program in supporting and training the health board members across a range of matters, such as financial management, about what the health services delivery issues are. It is about the health issues themselves, making relationships between disease and health outcomes. In Katherine we need to give further input into that one.

CHAIR—If you feel there is a need for modification in the way it operates, that is the kind of information we would appreciate. One of the things that is a bit annoying for us is that we would probably be cheated of an opportunity to table a report in parliament. It is fairly clear that there may well be an election before we have the opportunity, but we would still like to see some process by which we can ensure our inquiry is ongoing into the new parliament. There are some good things happening, and we think this is one of them.

Ms Angus—We would like to give you more on that. I think this is a good effort where the Commonwealth, the Northern Territory and the communities are working hard for these trials to succeed.

CHAIR—There are two things we would like to get documented: first, those successes and, second, if there are any changes in the way it should be delivered.

Mr ALLAN MORRIS—Is it your intention that the organisations are not at risk themselves? The big fear was that because they would access more services they would go beyond the funds that were provided. We spoke with the department about that ourselves—I should make you aware—in Canberra. We had a meeting with the department after we went to Western Australia, and we had apprehensions there. We had very strong assurances from the department that they understood and they would not undermine the effects of the program through some artificial notional spending per person. So we would be interested to know whether or not that has been maintained because we had some very strong assurances that the federal department would be supportive of the kinds of problems which were likely to happen.

Ms Angus—I believe they are.

Mrs Prince—As you know, the cash-out was only at the national average of the Australian level.

Mr ALLAN MORRIS—We discovered that in Perth. We found that Perth did not want to go ahead because of the risks that would be involved and it could destroy the organisation. We had a meeting with the department, which the chairman convened, and we put that to them. They gave us very strong assurances that they understood the problem and they would not expose the organisations to financial disaster. Is that correct, Mr Chairman? I am asking for your confirmation of that, Mr Chairman.

CHAIR—We did not get any reports of any disasters, if that is any encouragement.

Mr ALLAN MORRIS—What I am saying is that we had the assurance of the department the other day that they understood the problem and would be supportive.

Mr Williams—There is no doubt that the inclusion of the MBS, the Commonwealth commitment into our health system, is the key. There is a whole range of other accompanying features and factors that need to be considered. For instance, in central Australia, including the Yuendumu area, there are two years of consultations between the communities, the Commonwealth and ourselves to look at devolved models, to look at getting either cash-outs or the MBS-PBS funds in to look at sustainability and expansion of the health system.

So things are poised. It is fair to say the Commonwealth is very cautious about the next steps, either cash-out or changing the MBS schedules or whatever is required to make it work. I think that is the challenge, both for a committee like yours and for the Territory government, to go those next steps, because they are the missing millions in the equation. They are very much a starting point to build a whole range of other features into a viable and sustainable scheme.

Mr QUICK—I have one last question. It is something that we have not tackled and I am a little disappointed that we have not. I am surprised that there are only six lines in your submission about environmental health standards. As we are running over time, could you provide some further details about how the standards were developed and what they cover, and, as you have visited quite a few Aboriginal communities—this is probably the most important thing—the methods for enforcement?

Ms Angus—I can provide that.

Mr ALLAN MORRIS—I would like to place on record my advice from a vet that the treatment—the medication or the chemicals being used—for scabies that is being used in some parts of the Northern Territory is no longer used on animals in the eastern states because it is too painful. In other words, the scabies treatment used in central Australia is no longer used on animals. It is used because it is cheap, it is easy to use and I do not think it requires a doctor to prescribe it. There are some other reasons for it but I found that information fairly distressing.

Ms Angus—Some of us might find it unpalatable, but there is good research that shows that the scabies that affects dogs and humans is not related to—

Mr ALLAN MORRIS—The medication being used on humans was too painful to use on animals but it is being used on humans in the Northern Territory. There are a range of other medications that are a bit more expensive and that may require a more prescriptive capacity to prescribe it. I am not sure of the medical thing, but this vet was horrified to discover that people were being treated with things which of course they were avoiding because it was so painful.

CHAIR—I think we could talk all day but we have a busy program for the rest of the week with other people and with a visitation program. As I indicated earlier, we are doing what we can to ensure this inquiry continues on to the next parliament. We have come across some good progress but I must say that the frustrations we have experienced are the same as yours. I think Mr Quick's question is indicative of some of that and of why we cannot make progress on this. It is just incredible. As Mr Morris has mentioned, if some of these diseases were prevalent in some of our big eastern cities, there would be a public outcry. We are trying to conduct our inquiry without a lot of emotion from the media, because we are determined to make progress. We can give you that assurance. I am hoping you will respond with some more information in terms of those questions that you have taken on notice. Thank you for coming today.

[9.59 a.m.]

AH MAT, Mr Lindsay, Chairperson, Danila Dilba Medical Service, GPO Box 2125, Darwin, Northern Territory 0801

ROBINSON, Mr John, Administrator, Danila Dilba Medical Service, GPO Box 2125, Darwin, Northern Territory 0801

CHAIR—Welcome. This committee does not formally swear its witnesses, but you need to know that 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 is therefore considered as a contempt of the parliament. It is a process that provides protection for witnesses so that you can be fearless in what you tell us today.

The committee has not had a submission from your medical service but has received one through the Aboriginal Medical Services Alliance. We are pleased that you have been willing to come and talk to us to add to that submission from your own perspective. I will give you an opportunity for a brief statement to make your points, and then we will proceed to questions from my colleagues.

Mr Robinson—I think one of the first things that we would like to talk about is, basically, what is Aboriginal community control. That is very much an aspect of the AMSANT submission that you already have. It is also very much an aspect of the Congress Aboriginal Medical Service submission that they made, I believe, in October when you were in Alice Springs.

You will have heard from Territory Health Services, and you asked questions regarding community control. We have a slightly different perspective on what we believe is community control. Firstly, community control arises from the community itself. Is it a community initiative? To us, this is probably the most important ingredient. Community control should not be imposed by governments for whatever reason. It has to arise from the community.

Secondly, the community elects a committee to worry for the organisation. Their role is the philosophy, direction, policies and vision of the organisation. It is not the role of the committee to participate, interfere or direct the day- to- day running of the organisation.

Thirdly, the committee of an Aboriginal community controlled service employs a senior staff officer. In the case of Danila Dilba, this is the director of the medical service. Our director is Pat Anderson, and she is currently in Alice Springs with another committee which, I think, is the MBS and PBS. I give her apologies for not being here today. The director is directly answerable to the committee and, in turn, the community. In effect, the

director has many, many bosses in the community. The committee hires the director, and it is our philosophy at Danila Dilba that at all times the director of the medical service must be an Aboriginal person. The director is responsible for hiring, firing, management and all aspects of the service.

The fourth aspect of what we believe a community controlled organisation is is that it is an incorporated organisation. In our case, it is incorporated solely to worry for health. It can be incorporated under the Aboriginal Councils and Associations Act, it could be under Australian company law or under the Local Associations Act here in the Northern Territory, but it must be incorporated and should be solely to worry for health. There must be a register of members, and at annual general meetings it is only the members who should be allowed to vote.

The fifth characteristic of what we believe a community controlled organisation is is that it should operate at all times within the budget, whatever that may be. Sixth, community organisations must be totally transparent—that is, open for all to see. An annual report and an annual general meeting are essential. This is where the organisation reports directly to the community about the progress of the organisation, the difficulties, future directions, the wins and the losses. As well as that, we submit audited accounts for the public record.

As I said before, the directors have many bosses—the community. Our service at Danila Dilba is very public. We are in the eye all the time. If we do something wrong, we will hear about it. An important part of our work, and an important aspect of the community controlled organisation, is the politicisation of our work. Health cannot be separated from land rights; it cannot be separated from education; it cannot be separated from employment. They all go hand in hand.

Community control is self-determination in practice: communities making their own decisions about their own health. We have taken the mainstream model and adjusted it to suit the needs of the community and, in our case, the Danila Dilba way of operation.

Lastly, we believe that an Aboriginal community controlled service must accept that close enough is not good enough. The community deserves the best, and it is a cop-out to say that there is an Aboriginal way of doing things, Aboriginal timekeeping. This is something we do not accept at Danila Dilba. We must provide a quality of service to our clients. Anything less than that is a cop-out. The community demands that what we do is the very best of whatever we can do. This is true for all community controlled organisations, be they education, legal, housing, land councils, et cetera.

Basically, to sum up, we believe that a community controlled organisation must be directly elected by the community, that it must arise from a need expressed by the community, that it must be controlled by the community and must, of course, be responsible to that community.

CHAIR—How is it initiated, though? You are saying that the community has to decide it wants to do it, but it needs to be stimulated enough for them to have that debate and discussion, though, doesn't it? It is a partnership in getting it started, don't you think?

Mr Robinson—We started because there was a need in the community. There had been several attempts to create a medical service, but I think one of the problems we had was that it was quarantined because it was inside Bagot, which is an Aboriginal reserve in the centre of town here. I think people felt they were restricted because of the ownership factor of being inside Bagot. Since we have moved to McLachlan Street, and then subsequently up to Knuckey Street, the membership has increased. I think we are up to 500 members now, and that is in a period of about four or five years. So that membership has indicated the community's involvement in the service.

Mr QUICK—What sort of responsibilities does the community have? It is okay to say, 'Look, here are your rights and you want to go and set up your own medical centre.' The other side of the coin is that there should be some responsibilities. So what responsibilities are there amongst many of your members to say, 'Look, okay, we understand that there are certain behavioural matters which will affect our long-term health outcomes'? Do members then say they are going to willingly participate within some of the medical programs that you are going to operate as a community? Are there those sorts of rights and responsibilities, or is it all rights and no responsibilities? What sort of best practice are you trying to encourage within the community to say, 'Okay, if we can convince the bureaucrats of the Commonwealth and state to give us that autonomy, we will be part of a process with some long-term beneficial outcomes'?

Mr Robinson—I think that is a very valid point. When you apply to become a member of Danila Dilba, you are asked whether or not you wish to be a volunteer of the organisation. The vast majority of people who make application to be members do tick that box. We use the volunteers and actively solicit their involvement in getting that health education message in particular across to the community. That has been evidenced recently by the participation of community members in our stall at the Royal Darwin Show. It is evidenced in our other big event that we have each year—AIDS awareness week—where members of the community, not just members of the committee, put their names down to participate in these workshops and education sessions.

In addition to that, there are several programs we have established that we call advisory reference groups. Members of the community with a particular interest in a particular issue—it may be emotional and social wellbeing, it may be women's health, it may be sexual health—can participate in setting the formulation of policy and practices and programs in that area. I think that has been accepted by the management committee as an excellent way to involve the community and, yes, to get members of the community to exercise some responsibility. It is no good just bitching about things not being done without putting your hand up. It is rather like being in politics.

Mr QUICK—If there is, for example, substance abuse and petrol sniffing, and if you are a member of the community, you are willing to participate in preventative processes; is that the next step? Where are you in that sort of process?

Mr Robinson—In the area of substance abuse, particularly in Darwin, most of our work is of a referral nature from the other agencies who work in this area. There are other community control agencies such as the Foundation of Rehabilitation of Aboriginal Alcohol Related Diseases—FRAARD—or the CAAPS program. We provide the clinical-medical side of the programs that are run by both of those agencies.

We do not see very much petrol sniffing at Danila Dilba. It seems to be more down in the Centre, although there are anecdotal reports of it being in some of the island communities. Our direct involvement in some of those program areas is negligible—more in the way of clinical advice to the other agencies.

Mr QUICK—We took evidence in South Australia where the community has taken over responsibility for alcoholism. Rather than the police going around and picking up people, they have their own van in which they go around. There is a community responsibility to remove them from the potentially dangerous situation, as far as custody goes, and then bring them into some sort of detox unit. Do you have something along those lines within your community?

Mr Ah Mat—We are a little different because of the nature of the place. In some communities, like Tennant Creek, where they have got the night patrol, they have their own people looking after their own people. Because of the diversity of Darwin, we have not got the same luxury of having our own resources to look after our own mob. The night patrol has just started here.

Mr QUICK—How do the various communities within Darwin get together, instead of having 14 vans wandering around trying to identify each individual community's responsibility? How do you put in place an overarching strategy to deal with that sort of situation?

Mr Ah Mat—We, from memory, supported the AMS submission that went to the government here—that they be the organisation that manages that program. I am not aware of how they have done that. I think they have advertised the positions and people have applied. There were some concerns that, because it is only in its infancy, it needs to be tested as to whether it is an effective way of dealing with the alcohol problem in the town. This program has been operating for less than six months. We were concerned that it had to be on the basis of groups looking after themselves and, because people from the Centre and from west of here come into this town, we would need a whole lot of resources for people to look after their own mob.

Mr Robinson—We did a snapshot a couple of years ago of people who used

Danila Dilba and where they came from. It showed that 41 per cent of all of our clients over a three-week period actually came from Darwin. The remainder were visitors passing through. It is important to remember that Darwin is a hub centre. We get the east Arnhem coming through, we get the Tiwi coming through, we get the Kimberley mob ending up this way, and the Katherine mob come up. A lot of it depends on the sporting events at the time. Trish Angus mentioned the Tiwi football final. Usually, there is a big influx of people going through. In addition, we get people coming to Darwin for specific medical problems—men's business or women's business—because of problems talking about that or a lack of resources in their own community.

Mr Ah Mat—Our contact with the community where these people come from in terms of us looking after their health indicates our community approach to dealing with the matters. I think we can be linked up to a computer system to contain records, et cetera. That is another way in which we are influenced by what the community is saying about particular patients and their needs.

Mr QUICK—Are you the only Aboriginal medical service in Darwin?

Mr Robinson—We believe we are the only Aboriginal medical service in Darwin. There are facilities provided in the Bagot community by the Bagot Council. The direction of that is by the community council and they do not specifically wave for help.

Mr QUICK—How do you liaise with the various communities? You mentioned that 60 per cent came from other communities. They all get their own bag of money and you get your bag of money. How do you dip into theirs and say, 'In any given period, we are going to be dealing with some of the people from your community'? How do you then prioritise strategies to say, 'We need extra money to provide dental services because we realise we can't cope because of our own budget constraints'?

Mr Robinson—This has been an issue for some time. It is one that we have talked about, particularly at AMSANT meetings—the Aboriginal Medical Services Alliance of the Northern Territory. Unfortunately, most of the people who come through our doors are from areas that are not covered by AMSANT members. Yes, there has to be some facility so that this can happen. It is a question that was raised with the Tiwi coordinated care trials. What happens if a person who is on the trial comes through Danila Dilba? That is a question that we really have not resolved. It has not happened yet, but it may happen in the future.

We talk to those other communities, but those other communities are quite often strapped for cash as well. I think it is probably fair to say it is pretty much a one-way street. Most of the community members come to Darwin, not the other way around. Yes, it is of concern and we have talked about it. We have brought it up in the rebasing exercise that was undertaken by the Office for Aboriginal and Torres Strait Islander Health Services some years ago. We had hoped that these types of factors would have some

bearing on the money that we get to run the service, but it has not. With the funding that we get, there is no mechanism as far as I can see to allow for these people coming from other communities. We are not suggesting that a bill should be sent off to the Tiwi Islands once a month or whatever, but there has to be recognition that we do service more than just the Aboriginal and Torres Strait Islander population of the Darwin area.

Mr QUICK—What would your solution be regarding the educational opportunities and training of Aboriginal medical workers? Is there a solution or are the educational opportunities so small that we are never going to resolve it?

Mr Robinson—Danila Dilba is a registered training provider and we run an accredited course for the training of Aboriginal health workers.

Mr QUICK—Just in Darwin?

Mr Robinson—We just do the Darwin area at the moment. Last year we had over 100 expressions of interest—people wanting information. I think we ended up with 52 applications and in the end we accepted 15 people into the course.

Mr QUICK—Why was that?

Mr Robinson—We are only funded for 10 and that is the basic factor in it. There is a crying need for trained Aboriginal health workers.

Mr ALLAN MORRIS—Who funds that?

Mr Robinson—That is funded by the Northern Territory Employment and Training Authority, NTETA.

Mr ALLAN MORRIS—Through DEETYA?

Mr Robinson—ANTA, I think it is. They give us $98,000 a year. That seems to be non-negotiable and non-changeable. Already, the clinic supports that training effort to the tune of something like $10,000 a year. We run a very basic service. It is pretty well no-frills in the training area and any extra money we get would improve the numbers of people we can put through. That has been a priority identified by the committee. Last year they wanted to see the numbers that we could put through double but the funding just is not there to do that at the moment.

Out of those health workers that we have been training, we have had two graduations, I think. The third class is going through this year. To the best of my knowledge, the health workers that we have put through have found employment. We are employing three or four of them at the clinic at the moment. They are working at the Royal Darwin Hospital. They are working in the various island communities. All reports

coming back are that their training and expertise is excellent and quite exceptional.

Mr QUICK—Where do they go after they receive their basic training? Is there a series of steps that they can progress through?

Mr Robinson—They leave us with an ASF3 certificate. That will allow them to move on to an associate diploma and then on to a diploma.

One of the features of our course is that we have a high clinical competency component, and I think this is borne out in the quality of the graduates. We would like to offer these higher courses, and we have permission to offer them, but the big problem, of course, is the resourcing of that. When you come to visit us, as I believe you will on Wednesday, we will show you our training facilities. We seem to be well resourced in the form of equipment, but, like all things with government, sometimes it is easier to give a one-off capital grant than make a commitment for the ongoing, recurrent funds that are needed. Unfortunately, what we need is recurrent funding to put more Aboriginal people through that health worker training course and so get them out into the community.

CHAIR—Is that the main thrust of what you will be showing us on Wednesday?

Mr Robinson—That is just an aspect of what we will be showing you on Wednesday. We are quite proud of our little training school and the quality of the candidates it is putting out.

Mr ALLAN MORRIS—That is the ASF2 effect. With regard to this argument about level 2 and level 3 that we have been hearing about, can you just go into that slightly and how you fit into that categorisation?

Mr Robinson—The course that we are running is an ASF3 course, and that fits within the national framework and meets the national competencies for Aboriginal health workers. Like all the employers of health workers in the Northern Territory, we are having, or will have, some problems, because we do have health workers who do not have the equivalent training to an ASF3, which puts them out of the revised Aboriginal health worker career structure, an award structure where you have to have the level 3 to actually start advancing up through the various grades. That is something that we have been talking about with Territory Health—about coming up with a combined program, or some way that we can assess our health workers and perhaps get them up to the level of ASF3.

Mr ALLAN MORRIS—For many people, the academic skills that are required would make it difficult for them. So far, we have heard this argument that the ASF3 level, particularly with regard to academic background and training, is not appropriate for a number of people, so people from remote communities will not be able necessarily to reach that level; hence they will never be able to establish an appropriate level with their own community members.

Mr Robinson—That is a problem that does exist. We have one particular person with 18 years experience as a health worker. He can do anything you ask of him, but he is still at that ASF2 level. There has to be some way of surmounting those problems, and they are very valid concerns to be raised.

Mr ALLAN MORRIS—The move towards competency based training and competency based assessments and so on would seem to be the way that it is happening in other disciplines. Is that happening in this area, and, if not, why not?

Mr Robinson—It is happening in this area. The course that we are running now is based on the South Australian Health Council course. It is very much into competencies; it has been targeted to fit in with the Aboriginal health worker national competencies. It is one of the reasons we changed from running the Batchelor College course to the South Australian one—more of that competency based training.

Mr ALLAN MORRIS—Two things have been said to us so far. One is that many Aboriginals will still be treated as second-class citizens in terms of being health workers, and that diminishes their capacity. The second thing said to us somewhere, possibly in informal discussions, was that the establishment of Batchelor—and we will be talking to Batchelor at some stage as well, by the way—has tended to make it more academic; that there is now a different agenda, which is an academic agenda rather than a community worker agenda, and that is in danger of locking some people out even further. So, whilst Batchelor has good intentions and good ambitions in terms of what it is trying to achieve, it may be inadvertently excluding a lot of Aboriginal health workers from being accredited adequately or being able to be effective.

Mr Robinson—That is a valid point, but I think you have to bear in mind also that those health workers that we in the Northern Territory call Aboriginal health workers are registered under the Health Practitioners and Allied Professionals Registration Act that exists up here and is administered by the Aboriginal Health Worker Registration Board. You cannot practise as a health worker in the Northern Territory unless you have that registration and a practising certificate.

What health workers can do in the Territory is quite substantial. They can take blood and they can do lots of other things—and I am sure you know what health workers do in the Territory. To do all that and to administer medicines—I am not saying prescribe, but administer medicines and explain to clients what the dosage rate should be—you have to have a modicum of understanding of the theory behind it, that is, the written language—

Mr ALLAN MORRIS—Yes, it has been put to us that many people are doing all those things with many years of experience. In fact they are saying that when they go, a generation of 20 years experience will not be replaced. They are doing all the things that are required of them, but they are not being paid and recognised appropriately and

therefore they are not being role models, if you like, for those who are less educated and to whom they could show a pathway. I suppose the concern was that the move towards academic qualifications can be counterproductive.

I am not diminishing the standards that are required, or the quality of care that is required; I am simply talking about the accreditation process and, perhaps, the misuse of people. We have been told that people are being misused; they are being treated as second-class. They are doing all the work, but they are not getting the same money and they cannot ever be accredited because their academic backgrounds are not adequate. They are good enough to do the work, but not good enough to be recognised for it. Is that a fair comment?

CHAIR—I would like Mr Robinson to respond on that.

Mr Robinson—There has been anecdotal history where, in some communities in the past, there have been people used as health workers who have not been qualified and who have been acting in those positions for some time. I could only say that at Danila Dilba all health worker employees are accredited and we do not employ health workers unless they are accredited.

Mr ALLAN MORRIS—I did not mean yourself, by the way; I meant in remote communities.

Mr Robinson—Yes, I realise that. I must speak primarily from my experience at Danila Dilba. The point you make is that being an Aboriginal health worker has not been a very attractive career. Basically, that gets down to the abysmally low wages that have historically been paid. We have tried in the past through the rebasing exercise and the introduction of our own award in the Northern Territory which covers our organisations—the Aboriginal health and other related organisations award—to raise the wage structure for health workers.

Where we came a cropper back in 1994 was in the fact that the Industrial Relations Commission had determined that the rate of pay paid by Territory Health Services was the community standard. That was the most the Industrial Relations Commission would pay. That has subsequently been changed and the problem now is actually getting funding bodies to provide the monies to pay to that appropriate level of health worker. For instance, currently we pay round about $22,000 to a newly graduated health worker. You are asking somebody to provide that type of primary health care: to get blood, to take blood, take obs, perhaps, and do some emergency stuff. It is horrendously low pay. Under the introduction of a new career and award structure, you would expect that to go up by about $8,000 and that is probably a little bit more realistic. Of course, then it goes up for other experienced health workers.

You are setting up a career path where you can progress and, by the attainment of

more competencies, progress up through the salary scale. That is the concept which, I think, we are all finding a bit difficult. It is not the old do a year and we'll up your grade. Then do another year. It is based on competency. So it is very quickly possible to move from a base grade up to the top of the level, and that may be a range of pay from, say, $25,000 up to something like $37,000. If you can demonstrate the competencies through whatever mechanism is decided upon, then you can go up that scale. That is difficult for governments to get their heads around as well.

The Office for Aboriginal and Torres Strait Islander Health Service has recently done a study into the costs of implementing a new Aboriginal health worker career structure. I believe that that report has now landed in the office in Canberra and we anxiously await the outcomes of that. That pointed out, for instance, that for the health workers we employ at Danila Dilba that are funded by the Commonwealth, we would be looking at around an extra $114,000 or $120,000 a year. That is to meet the revised salary structure for the six or seven health workers that the Commonwealth employs.

CHAIR—Where in particular would it have landed in Canberra?

Mr Robinson—It would have landed in the Office for Aboriginal and Torres Strait Islander Health Services. What they did there was help to establish some mechanism for introducing this. We are in a position whereby the Territory government has accepted in principle that they would fund community health services and the AMSs to that level. We are in the unusual position at Danila Dilba where half the work force is funded with money provided by Territory Health—I am talking health workers now—and the other half is funded by the Commonwealth.

We have taken the philosophical position that we are not going to have some health workers on $25,000 and some on $30,000 when they are the same grade and doing essentially the same work and it just depends what bucket of money your salary comes out of. We put that position to staff some time ago and we have been saying this same story now for about the past 12 months and we still have not got money from either. We are hoping that the consultancy that was undertaken by the Commonwealth will come up with some mechanism whereby that can happen.

We had a look at that at the congress at Alice Springs—in Wurli Wurlinjang at Katherine, in Danila Dilba and the Pintubi homelands. From the study of that the idea came that there be some mechanism applied over the other services that they fund in the Northern Territory for both the members of AMSANT and other organisations, such as Maningrida that they fund separately. We are all anxiously awaiting the outcomes of that report. We received our copies about a week and a half ago.

Mr ALLAN MORRIS—There was a question raised with us about DEETYA shifting its funding away from Aboriginal health training. Can you enlighten us on that at all in terms of your on-the-ground experience? I do not want you to compromise your

situation.

Mr Robinson—For the first year of operation of the training school it was half funded by NTETA and half funded by DEET or DEETYA at the time. That was a particularly horrendous experience and one we vowed we would try desperately never to participate in again. Basically, to get the funding from DEETYA, we had to accept their concept that the trainees going through would be from the long-term unemployed. The basic idea was that, if a person had been unemployed long-term and wanted to continue getting benefits, that person would do the course.

Luckily, we fought tooth and nail to have some say in the selection of those original trainees, but still they had to come from the long-term unemployed bucket. We felt at the time that that unnecessarily restricted our choice of trainees. We may still have ended up with trainees who may not have been 100 per cent committed to Aboriginal health, but it was a way of getting some training and continuing to receive some moneys.

That was our fear at the time. We went through quite a rigorous selection process. We rejected some whom we felt were just in it for the benefits. We were quite happy with the students from that first year. Out of 10 who started I think we ended up with eight who graduated, which is a particularly low attrition rate when it gets down to looking at, for instance, something like Batchelor College. We have maintained a reasonably low attrition rate over subsequent years.

Mr ALLAN MORRIS—Is DEET funding still there?

Mr Robinson—We do not have DEET funding at the moment. What we wanted was a free hand in selecting those trainees whom we thought would make good health workers.

Mr ALLAN MORRIS—So you lost the whole lot.

Mr Robinson—We went cap in hand to NTETA, put in a separate application, and they doubled the funding that they had provided previously, from $52,000 up to $98,000, which is still horrendously low for what we are trying to achieve.

Mr ALLAN MORRIS—Firstly, you may have heard me ask earlier the question about non-Australian doctors working in the Northern Territory. Secondly, are you aware of any Aboriginal doctors working in the Northern Territory?

Mr Robinson—I am not aware of any Aboriginal doctors working in the Territory.

Mr Ah Mat—There is one at the Royal Darwin Hospital.

Mr Robinson—That is right. He is doing an internship.

CHAIR—Which hospital?

Mr Robinson—Royal Darwin. We have had an Aboriginal student come through from the University of Newcastle who has done a placement with us in the past. Your second question was about—

Mr ALLAN MORRIS—Overseas doctors working on temporary medical visas.

Mr Robinson—We have not had any at Danila Dilba, although we have a web site on the Internet and quite often we get expressions of interest coming through from overseas from doctors seeking to work at Danila Dilba: I do not know what the procedure is, but to do a 'penance' at Danila Dilba almost and then get some form of accreditation to actually practise in Australia. We have expressions coming through on the Internet from Pakistan, from Saudi Arabia, you name it—lots of countries from where people want to get into Australia. But all of our doctors are fully accredited to practise in Australia.

Mr ALLAN MORRIS—But from Sydney and Melbourne normally?

Mr Robinson—Normally from the eastern states, yes, and that does cause some problems with recruitment. We try to have a pretty rigorous selection process and it is a little bit difficult when we have not got the funds available to fly people up. Luckily, what has happened over the last couple of years is that we have actually had people ask to work for us as doctors, originally as locums, and they seem to like us, I suppose, and continue working with us.

For instance, this morning I met a new locum that is with us. We did not solicit. He had heard about what we do, checked out the web site and thought, as he was in Darwin for a couple of weeks on holidays, he would like to do a bit of work with us. That is the type of level of acceptability and how people are starting to know about us, and we are getting a lot of doctors now. I think there are another two applications from people wishing to be considered for positions with us.

Mr ALLAN MORRIS—Your doctors are short term or long term, on average? What is the average stay of a doctor with you?

Mr Robinson—We have had one doctor with us since the day we opened our doors, back in September 1991. The other initial doctor with the service is now doing a PhD at Menzies School of Health Research but still maintains an active interest with the organisation. We have two female doctors, both of whom are on maternity leave at the moment but they had been there for something like two years before they went on maternity leave. We have also had a doctor who went through the Royal Australian College of General Practitioners training with us and did his second term there, and has now come back to work for us. About the shortest permanent position doctor that we have there at the moment I would say has been there for something like nine or 10 months. So

we have a pretty good retention rate.

Mr JENKINS—When we visit on Wednesday, we will get a better understanding of how you go about your business, but how would you characterise your approach? I take it it is not a medical model, it is more a community health model.

Mr Robinson—Yes. We believe in the holistic view of health. If you come into the clinic, no matter how important or unimportant your problem may be, the first person you will see is an Aboriginal health worker. All of our patients see Aboriginal health workers first—as an aside, this is a bit of a bone of contention with PBS and MBS. The health worker takes your chart, takes your observations, listens to what you think your problem is and then makes an assessment of whether or not you need to be referred to the doctor. Approximately half of all people who come through the doors of Danila Dilba just see a health worker; it may be for something like scabies treatment, it may be that they need a flu shot or something like that, and the doctor does not necessarily need to be involved. We have senior health workers on duty, and we have one senior health worker each week who is rostered on to make a bit of an assessment about patients as they come through and we do some fast-tracking there. So that is the way we operate when you come in.

The standard consultation time at Danila Dilba does not fit into your long, short, medium, or whatever it is, general practice consults. We did a short study a year ago and the average time through the clinic then could be anything from 45 minutes up to two hours. Quite often if mum comes in with three or four kids we just do not see mum, we see the three or four kids at that time. They may be passing through Darwin, we may not see them again and we have to check up on all the immunisations, the growth rates and all of that stuff. That is the approach we have. While you are there, we have the opportunity to provide health education materials. Our health workers, especially those with particular interests, bombard you with good health information about diabetes, about whatever else you want. We have always maintained a very large commitment to making the resources available to the health workers and the other staff.

We have, employed by the service, a principal health educator who also coordinates the education activities. We have a women's health educator. We also have some male and female educators working the area of sexual health. We do not fit into the norms: we do that holistic view and we do the health promotions when we can. We try to test people for everything that needs to be tested. We check everything. We give people all of the immunisations that they need when we see them because we just do not know when they may be in our area again. This goes to that mobility thing again, as well as the population, and it has been one of the major stumbling blocks to our accessing Medicare. As I said, not all of our patients are seen by health workers and the whole health system seems to be so doctor based. You only have to look at the various programs around, be it the rural incentives programs or whatever, to see that they are all doctor based, and that has been a stumbling block to accessing the bucket of money that is called Medicare.

We have been negotiating on and off since Carmen Lawrence was health minister to overcome this problem, both by ourselves and later with AMSANT. I think we are getting there but it is going to take time and the whole process will have to be streamlined somewhat. As I said, our director is currently in Alice Springs furthering the cause, I hope, at this precise moment.

Danila Dilba is not a general practice. We do not claim to be; we do not set ourselves up to be. We are a whole of family service. In addition to these areas, and those that I have mentioned relating to training and health education, we are also in the process of setting up the emotional and social wellbeing program which is to do with counselling.

Mr Ah Mat—Just to cut in there, we also have a mobile patrol which goes to the town camps around the Darwin area.

Mr Robinson—The service visits 15 or so town camps daily. It also visits old people in their homes. Quite often we have the situation where the hospital discharges a patient and then asks us to take over some of that patient's care—for instance, checking up on their dressings and making sure that they are taking the medications that they should. That sometimes leads to a bit of a conflict because of the timing: it leaves a little to be desired when we get a phone call at five to four on a Friday afternoon. For us to adjust our resources at that late stage causes a problem.

The mobile service goes out once a day with a senior male health worker and a senior female health worker on board. The service also does some contact tracing for STDs and any other thing that other agencies need people to be traced for. A doctor goes out once a week with that as well. About half of their time is spent visiting people in their homes, and quite often they are the frail and aged.

Mr QUICK—How many people are on your books?

Mr Robinson—We have over 14,000 patient files that we deem to be active. I think the latest census that has been done shows that there are 7,000 or 8,000 Aboriginal people living in the Darwin, Palmerston and Litchfield local government areas.

Mr QUICK—Has there been an evaluation of just how effective—I am always on about longitudinal studies—that service is so that you can say to someone in Canberra or Darwin, 'Look, X number of dollars is being spent wisely, because the incidence of STDs within our client group has diminished from so many per thousand down to such and such, and the immunisation rate of our children is such and such.' Do you have those figures? When they are handing out bags of money, that is what Canberra bureaucrats are looking for.

Mr Ah Mat—That has been one of the things that, as a committee, we have been trying to come to grips with—in terms of finding out how effective we are. With the

limited resources that we have our focus is at the other end rather than at the end that you are suggesting.

Mr QUICK—We have discovered that, even with hospitals, the people who are collating the information are usually the first people that disappear when the hospital restructures so that the bare statistics are not there. One assumes that, if you are operating under this holistic approach, this is probably one of the key things that you need to have to convince people to change the MBS or PBS schemes, because you could prove to them that this is far more effective than the doctor driven approach that the health departments are on about.

Mr Ah Mat—Our approach to that has been that, prior to our establishment, where did these people go? It is clear that the people were not going to the services that were already in existence. Now that we have established ourselves, people are coming to us. They just were not going to see the other health services before that.

Mr QUICK—How responsive is the Northern Territory government to saying that as part of the health education issue they ought to give you some money so that you can set up some longitudinal studies to follow, say, a 16-year-old woman for 10 years to chart not only her health but also the health of her family? In that way you can get some statistical information from which you can say that it is proven that compared to the GP based system that is working in other areas the holistic thing is working here.

Mr Robinson—I think we accept your supposition there. It would be great if we at Danila Dilba were able to do some of that ourselves. We must bear in mind that, when we were established in 1991, we had a staff of seven, of which two people were involved in administration—that is, the administrator and the director of the service. Since that time, we have gone up to a staff of 50. After the interviews for the emotional and social wellbeing program are completed this week, the number will probably be around 55. But we still only have two administrative staff. When Pat goes to Alice Springs and I come here that is it: there is no-one else in administration at Danila Dilba at this precise moment. That is where we have come up against a brick wall, getting the support to look at the administrative side of the service and getting somebody here to pull out the data that we collect. We collect the data; it is just that no-one has any time to do anything with it.

The service is growing in leaps and bounds. We see 1,200 to 1,400 people a month. When we first started with the same two administration people, we had 100 people go through the doors in the first three months and we thought we were going great guns. Since the transfer of Aboriginal health from ATSIC to OATSIHS, we are constantly asked, 'What are the mechanisms for expansion of services?' Expansion of the services is just not that clinical site; there needs to be coordination. I am getting to the stage where I am sick of working from 6.30 in the morning until 6 o'clock at night, five days a week and then coming in on the weekends to fix up the watering system. There has to be

greater capacity in the organisation to do these other things you are talking about, to look at the stats that are there and to come up with these ideas to government. It is very circular. We need the information to get the money, but we need the money to get the information.

We have talked about these with Territory Health Services as well. The response there is basically, 'You are funded by the Commonwealth,' or, 'Speak to the Commonwealth.' The answer from there has been, 'Use Medicare.' We have talked about the problems that we have had with that and we have to sort those out first.

Yes, the studies need to be done and I am sure that if they were done, you would see that we and the AMSs are providing value for money. I think we provide a very cheap primary health care system to the people who come through our doors. It is only going to be stuffed up now by the goods and services tax.

Mr JENKINS—That is a very opportune time for me to come in. There are a couple of levels that I want to go on from your description of where you are at at the moment. There are two levels. One is the internal level where you have described the model of how the community controls the service. You said that the committee's role is to worry on behalf of the community but not to interfere in the day-to-day running of it. Is there a clear demarcation in setting priorities or areas that you would like to expand into? Is it integral that the committee be involved in the setting of the priorities or setting the dimensions of the vision of the organisation?

Mr Ah Mat—We have a number of subcommittees operating at community level, and we have asked others to come and join us to work on that so that we can set the priorities ourselves. We can then pass that onto management and the management takes up that role.

By operating as a committee, we are able to get advice on what are the concerns and the problems in the community, and we can then set directions which are clear and precise. We can say, 'These are the problem areas that we are experiencing now. This is where we need to start focusing our attention and our resources.' What we are faced with here is that we have to wait for someone else to provide a report to government to highlight the illness in the community and then we can access the programs as the dollars become available for that particular program, but it becomes a body part type of situation.

We are not fully in control of our own destiny. We need to be able to look at our community at this level and say, 'This is what we need to address next.' So that is the problem that we have. We need to be fully resourced so that we can make good choices. At the moment, we cannot make those good choices. We are restricted. The options that we have available are restricted by the programs that are coming out in terms of whatever the illness may be.

The other point is in terms of the cultural aspect of how we want to do things. We gave the example of DEETYA wanting to get involved in the selection of health workers. What we are trying to do is to allow the community to put up the people who should be the health workers. Only very recently we took on some Torres Strait Islander trainees. They were, in a roundabout way, put up by the Torres Strait Islander community.

Mr JENKINS—How much of a problem is it if you want to concentrate on wellbeing rather than on illness?

Mr Robinson—Our philosophy—and I think it is in our constitution—is very much about wellbeing. There is the matter of the lack of resources of the service. I am not belittling the efforts that successive committees have made in obtaining resources or the efforts of the office which funds us. What we are still doing is scratching the surface of the illness. Health education people cannot do as much as we want. We are constricted by that area. A lot of people think that you get into education and the illness disappears overnight. It does not. You cannot take funds out of one and do the other. You have to do both concurrently. We just have not been funded at the appropriate level to do it. We are still treating the illnesses without looking at the prevention side of things as much as we would like to.

Mr Ah Mat—Also, there is a perception that because we are in town the health services provided are much better. That is clearly not the case. A lot of the resources get sent out to the communities, or that seems to be the target. Danila Dilba has been at the forefront of trying to highlight the concerns in urban centres as to what the issues are.

Mr JENKINS—You gave an example of the problem of day-to-day coordination with other agencies—for instance, on discharge from hospital, being told at the last minute. My question is more directed at planning and coordination. What avenues or mechanisms are available at Danila Dilba to be involved with other agencies, whether it be at the territory level or at the Commonwealth level, or even with other NGOs, about the provision of services?

Mr Robinson—Danila Dilba is a foundation member of the Aboriginal Medical Services Alliance, which is one of the four partners in the framework agreement in the Northern Territory, along with the Commonwealth Department of Health, the Territory Health Services and ATSIC. At the moment, the chair of the state forum is the Director of Danila Dilba, Pat Anderson. I believe that we coordinate with those other partners at that level. In addition, Danila Dilba, along with the other largest AMS in the Territory, which is the Central Australian Aboriginal Congress, is a core partner in the cooperative research centre in looking at Aboriginal and tropical health, along with Territory Health Services again, the Northern Territory University and the Flinders Medical Centre.

We do participate in these forums and raise our issues, and there is some form of cooperation and coordination. In addition to that high level stuff, the service is a member

of NACCHO, the National Aboriginal Community Controlled Health Organisation; we have been particularly involved, both as Danila Dilba and AMSANT, in its incorporation. AMSANT members hold three of the executive positions on NACCHO, and we get our point of view across at that national level.

The Territory has been particularly strong in lobbying. We were one of the organisations of Danila Dilba and the Territory in particular that lobbied hard and long to get health transferred from ATSIC to the Department of Health and Family Services. We were quite successful in that. So that is the national level at which we participate.

At a local level, our clinic manager and the director, when available, meet with the other community care centres around the Darwin area to talk about coordination problems. We also meet and talk informally with the other Aboriginal health agencies around town. So there is that level of coordination, we believe, at the different levels. We are at the stage that, if we have a problem, we are in a position to get on the phone and talk to Peter Plummer at Territory Health Services, for instance, at that level, or to Trish Angus or the minister's office, in order to work out some way of sorting out any problems we could have.

The whole question of coordination was actually raised in a report that we commissioned several years ago, called *It's not good enough to know about diseases*. It was highlighted then that there needed to be greater coordination between the services, and we have worked towards that. I will give you an example. They are reviewing the Mental Health Act here in the Territory, and part of that is reviewing the criteria for admission. They have established a series of working groups to look at each of the criteria. Eighteen or so working groups have been established, and we have been invited to participate on 15 of those 18. Clearly, that is taking coordination a bit overboard: we cannot spread ourselves around to that level.

So there is a willingness but, once again, there is the whole question of resources. We cannot do everything. Territory Health Services have hundreds of people. They can set up little specialist committees all the time. They can invite us to participate, but there comes a time when we have to worry for Danila Dilba and keep it on track and keep it running efficiently, without participating in all these other forums. We have been criticised in the past for not fronting up at some particular strategy group meeting or other, but we cannot spread ourselves around. As I said, there are just the two of us, and we cannot go much further than that. So the real problem in that coordination, for us, is simply people time.

We are finding now that we are employing our doctors to get submissions done and reports read, and that is basically a waste of their time. They are the most expensively paid members of the organisation. The fact that they are doctors does not necessarily mean they have skills in research, report writing and all of that. We have to look at the way we can operate. With greater resourcing in the administration area, we will be able to

participate and coordinate a hell of a lot more.

CHAIR—This inquiry is unusual in the way we are conducting it. We have brought Jim Kennedy in, seconded from the department in Canberra, and Puggy Hunter from NACCHO has been accompanying us around on our visitation; so we are trying our best. One of the recommendations has been the need to have regional forums, but I have just heard you say that you are so busy delivering that you have not got time to assist in planning for the longer term. What is the answer to that? Resources, obviously.

Mr Robinson—That is a problem. It is difficult to participate. Two or three faxes marked 'Urgent' come in each week asking us to participate in some forum or meeting being held somewhere in the country. For us it is not just a case of hopping on a plane. If you are in Sydney you can fly to Canberra in 20 minutes. For us it is a four- to five-hour plane ride, quite often with a stopover of a couple of hours in Brisbane or Sydney. An Ansett flight leaving here at that dreaded hour of 5.55 in the morning means getting into Sydney or Melbourne at perhaps 3 or 4 o'clock in the afternoon. So, for a one- or two-day meeting, add a day's travelling each time.

And we have to weigh up whether our being away from the organisation is worth the benefits achieved. There are some things that we should be doing that we just do not do because of lack of resources within the organisation. It would be great to be able to go away for a couple of days and know, for instance, that the mail box is being emptied. It is things as basic as that. When I say there are only two of us, there are only two of us. We do not have a secretary or an administrative assistant. Pat and I are probably the most expensive people to sit down for an hour and do nothing but photocopy handouts because people may visit the clinic.

CHAIR—I hope our visit on Wednesday is not seen as an imposition. We could do some photocopying while we are there.

Mr Robinson—If you know how to push that button, feel free.

Mr Ah Mat—I would like to make a comment in relation to the Northern Territory government. Of the health works that have come through our school, I think the majority may have gone over to the Northern Territory health department. The Northern Territory health department spends a lot of money on Aboriginal health, but to a lot of us it is unclear where that money is being spent. We see a lot of health workers in the hospital areas, but they are not actually in the hospital system. It is really difficult to work out what it is that they do there. Some are on specific programs, but it is unclear as to what they are doing there. That is something that may need to be investigated to find out where the dollars in Aboriginal health are being spent so that community controlled institutions and remote communities can get a slice of these dollars. Our workers are leaving us because our salaries are lower than those in the department. They do not have to do the same sorts of things they are doing at Danila Dilba but they can get more

money.

Mr JENKINS—What role is there for mainstream services outside hospital or tertiary care? We have received a lot of evidence about the need for things done there to be culturally sensitive. There must be things that even in your wildest dreams you could not see yourselves getting sufficient resources to be able to do, so you must be reliant upon other providers. What has to happen to those other providers to make them able to deliver a quality service to indigenous Australians?

Mr Ah Mat—There was a clinic at Berrimah. Just down the road from that is Kormilda College, which has a fairly large contingent of Aboriginal students from remote areas. They chose to use us. In fact, their parents said that they wanted their kids to come to us because of the appropriateness. We have said before that our numbers are around 14,000. Where were these people going before? If they were going to the NT health service, what is that service doing now that there is this huge decrease in numbers? They are the sorts of things that we often talk about. They are still getting the same amount of dollars and we are constantly waiting for another body part program to come up so we can try to access it. We had a new member join us recently on the committee. At each meeting we have financial statements presented. At the moment we have 20 accounts that we have to administer because they are all from different programs.

If you are interested in helping to resolve indigenous health, they are some of the things that need to be addressed. Instead of us applying under a certain program, we are saying, 'Give us an amount of money so that we can go and do what we have to do.' It is important for us to do what is needed in the community—not to respond to another report that has caused a lot of hullabaloo by saying that kidneys are the problem, so there is a large emphasis and a lot of money spent on kidneys until someone else comes up with another favourite body part that is special to them. We are trying to look at people in their entirety and yet we have to constantly chase programs in this manner.

Mr Robinson—Having that large a number of programs is an administrative nightmare. We have tried, as well as we can—again the problem has been the availability of capital money—to set up systems such as the accounting system and the IT system to compensate for the lack of bodies on the ground.

Mr QUICK—Is it realistic to have one model for Aboriginal health? Some of us think that perhaps we should have a Redfern model and Wilcannia model and an AP Homeland model.

Mr Robinson—It is like saying that there is only one Aboriginal group of people, and that is clearly not true. There are a lot of different nations of Aboriginal peoples around the country. You cannot have just the one model. It has to be specific to the region, arising from what the community, through that thing I spoke about at the very beginning, has determined that service is going to do.

Mr QUICK—Are OATSIS and the Canberra bureaucrats still thinking of one model for Aboriginal health? Is that lack of flexibility the problem—the inability to access MBS and PBS to say that what they need at the AP Homelands is completely different from what they are going to use in Redfern?

Mr Robinson—That is a problem.

Mr Ah Mat—There are certain aspects that can be standardised, for example, the reporting mechanism. You could standardise that. But how we operate on a day-to-day basis is our business. As long as we maintain our reporting—and our record on reporting is impeccable—our job is to look after people's health. Let us get on with that. Let us not chase dollars and go to meetings that sometimes we feel we have to go to to make contact with people to find out what the next lot of money coming out might be. Chasing this stuff around wastes the time of the director and administrator. You asked us about our needs. That is far more important to us than running around the country doing silly things.

Mr Robinson—Your question about the flexibility of funding is crucial to this. Unfortunately, it is quite often you guys who are insisting on that through accountability to the various departments, the National Audit Office, et cetera. In my original discussions with various officers in ATSIC and the Department of Health and Family Services they did see the need to be a little more flexible to take into account the various needs of the services, but unfortunately programs are not designed that way and out come the application forms and you get it. If you do not conform to that you are out of the running.

Mr Ah Mat—If we are talking self-determination, we should be able to determine how we spend the money and what our priorities are. If we do not report correctly or if we misuse that money, then close us down. Get someone else to do the job. It is as simple as that. Do not keep us on a short lead that is jerked every time someone has a disagreement or a new body part comes online.

Mr QUICK—Are the Territory government and the Commonwealth being a little bit more flexible at this stage, or are they both set in concrete?

Mr Ah Mat—They have their moments.

Mr Robinson—Yes, they have their moments. With the funding from Territory Health, the letter of offer we get is quite flexible. It says 'assist in the provision of clinical services'—which is very open-ended. The Commonwealth one says 'operation of clinical services'. We do have flexibility there; but, while saying that we have that flexibility, we are still expected to put in a budget that clearly lists what the line items are between capital recurrent and salaries, and we still have to get permission to transfer any moneys between them. An example of that is that I went away on holidays for eight weeks last year, for the first time in about five years, and we actually filled my position by getting a

temp. We then had to seek a budget variation to transfer that amount of money from salaries through to whatever, to cover it.

To my way of thinking, that was ridiculous but it was something we had to go through. There has to be greater flexibility than that. I totally agree with what our chairman is saying. We should be given that bucket of money. We should set the priorities and determinants, as long as we do not misuse the money and—I take your previous point—as long as we can demonstrate value for money in providing a good health service delivery. Perhaps the two go hand in hand.

CHAIR—I propose a short break now. We look forward to talking with you some more, John and Lindsay. Thank you very much for your time today. You have basically come in to affirm the alliance's submission. It has been good to have a chat with you before we have a detailed visit. We look forward to seeing you on Wednesday.

Proceedings suspended from 11.12 a.m. to 11.31 a.m.

WALKER, Professor Alan Courtenay, Darwin, Northern Territory 0812

CHAIR—Welcome, Professor Walker. Could you please tell the committee in what capacity you appear to give evidence?

Prof. Walker—I appear as a private individual. I am a recently retired paediatrician who spent 31 years in the Northern Territory and was also Dean of the Clinical School for two years.

CHAIR—Good, you will have some experience to relay to us. Before proceeding, I need to point out that this committee does not formally swear its witnesses, but you need to be aware that the proceedings are legal proceedings of the House of Representatives, warrant the same respect as those in the House and are duly recorded in *Hansard*. I am sure you know the procedure. Any deliberate misleading of the committee would be regarded as a contempt of the parliament, but this provides you with an opportunity to be fearless in your evidence.

We have a submission from you which goes back as far as September last year, so obviously things may have changed from your perspective since then and we would be interested to hear from you in that regard. Your submission is already part of the formal inquiry, so there is no need to read it all into the evidence. Bear in mind that colleagues like to get in with questions, so do not take too long with your opening statement. We will get to the bone as quick as we can.

Prof. Walker—Okay. I would be happy if people were to start off by asking questions. I do not have much elaboration on my statement. There are, I guess, several things I would like to emphasise and particular problems that I would like to draw attention to. Perhaps I should say that, when I speak about Aboriginal health, I speak about the Northern Territory and, in the main, the remote communities. Although I am familiar, from reading, with Aboriginal health problems in the major cities, I have no expertise. I have spoken to people from Queensland and the Kimberleys, but I have never worked there. So I would like it understood that my remarks relate to the problems of Aboriginal people in the Northern Territory and almost entirely to those Aboriginal people living in the remote and rural communities, in both the Centre and the Top End of the Northern Territory. I make that proviso.

I believe that the resolution of the problems of Aboriginal health lies almost entirely in the areas of education and economic development and that anything else that happens in the meantime is merely dealing with the problems that arise as a result of poor educational achievement, a lack of any economic base for most communities and a lack of employment opportunities.

The one thing that I think needs serious thought and which I rarely hear discussed

is, if you believe that economic development is the key to the improvement in health, whether economic development is going to be a feasible proposition for many isolated communities.

As an ordinary citizen, I wonder what economic activities in the new millennium in many Aboriginal communities are going to be able to be developed that will provide for employment for the community members. I do not hear this problem discussed, but I think it is one that does warrant some thought. It is linked with education, because education is important, but, if the people are not going to have the opportunity to use the educational skills that they obtain, the value of education will be certainly diminished. I think that is an important thing to recognise. Would anyone like to ask me questions?

CHAIR—I think there would not be anybody that we have spoken to, or even on the committee, who would disagree with the educational aspect. The trouble is we have a very short-term crisis, so there is a need for both to be in parallel. It is the short-term crisis that we are having trouble addressing. I think Mr Morris was expressing some frustration this morning that we have been talking about this for a long time. That was renal failure.

Prof. Walker—I accept that.

CHAIR—So we have the crisis in the meantime; how do we balance both of those?

Prof. Walker—It is a real problem, and I think that significant advancement is not going to occur without education. I would like to state that, in my belief, the educational achievement in remote Aboriginal communities is less than when I first came here 30 years ago, and that one important thing that could be done is to introduce compulsory education. And, by compulsory, I mean compulsory. The attendance at many community schools is poor, and little effective action is taken. I think that, if you want to do something quickly, you need to compel children in the communities to attend school, as children are, in effect, compelled to attend school in other Australian communities.

CHAIR—That is fine, I think, but sanctions are needed to pursue an idea like that. Sanctions are something that the culture of white Australia is used to, but how would you introduce that?

Prof. Walker—It was compulsory once.

CHAIR—What are we going to do—lock them up if they do not go to school?

Prof. Walker—I do not have any solutions for that. I do not know what sanctions should be applied, but I would suggest that the communities should be able to develop their own sanctions. As a follow-up to that, I think the leaders of Aboriginal communities

do have to be forthright about the importance of education. From time to time it is mentioned as being important, but I do not hear it addressed loudly, frequently and forcefully.

Mr QUICK—On getting teachers out into those communities, I know what it was like teaching in isolated parts of Tasmania, which is ridiculous compared with the isolation here. What incentives do we need to get practitioners out into those communities—practitioners who are willing to be there and to get some recompense and reward for doing three years at a place like Kintore or Yuendumu or some of the other more remote parts?

Prof. Walker—I think the incentives have to be both financial and in terms of their careers. Let me tell you that career opportunities for teachers and other health professionals who served in isolated communities were far more significant 20, 25, 30 years ago than they are now. There was a road to advancement if people were prepared to work in isolated communities, and I do not believe this exists any more. However, I am not in the Department of Education, so I would say that I do not believe it exists any more, but I do not know for certain.

It has to be recognised that working in remote communities does impose considerable difficulties on the people whether they be nurses, doctors, teachers or whatever. You have to offer an incentive to stay. You have to offer a good salary but a package which ensures that there is a real financial incentive to see out the contract rather than to leave as soon as there are some significant difficulties—and there are real difficulties for all people. There are frustrations; there are increasing threats and so on. People often go there and then just pack up and go when faced with some real difficulty. I personally believe that if something like 25 per cent of the salary package was contingent on staying for two or three years, that might change. Certainly, having worked in Saudi Arabia for three months, in a most unpleasant part of the country, there were plenty of people willing to go there and work. The incentives were almost entirely financial; no, entirely financial, not almost entirely.

The other thing, I think, is the question of professional advancement and status. In the area of medicine the status of people working in remote communities is not high. The glamour, the high salaries and the high remuneration in the area of medicine are attached to cardiac surgeons, neurosurgeons and the like who live—

Mr ALLAN MORRIS—Professor Walker, can I just perhaps try and switch that around a little bit. Firstly, if we are going to conscript doctors to work in areas then we will get the same results we get with teachers. They work there because they are being paid for it, but they do not really want to be there so their sensitivity with others may not be what you would want. Secondly, the status of doctors in those areas is, as you indicated, low.

On the other hand, in those areas they have some health conditions which are really worthy of study and professional treatment. May there be a way in which we could actually introduce some specialisation in both academic research and developmental skills dealing with nutrition and with what appear to be the mysteries of renal problems? No one can tell us exactly why we have so much renal failure. They can tell us the reasons that may be involved but no-one actually quite knows. Then there are the diabetes questions.

May it be possible to develop some areas of medicine which actually relate to remote communities as specialisations so people are paid more to be there, but in being there they are doing more than just simply being doctors? It just seems to me that we make some exotic specialisations in cardiology and all kinds of other issues for the other parts of society, perhaps we need to look at making some specialisations in things that relate to remote Aboriginal communities where both academically and professionally and in terms of their work they are seen as being people who are doing special things, with special rewards and with special long-term results as professional operators?

Prof. Walker—I am perfectly happy with that and that is, in effect, what I am saying. As far as recruitment is concerned I think most people, particularly medical people and nursing people, go there with enthusiasm. They are not coerced into going there. They are not conscripted but what happens is that they, for various reasons, become disenchanted and leave—

Mr ALLAN MORRIS—It was not what they thought it would be.

Prof. Walker—and the turnover is higher. It is not what they thought because they do not achieve things quickly.

Mr ALLAN MORRIS—If you pay them more they stay there but they still do not want to be there. They do not see it as professionally developmental anyhow so we have to rethink some of the phraseology. People go into the most exotic areas of specialisation and spend years becoming highly specialised because it is significant, has status or because it is relevant. There are things that we could do in remote Aboriginal communities that cannot be done anywhere else in the world but we do not actually tell them that. We do not actually recognise it, nor do we actually have any accreditation for it, it seems to me.

Prof. Walker—No, we do not. I guess it is important to realise that the health problems of Aboriginal people are not unique to Aboriginal people. They are the same illnesses that everybody else has. It is just that they are—

Mr ALLAN MORRIS—I am sorry, I do not agree with you. I think they are unique in the sense that there are very few people in the world living in those situations, and the incidences of both the medical condition and the environmental circumstances are in fact unique because it is the totality, not simply the body condition.

CHAIR—I think what Professor Walker was saying is that the disease is the same.

Prof. Walker—The prevalence is vastly different.

CHAIR—The prevalence is different.

Prof. Walker—The social circumstances are—

Mr ALLAN MORRIS—We talked to the Kidney Association specialists, a doctor from there, and we said, 'Okay, can you actually tell us what is the biological cause?' The answers are, 'We think it is to do with low birth weight; we think it is to do with high infection levels in early childhood; we think it is to do with nutrition.' I said, 'Why do they actually fail biologically? What is the actual cause?' And he said, 'We don't actually know; we have done very little research on the actual cause of renal failure in remote communities.' So we do not know. We say they have failed, sure, but we actually do not know why they have failed with those communities in quite that way because we have never bothered studying it.

Prof. Walker—I do not know that that is true. Let me tell you that research is increasingly difficult, and the communities and the national and regional Aboriginal bodies are difficult to persuade that research is either necessary or worth while.

As far as renal disease in Aboriginal people is concerned, I would think that Wendy Hoy would take issue with what you said. What she is saying is that there is no single cause. In different individuals there may be factors which are important, particularly diabetes or kidney infections in childhood, but, in many, there are four, five, six or seven factors which are contributing to end stage renal disease. There is not one cause.

Mr ALLAN MORRIS—In 2006 and 2007, there will be 662 people in the Northern Territory on dialysis, and no-one quite knows why.

Prof. Walker—We know that they have got end stage renal disease.

Mr ALLAN MORRIS—They can give us the precise number, but they cannot tell us precisely why it is happening. It has been coming for decades, and we have watched it coming for decades, but we are still sitting here saying, 'Well, it is just one of the facts of life. We know it is renal failure and we know renal failure is as a result of all these things.' There is a doctor up here now doing some research that we have heard about. We have seen some material from—I forget the person's name—a doctor who is doing some work on it now for the first time. He is having difficulty getting funding for research, I understand, from what we were told in Sydney.

I am sorry, I am not holding you responsible. I am just expressing my frustration, I guess. It seems to me if you get a grievous condition in Sydney you have all the support

and recognition and so on, but a major health crisis in a remote community will lead to 660 people on dialysis in eight years time. That is an absolute disaster coming.

Prof. Walker—Sure. I could tell you five or six things which people could do which would lessen the prevalence of end stage renal disease. They could stop smoking, they could become aerobically fit, they could lose weight and they could be given better living conditions so that the infections in early childhood and in adolescence which are so prevalent would be less prevalent. If that happened, then the prevalence of end stage renal disease would drop considerably. The prevalence of end stage renal disease is a new phenomenon. I have been here 30 years, and it was not a major problem. The Aboriginal people then were fit and healthy. I have got photos of them. Obesity did not exist.

Mr ALLAN MORRIS—Yes, we read all that. You have been here watching it happen, and then saying, 'But we don't need to research it'?

Prof. Walker—No, I do not say that at all. We do need to respond to it.

Mr ALLAN MORRIS—If we could work together to get it on the national agenda in terms of this being a major area of medical research which is underserviced, then research it, you may need to work in remote communities to actually research it.

Prof. Walker—Yes.

Mr ALLAN MORRIS—So the coincidence of research and additional funds for that research and professional status could in fact all coincide. They could all come together.

Prof. Walker—Yes.

Mr ALLAN MORRIS—If the medical fraternity actually was of that view.

Prof. Walker—I think the medical fraternity are of that view.

Mr ALLAN MORRIS—No, they are not. You have just told us that you cannot persuade the funders to actually fund research in this area.

Prof. Walker—I can tell you that it is not just a question of funding. It is a question of acceptance by communities and organisations that the research is necessary. It is not easy. There is a perception that research in Aboriginal communities has been, firstly, a waste of time and, secondly, an imposition on the Aboriginal people. Again, I emphasise that I speak only about the Northern Territory. I do not think research in the Northern Territory has been an imposition or inappropriate. There certainly has been in the past poor communication between the people doing the research and the communities about the outcomes but, then, I think that was so in the whole of Australia.

Mr ALLAN MORRIS—I am with that. I am sorry; perhaps I misled you slightly. I did not mean research in the sense of pure research done on a statistical basis. I was talking about doctors who work in the field who are contributing to research because of their work, where you coincide the actual research with the provision of services. In other words, I am not talking about the career researcher who comes in, does the measuring and goes away again and uses it indiscreetly but rather someone who is providing a service. We have this strange event: we have poor outcomes, we have low levels of services and a mystery as to why that is happening. It seems to me the solution may well lie in putting in providers or services that are also part of the longer or the bigger question. In other words, the only way you can do decent research on these communities is to actually work in the communities as a doctor.

Prof. Walker—I think the role of a medical practitioner or a health practitioner in a community should be a mixture of service provision—curative services, preventive services—and applied research.

Mr ALLAN MORRIS—I guess that is the point I am trying to get towards. But we do not see it that way, do we? You see it that way, but the community does not see it that way. We see doctors, mechanics, plumbers or electricians as service providers, and that is how we project it, isn't it? That is probably the fault of all of us.

Prof. Walker—Possibly down south; I do not know. I am sure Michael Glasby, who is here, can give you a better perspective from the person working and living in the community than I can. The responsibility of health workers and doctors is to not only provide a curative service but also to be part of a preventive service and to do some research particularly into delivery of services. All the problems of Aboriginal people are related to social and economic problems, and there is no mystery about that.

Mr QUICK—Let us use the community of Kintore as an example; what economic development can we institute out there? We can provide them with a local school and say, 'When the children get to year 6, they will have to disappear hundreds and hundreds of kilometres to Alice Springs to do a senior secondary or a secondary education.' When they return to Kintore, which is 700 kilometres north-west of Alice Springs, what economic development is there? Unless you are a cultural site such as Uluru, where you have lots of people who want to go there, you do not even get a decent road.

Prof. Walker—That is a real dilemma. In my opening remarks, I emphasised this. It is depressing for me to think about what economic advancement is potentially possible in many communities. The easy answer, of course, is the answer in our communities—that people just go where the development is. But there are serious cultural difficulties for the Aboriginal people in that concept as there is with many North American Aboriginal people. But it is there and, in part, that is the essence of the problem. Welfare dependence is certainly not part of the road to health.

Mr ALLAN MORRIS—I would like to switch your attention to an adjacent area. As a paediatrician for 30 years in Darwin you would be fairly exposed to the separation of children from mothers. We have been told around Australia that for Aboriginal people hospitals are not a pleasant place, partly because it was where their mother, grandmother, uncle or auntie lost their baby. In many cases they were told the baby died and other various things, so there is a resistance to them. That also seems to affect, firstly, their approach to hospitals and their acceptance of so-called Western medicine as being curative and, secondly, their social wellbeing and hence their health. Can you talk about that?

Prof. Walker—I can certainly say something about it. What I would like to say is that it is far less important than it used to be. The professional people working in Territory hospitals, in children's wards in particular, go out of their way to minimise the cultural problems associated with hospital. The ethos is to make the paediatric unit as friendly as possible for Aboriginal people.

There is an informality about the paediatric department which is totally different from some hospitals. Let me tell you that the number of children admitted to hospital over the last 20 or 30 years has escalated enormously. I think that must mean that people are not as frightened as they used to be. Certainly, deaths in hospital are now a relative rarity so the old idea that the admission of a child to hospital meant that it was going to die has gone. Many Aboriginal people will pay their own way into Darwin to see me and my colleagues because they have faith in what we do.

So I believe that problem is far less. I believe there is evidence in the form of far more children coming into hospital and far fewer people leaving—absconding is the word; not a good word, but that is what it was called—and far less difficulty in the community in persuading mothers to have their children come to hospital.

Again, Chris Harrison and Michael Glasby, who will be speaking to you later, will be able to say something about the current attitudes. I am sure Aboriginal people do not like coming to hospital, I would not pretend that, but the fear, reluctance and refusal to come that was prevalent a few decades ago is far less prevalent now.

Mr ALLAN MORRIS—And the effect of the stolen children, of forced adoption or forced separation, on Aboriginal health?

Prof. Walker—In the 30 years that I was in charge of paediatrics in the Northern Territory that never happened with children under my care.

I would like to say something about the role of Aboriginal health workers. I think the training and the role of Aboriginal health workers should be very much towards prevention rather than provision of curative services. When they are sick, people in Aboriginal communities want to be cared for by the most skilled people possible. Therefore, they want, and should have, the same types of services as anyone else in

Australia. That basically means access to medical care when it is needed, and medical care means care by medical graduates. We should be able to get medical people out there. We do not have to provide them with a reason for going there, because that reason exists already, but a reason for staying. Their role should be curative, preventive and have a research component. Reward for staying is important.

I have indicated that research is very important. I am concerned about the bad name that research has got, because in my opinion that bad name is not soundly based and I would argue that in any forum.

Mr JENKINS—Is there a role for traditional medicine and how should that be integrated with western medicine?

Prof. Walker—Everyone has a personal view about that. As a person trained in western scientific medicine, my belief is that something has to be wherever possible proven to be effective. I am not saying that all western medicine interventions are proven to be effective. They are not, but at least that is what the aim is.

We in the paediatric department cooperate with traditional healers when they come, as long as we believe that it is not detrimental to the people concerned. We cannot just sit around while detrimental things happen, which is rare. It is no different to—for want of a better word—alternative medicine in our society. I do not have a problem with that, as long as the people are not fleeced financially or prevented from getting, in the case of serious illnesses, proper care.

If the people have faith in those healers, that is good. They should have access to them and we would cooperate with them. I think most nurses and doctors who work in communities would see it the same way.

Mr JENKINS—What about care for the family of patients? In evidence we took in Adelaide one medical practitioner put to us that the thing that shocked him in the treatment of a child was the fact that, when the family accompanied the child to hospital, they actually had to spend more time treating the parent because of the parent's inability to cope with the situation.

Prof. Walker—Yes. I would like to say that I believe that is less in Territory hospitals, because of the fact that people who work in Territory hospitals are in large part treating Aboriginal people and their families. We would try hard to bring the families into the management of whatever the episode is. We are certainly not perfect at it and there would be many families who would be unhappy with their experience, just as many non-Aboriginal people are unhappy with communication and holistic care.

The bigger the hospital and the fewer the Aboriginal people in it, the more likely it is that the cultural problems associated with being in hospital will be poorly dealt with. In

Territory hospitals 50 per cent of the patients are Aboriginal people and if you do not do your best to look after them and their families, then you will be a failure.

Mr JENKINS—What percentage of the staff are Aboriginal, even the non-health staff?

Prof. Walker—Not many. I would guess at the Royal Darwin Hospital about five per cent, possibly less. In the last two or three years there has been the employment of liaison officers who are specifically there to try and minimise the disruption and cultural problems for Aboriginal people. I think there are four people in the Darwin hospital. The real problem is educational attainment and it is poorer now than it was 30 years ago in terms of the number of years of effective school years completed.

Mr JENKINS—Do you have a view about fast-track methods of educational identification early on for people who might be streamed?

Prof. Walker—I have a personal view, yes, that I think it should be done. As you know, in medical schools there are increasingly ways in which Aboriginal people can enter the medical faculties other than by passing the normal barriers, and I certainly support that. The clinical school of which I was dean certainly had that view. Unfortunately, we were not able to attract any applicants from Aboriginal people who had completed the necessary basic educational requirements.

Mr JENKINS—Is that because the small number wanted to pursue other things?

Prof. Walker—I think the opportunities for educated Aboriginal people are enormous. There are many organisations and government departments willing to employ people. So to expect an Aboriginal person to do an undergraduate degree and then commit themselves to four years of medicine is a big ask when they can get well remunerated employment with their basic degree.

Mr QUICK—With 70 per cent of the Northern Territory's indigenous population living in remote communities there is the issue of environmental health and standards. Have you seen any marked improvement over the last 30 years?

Prof. Walker—Yes. I think the housing is significantly better. The quality of housing and the quality of water are significantly better than they were when I first came.

Mr QUICK—Are we at a stage where that is not going to be a major factor?

Prof. Walker—No. It is a lot better than it was. Most Aboriginal people in remote communities would still be poorly housed.

Mr QUICK—In comparison to dwellers in Katherine and Alice Springs, on a scale

of one to 10 what are the environmental health standards?

Prof. Walker—There is a range.

Mr QUICK—For example, in Kintore and Yuendumu in the AP homelands.

Prof. Walker—I could talk about Bathurst Island and Milingimbi and those places better. I would say that probably somewhere between 30 and 50 per cent of people are now housed in houses of reasonable standard. There are plenty of surveys which will tell you.

CHAIR—What about central Australia? We are going to Bathurst Island tomorrow.

Prof. Walker—I would have to be careful about commenting on central Australia.

CHAIR—We are going there tomorrow.

Prof. Walker—My service there was when I first came and before there were other paediatricians employed. I would not like to say anything about the Centralian communities.

Mr QUICK—Is there an emphasis on environmental health standards? Is a huge amount of money necessary in your view?

Prof. Walker—One would have to ask the people involved in the provision of housing and such services. All I can say is that housing has improved, but plenty still needs to be done. For example, water purity is far better now and sewage and excreta disposal is better in most communities than it used to be.

Mr QUICK—Have you seen much sign of inter-agency cooperation in order to solve a problem rather than getting money from various bags in the hope of, perhaps, sorting out one community's needs? The problem is not necessarily one department's fault and responsibility; a whole series of interactions are necessary. In your 30 years has there been a huge increase in cooperation, or just a marginal increase?

Prof. Walker—No. I think there has been a significant increase in cooperation and less hostility and less of a proprietorial attitude to various aspects of community development than there once was. I think things are improving; I am sure they could be better.

Mr QUICK—So people who say, 'Look, we have been pouring billions of dollars into Aboriginal health.' I think the first inquiry by a Commonwealth committee was in 1977. Are we at the stage of saying that in five years time, with all the things that are put

in place, we will see a marked improvement?

Prof. Walker—I would have to go back to education and economic development. Is that going to occur in that time frame? Probably not, particularly given the difficulties in many communities that we have mentioned. What economic development is there going to be there? One of the depressing aspects of Aboriginal health from my point of view is the difficulty that I see in dealing with the underlying social and economic problems.

Mr QUICK—You alluded to the North American Indians with a similar problem, and people have said that the Maoris have perhaps a similar problem. But they seem to be able, for whatever reason, to sort some of the problems out and implement planning.

Prof. Walker—I think it is only relative. The data from the North American aboriginal people and the Maoris is simply a decade or so ahead of here. If you look back to mortality rates and disease prevalence among North American aboriginal people 10 or 20 years ago, it was the same as it is now amongst the Australian Aboriginal people. They, of course, do have increases in lifestyle diseases, such as diabetes. In some ways some of the problems are greater than the problems of Australian Aboriginal people. In other ways, of course, some of their problems are significantly less. Their mortality rate is lower and they have fewer children with hearing disease, but diabetes and coronary disease and things like that are worse amongst some groups of North American aboriginal people.

Mr QUICK—Assuming we could wave a magic wand and sort out economic development and education, how marked an improvement in the health of the indigenous population do you think we could see in the next 10 years? If one of our recommendations were to pour resources and money into economic and educational development for the indigenous people, could you see a marked improvement in health outcomes in 10 years time?

Prof. Walker—I think that if people were empowered to take responsibility for their own health then remarkable improvements could occur in a relatively short time. How you persuade people to do that is another matter. You would know the difficulties that occurred in the general Australian community regarding education about smoking. Enormous amounts of money were spent over a long period of time before anything significant was achieved. There has been achievement in reduction of smoking in our communities, but it was not achieved easily. There is some evidence, I believe, that obesity is increasing in general Australian communities. It is not easy to persuade people to change their way of life. Most people who change are the better educated people because the television messages get to the people who are relatively sophisticated and educated, and the messages are not enacted upon by the people who are less educated. That applies to all communities.

CHAIR—Colleagues, unless you have any more questions, I think I will wrap it

up there and we will have a break for lunch. Dr Walker, I think it says something about you that you are prepared to come and give us your time and to sacrificially favour us with your experience over the last 30 years. Thank you very much for that.

Mr ALLAN MORRIS—Could I put one question on notice? We keep hearing about birth weight: are there any statistics available on birth weight variation over the last 20 or 30 years? You do not have to answer it now necessarily, but perhaps you might want to give us—

Prof. Walker—Yes, birth weights have risen. The average birth weight is still significantly less than the non-Aboriginal—

Mr ALLAN MORRIS—Is anything available on that in the Darwin Hospital?

Prof. Walker—Yes.

CHAIR—We have actually seen some of that information. It is the only thing we can claim to have made some progress with.

Prof. Walker—Aboriginal child mortality is a quarter of what it used to be.

Mr ALLAN MORRIS—I was looking at Darwin Hospital where the records are. You can see some state-wide facts, particularly in Darwin—

Prof. Walker—Yes, the Menzies School would certainly have data. I believe the bureau of census and statistics has got it. Just before I go, I have got to remind you that Aboriginal infant mortality 30 years ago was 150 per 1,000; it is now 18. Mortality in hospitals was once about eight or nine per cent and is now around 0.3 per cent.

Mr ALLAN MORRIS—We have also been told, Dr Walker, that part of the reason for the renal failure is that babies do not die any more as infants. In other words, ones that used to die as babies, are now dying of renal failure in their 30s. We do not know whether that is true or not; it was one of these other anecdotal things that is going on.

Prof. Walker—Exactly. In other words, the fall in death rate in childhood has not been a totally unmixed blessing.

Mr ALLAN MORRIS—That could do with some interesting research.

Prof. Walker—Wendy Hoy is certainly doing that.

CHAIR—Thank you very much, Dr Walker.

Proceedings suspended from 12.18 p.m. to 1.18 p.m.

MATHEWS, Professor John Duncan, Director, Menzies School of Health Research, Building 58, Royal Darwin Hospital Campus, Casuarina, Northern Territory

CHAIR—Welcome. In what capacity are you appearing before the committee?

Prof. Mathews—I appear before you in both a personal capacity and in a professional capacity on behalf of the Menzies School of Health Research. Anything I say that is a bit outrageous you can say is personal rather than—

CHAIR—Before proceeding I need to point out that this committee does not formally swear its witnesses but you need to be aware that they 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 would therefore be regarded as a contempt of the parliament. This process serves to protect you in the evidence you give, which is covered by parliamentary privilege.

We have already authorised for publication a submission that you provided to us in October last year. There could be some things you would like to bring us up to speed on, since that was nearly 12 months ago. I will give you an opportunity to make an opening statement and then we will proceed to questions from members of the committee.

Prof. Mathews—What I can update is the fact that we mentioned in the proposal that the Cooperative Research Centre for Aboriginal and Tropical Health was being established. It has now been formally in operation for 12 months. It is able, through its board and through the cooperative research program, to address some of the areas we have looked at in our submission where there is inadequate background information as a guide to more effective interventions and program development. That is all I would like to say by way of introduction.

CHAIR—That has been operational since before Christmas last year?

Prof. Mathews—Yes. In fact, it was formally inaugurated in September last year, just before the submission went in. At the time the submission went in I was at Oxford. The submission was prepared by Dr Chris Burns and Dr Bart Currie in the Menzies School and I had the opportunity to look at it before it was submitted.

Mr QUICK—Concerning the whole issue of environmental health, we heard evidence today from the Northern Territory government that health problems seemed to be on the increase but in your submission it says:

Housing, hygiene and nutrition programs are making slow but welcome progress.

In other parts of the submission there is mention of Maningrida. It is one of the largest remote Aboriginal populations in Australia and the statistics there are horrendous. How

'slow but welcome' is the progress?

Prof. Mathews—One of the messages in our report that I can emphasise for the committee is the fact that there is obviously concern about the rate at which the appropriate inputs to improve Aboriginal health are being made. But the committee also needs to understand that there can be long time lags between the inputs and the outputs. There can be very long, latent periods between the inputs and the outputs.

If we look at the inputs in relation to housing, then, since the report went in, the housing program, particularly in relation to out-stations at Maningrida, has advanced. It is certainly the case that the inputs in terms of housing and health infrastructure generally are being worked on. But this committee needs to understand, just as the Australian public needs to understand, that there is a long time lag between the inputs and outputs.

One of the ways of understanding that long time lag is to look at the historical health transition in Australia as a whole. If we go back to the last century and look at people living in the slums of Australian cities, their health outcomes were very similar to many of the health outcomes of Aboriginal people today. It took a long time for the health inputs—education, improved housing and improved nutrition—to feed in and help to deliver better health outcomes.

That process in Australia, and the Western world generally, probably started in about 1850 with the introduction of universal education and public sanitation programs and it was finished in the first half of this century with attention given to public housing programs and improved nutrition. So, by about 1950 in large part the health transition for Australia as a whole had happened, but it took a long period of time.

What we are observing at the moment in Aboriginal Australia is that the inputs are still lagging behind and that the outputs are going to catch up, but over a much longer period of time. It is very important that one of the messages your committee addresses is that increased funding for Aboriginal health infrastructure and health services should not be made on the basis of funding only those things that in the short-term can be seen to have a direct benefit in health outcomes.

One of the unfortunate aspects of the current coordinated care trial, which is running in Tiwi and Katherine, is that it is a very good initiative, but I would not like this committee or the government to be able to consider an option that says that, because you have not got short-term benefits in improvement in health outcome, they would take that funding away—because that would be imposing a double standard on Aboriginal health services. Whereas most people in Australia today have access to health services and medical services on the basis of need, that is not yet the case for Aboriginal people.

CHAIR—Could you give examples of where you think that that has operated—where there has been funding for a political quick hit rather than for the long term?

Prof. Mathews—There is no precedent where money has been withdrawn, but the clear implication of the evaluation process that has been set up—for instance, with the coordinated care trials—is that it is in a sense putting a higher standard of evaluation on Aboriginal health services than is applied to most other health services. I am not opposed to evaluation per se; I am simply opposed to having a higher standard for Aboriginal health services than applies to other services. I drifted off your original point, but I wanted to make the generic point, Mr Quick, that the time lag between inputs—whether in terms of housing and health infrastructure or nutrition or education—and outputs can be measured over a long period of time.

Mr QUICK—Australia has, principally, five major population centres; and that was an urban problem and, I guess, an urban solution. But how do we deal with really remote communities? Do we need a different set of goals and objectives to deal with them? Someone mentioned this morning that 70 per cent of the indigenous population lives out in really remote communities, 500 or 600 kilometres away from civilisation, but that is civilisation in terms of the Northern Territory and not necessarily Brisbane, Sydney, Melbourne, Adelaide or Perth. Are we looking at longer-term achievement possibilities? One of the factors in our big cities is that local government can effectively reduce some of the problems pretty quickly—that is, assuming that they get involved in the process. But the evidence that we have seen put forward is that local government tends to ignore these remoter communities because there is no real benefit, for whatever reason that they see. It is a case of 'out of sight, out of mind', with roads, sewerage and the rest of the infrastructure that other communities accept as the norm remaining inadequate.

Prof. Mathews—Yes. The thing that comes through in our submission is that the long-term solutions are in terms of a greater capacity for Aboriginal people to make their own decisions over healthy living. It is very clear that there are diseconomies of scale in providing services in remote locations; but, on the whole, the health of non-Aboriginal people living in the bush is probably better than that of Aboriginal people. That is partly because their personal resources are better: they are able themselves to fund the hardware and the resources that are needed to live a healthy lifestyle, and also because they have had the benefit of an education that allows them to live a healthy lifestyle using Western resources.

The basic problem for Aboriginal people living in remote Australia is that the educational outcomes are such that they are caught between two lifestyles. If they could live their traditional lifestyle—it had many aspects which were healthy—but they cannot live that way anymore. They are also not getting the knowledge, skills and resources that they need to live a healthy lifestyle beside Western culture, because the education system is failing.

The education system is failing for a very large number of reasons. All of the international evidence and relevant local evidence tells us that we have to work very hard at the educational dimension, as well as at providing improved housing, nutrition and so

forth. The difficulty is that there are also questions of ownership and ideology about how the education system should work. It has been difficult for people coming from a health perspective to develop a working interface with the people who are responsible for education, and some of the health implications of education are no longer trendy inside the educational domain.

By about 1950, when the health transition was largely complete in the rest of Australia, a large part of health education, as a core part of the curriculum teaching health knowledge and skills, dropped out of the school curriculum in the 1950s and early 1960s. That has not mattered in mainstream Australia, because people learn those skills at home, but it does matter in remote Aboriginal Australia, because there you have not yet got a generation of mothers and grandmothers who have learnt the knowledge and skills to use Western foods appropriately and to understand issues of cross-infection and issues relating to the adequate use of health services—if the health services are available—and so forth. The issues of remote Australia are not only of providing the hardware but also of providing the software: the knowledge that is needed to make more effective use of health resources.

Mr QUICK—The other day we had what appeared to be a national catastrophe, because Sydney people had to boil their water. A few people were actually sick because they were drinking polluted water and, yet, in the remote parts of Australia, in the Aboriginal communities, that is part and parcel of existence.

Prof. Mathews—Yes. I am not quite sure how one deals with that point. Clearly, the maximum disaster in Sydney would have been greater if the level of contamination had been high enough, because of the large number of people at risk. As far as we are aware, there was no actual translation of the hazard into poor health outcomes; yet, on a day-to-day basis, Aboriginal people in remote Australia are experiencing hazards and are actually becoming sick because of those problems. The high rates of childhood admission to hospital are partly due to water supplies that are not safe. They are also due to poor nutritional practices and poor hygiene practices. We have got direct evidence from a community in Arnhem Land where a water supply was not being chlorinated, and it is very likely that there were deaths attributable to that lack of chlorination. That is objective data. As far as I am aware, with the scare in Sydney last week or the week before, there is no data to say that it actually translated into harm to anybody.

Mr QUICK—Surely there must be local government protocols to say that a community should have standard, basic access to water, sewerage and adequate housing?

Prof. Mathews—In theory that is so but the problem hitherto has been that there has been divided responsibility in all these areas. You have government officials, whether they are sitting in Canberra or Darwin, who have what pass for policies but the capacity for a remote community to administer those policies is greatly inhibited. You may have a very small number of people in the community who are being focused on by 20 or 30

different external agencies, all trying to get the community to do what they say needs to be done to improve the quality of services and health infrastructure in that community, and there are no mechanisms for putting more resources into the community to get the intersectoral cooperation that is needed in order to comply with the requests.

Mr QUICK—How do we get over that situation? We visited an Aboriginal community where people were living a traditional lifestyle. There were 30 or 40 'Western' houses that were totally empty. After torrential rain people who had their wounds fixed up had to walk through puddles and lakes of water. Surely someone could realise that something needed to be done. Who was imposing whose will upon whom? For us, coming from the outside, it was obvious that years and years of funding had achieved very little. Who had to grasp the nettle and say, 'We need to go back to square one'?

Prof. Mathews—The issue about resources is that, if you actually look at the resources that have been put into Aboriginal Australia compared with the resources and public infrastructure that have gone into the rest of Australia, the investment in public infrastructure in the rest of Australia has happened over a 100-year time frame and what has happened in Aboriginal Australia has been over a much shorter time frame and we have not had a similar investment in working out how education across a cultural interface can be made to work in Aboriginal people's interests.

The lack of Aboriginal people who are effective in dealing with the outside world is one of the very significant problems that everyone is grappling with at the moment. The analogy that I use when we are looking at the issues and the gap in knowledge, understanding and capacity to effect change is that, if we look at our great-great-grandparents living in the slums of Melbourne, Sydney, London or wherever, we do not dump on them because they were in a social situation which they did not have the knowledge and resources to change. We have to get the blame out of this and we have to bring the country along with us to understand that we are asking Aboriginal people, most particularly in northern Australia, to grapple with a cultural change which our ancestors took 200 years to work through. It was much easier to work through it when it was incremental and when one was not torn between two cultures, as Aboriginal people in remote Australia are. I really think that we need to compare the plight of Aboriginal people with the precedents that matter.

We need to look at health transition in the rest of the world as a guide. In almost every country in the world where a health transition has happened, it has been driven by more effective education. The education area is one that unfortunately has also become a bit of a battleground because some people have said that educating Aboriginal people in a Western style is going to destroy their culture. My personal view is that, unless Aboriginal people have the skills of Western education, they are not going to be able to protect themselves and use what Western society has to deliver.

At this time of change and social turmoil in Aboriginal communities, people say

there are no jobs. Again, my personal view is that the growth sector for Aboriginal jobs lies in the process of self-education and helping to produce a generation of Aboriginal people who have the knowledge and skills to do what is required to turn their health around and provide improved services and resources. There are some good programs that have started to work in that area.

But some initiatives in that area get tangled up because people coming from different perspectives struggle to control them. That is one of the reasons why I think that cooperative initiatives such as the CRC are very important. We have two universities, the Menzies school, two independent Aboriginal organisations and the Northern Territory government, through Territory Health Services, cooperating to try and explore some of the deep issues about how you unpack the knowledge base and skills base and get projects going that can help to solve some of the cross-cultural problems that everyone has been struggling with.

Mr QUICK—I have seen what the Maoris have been trying to do with total immersion schools, trying to have two streams so that you can cross from one to the other. I guess the Aborigines' education system pre-1788 was set in place for their existence, so I appreciate what you are saying. I think we have one Aboriginal dentist in Australia, which is absolutely appalling in my mind because I would like to see droves of them. I am not too sure how many Aboriginal doctors there are. We did meet one in Melbourne.

Prof. Mathews—There are about a dozen.

Mr ALLAN MORRIS—Thirty-two.

Mr QUICK—Allan Morris is always espousing the wonders of the University of Newcastle and the program that it is doing but it all seems to be a scatter gun approach. Because we live in states and territories and all want to do our own thing and because someone has drawn arbitrarily a line which means that you are in, say, South Australia, Queensland or the Northern Territory, there does not seem to be a collective approach nationally for a solution.

Prof. Mathews—I regard Aboriginal health as the biggest single failing in the public sector in Australian history. It is basically because the communication channels between where the problems are being felt and Canberra are far too long. The difficulty has been that, within the bureaucracies that have been dealing with it, the understanding of public health issues and social and cultural issues has not always been there. The squabbles about control between various levels of government, between governments and between Aboriginal organisations and non-Aboriginal organisations often have not been about what should be done but about basically who should control something.

If there were a better understanding of the issues that people shared and

understood, then people would actually come together and talk about solutions rather than about control. That is one of the reasons why the Menzies school has put a lot of effort over the last few years into public health education in the Northern Territory. We are working with the Northern Territory University to try to offer public health education not only at masters and postgraduate diploma levels, but at the short course, certificate and diploma levels, to try to make sure that many of the people working in the public sector, whether for governments or for Aboriginal organisations, have an opportunity to get a bit more content knowledge about health issues to inform their policy making and practice. That is also quite important, because we have found through our public health course work so far that when people come together from different organisations in an educational or problem solving type environment they tend to leave their ideological hats at the door and they are prepared to talk about the issues rather than about who is controlling what.

It is very difficult in a bureaucracy if the person at the top is not fully informed about the content issues, because they are not able to judge whether their subordinates are well enough informed to take the appropriate action. That does not matter when a public sector system is working well, because you do not need to change it. You just need to trouble-shoot the squeaky wheels. But if a system is not working up-front and you need to manage change, the sorts of bureaucratic structures Australia has got are not very good at solving problems of that kind. The systematic way of improving that is to bring some of the government decision makers and administrators into a framework where they have an opportunity to talk about the content issues and do some trouble-shooting, workshopping and discussion.

Mr QUICK—All that sounds fine, but we still have trouble getting a doctor at Yuendumu. How do we put practical solutions in place so that when doctors graduate from a Sydney or Melbourne medical school they say, 'One of my options is working at Kintore, Yuendumu, Daly River or wherever it might be,' rather than the vast proportion staying on and furthering their career in the CBDs of Sydney and Melbourne? We cannot solve that. We cannot get enough dentists, speech therapists and all the rest of it. What would your solution be? Do we say, 'Here is $50,000 and you can be in the top 10 of the pecking order to get into postgraduate studies in the medical schools in the hospitals in Sydney and Melbourne'?

Prof. Mathews—A number of people have spent a lot more time thinking about that particular issue than I have. Sam Heard, whom we recruited from Britain a few years ago and who set up the Centre for General Practice in Darwin and is now running the Department of General Practice at Flinders University up here, put a lot of time in working out how to support doctors in remote communities. There are no magic solutions. You have got to find people who are not primarily motivated by money, but who are going to be supported so they can do a good job. To do a good job they need support with things like leave to get away, support for their family, the kids' education and all those sorts of things. At the moment all of those support structures are all pretty ad hoc.

Mr QUICK—Why has the medical profession not put in place structures to get bums on seats out there? The medical profession say it is the Commonwealth health department's responsibility or it is the Territory Health Services' responsibility. Why cannot the medical profession say, 'Stuff them, it is really important that we get medical practitioners out there. We will design a program and we will show them and do it and then say, "In order to keep it going we need extra resources and funding"'?

Prof. Mathews—The AMA has on several occasions in visits up here made a commitment to help with that. I have not personally been involved with the discussions in terms of following up on its proposals, but part of the problem is the divided responsibility. There are some radical ideas circulating. Some people are now suggesting that all medical services for Aboriginal communities be privatised and put out to tender. That is one model. Other people are suggesting that the government get out of the way and just let Aboriginal controlled health services deal as they can.

There are not only the recruitment problems; there are the issues of finetuning, for instance, the Medicare system to make sure that funds can flow to those remote communities on a needs basis. Up until recently there has been almost no Medicare type funding to remote communities which has contributed to the gross underfunding. Many of you would know of the disparities in per capita funding for primary health care services as of a year or so ago. There was as little as $600 or $700 per head being spent in some government serviced communities in the Northern Territory whereas at Nganampa Health Service in the north of South Australia about $1,900 per head per year was being spent.

John Deeble's latest summary says, 'If you take government and private expenditure into account, then for a given social class Aboriginal expenditure is roughly the same as for non-Aboriginal Australians.' Even that is conceiving a gap because the health needs even at a given level of social class are much greater for Aboriginal people. So there are the issues of education and adequacy of resources and then the political issues of what model of service delivery are you going to use. I have got a firm commitment that the model has to be Aboriginal controlled. Aboriginal controlled with a tendering process for the provision of services from the private sector might be a way of cutting through all those problems, providing that the funding models are set up in such a way that the funds can flow to meet the need.

Mr QUICK—Is there a model working anywhere or are we still trying to figure out what the model is and then saying, 'We need X number of dollars per capita to put this model in place'? Are we still searching for the model or can you say, 'Community X has got something approaching the right model and rather than people going to Sydney and paying a fortune to listen to some eminent people presenting papers they could go along and spend a week out at community X and say, "Here's the solution"'?

Prof. Mathews—The problem is the huge gap between recommendations for trialling things and any action. For instance, we did a model plan for Maningrida to set up

a health service. It is now two and a half years since that was done and about two years since the report was submitted to the Northern Territory government. There has been almost no action.

Mr QUICK—What does that say about the system?

Prof. Mathews—That says that the position of the Northern Territory government is that they do not want to lose control and they do not think they have got the money to fund it properly.

Mr QUICK—It was interesting today when they came in front of us and said, 'Things are going well. There is an intersectoral approach.' I notice that they dumped on us their environmental plan for the next millennium, but there was nothing about Maningrida sitting around toeing the ground for the last two and a half years, and their needing an extra $1.7 million—or whatever the figure might be—to solve the horrendous statistical information that you put here in your submission.

Prof. Mathews—That is right. The issue is that at the moment there is no mechanism to allow resources to flow directly to meet health needs in relation to the provision of services. The coordinated care trial is cashing out the average Medicare contribution to go to Aboriginal communities. That by itself is increasing the resources substantially compared with what they were before. If you look at some of the morbidity information that is available through our work and the work of others, it is very clear that that resourcing is inadequate.

So even just talking about clinical service provision and preventive programs at the community level that are basically health programs rather than education or nutrition programs, there is no mechanism at the moment to allow adequate resources to flow. That contributes to the issue in terms of providing medical officers because, if someone is in a situation where they cannot cope with what they are faced with because of the overload, then they have to either practice second-class medicine or give up in desperation. Both those things have happened in the past. The thing that will help solve the recruitment problem is if the system as a whole improves and the only way the system as a whole can improve is if a funding mechanism is found to really allow resources to flow to where they are needed.

Mr QUICK—Do you not think the system is really stuffed though when World Vision suddenly brings a doctor from Africa to say we will work in a remote Aboriginal community in the middle of Australia? What does that say about the rest of us? It is hopeless. We have been studying this problem as a parliamentary committee since 1977.

Prof. Mathews—All I know is that the awareness is now much greater. When I first came to the Territory 13 years ago, some people were still saying, 'All the health problems are social in origin, therefore we do not have to deliver equivalent medical

services.' I think that argument is now dead. No-one would now argue that Aboriginal people are not entitled to have best practice medical care. It is just a question of how you do it and how you fund it. That was a very important battle which I fought up until three or four years ago. I think things are improving, but a lot of politics still gets in the way of commonsense in this.

CHAIR—We should ask Professor Mathews some questions on research, as he represents a health research facility.

Mr JENKINS—To change tack slightly, in questions earlier today Mr Morris expressed a degree of frustration about the level of research into a number of those things which are important in Aboriginal health. I make the observation that your organisation is one of the very few that seems to be well and truly into doing proper research into the basis of some of these problems. I am interested in whether it is a fair assessment that there is a lack of overall research. After responding to that, I would like you to then say how much progress we have made in a number of the important issues. For instance, this morning there was a bit of discussion about how much we know about the renal health problems here, especially in central Australia.

Prof. Mathews—It is true that we have been one of the few organisations that has been able to do substantial research. The reason why we have been able to do it has been that we have worked very hard to try to build a partnership with Aboriginal people. A lot of the work in relation to ear disease and renal disease has been done with the Tiwi Island people, and I think you are meeting with Chris Harrison from Nguiu later. They have clearly understood that the new knowledge and the research in both ear disease and renal disease has been of benefit to their health. We now know that improved primary care and treatment will improve ear outcomes. It does not totally get rid of the ear problem, but the NHMRC funded trial we have done has made substantial improvements.

We know from Wendy Hoy's work with the renal disease that if you diagnose it and people get onto treatment early it seems to slow down the rate of progression of renal disease. In terms of long-term prevention, you do not want to have to be treating half or two-thirds of adult Tiwi in order to stop renal disease developing. We think we know that childhood infection, malnutrition in childhood and, particularly, we believe, infection and poor nutrition during maternal pregnancy are a factor. If the mother is harmed during pregnancy then the baby is harmed during foetal development, and that harm may extend to its kidneys and maybe its immune system, which then makes the child very vulnerable to additional insults in childhood, and that child will then grow up and be at greatly increased risk of renal disease, diabetes and probably heart disease.

That concept is very consistent with some work which has been done overseas, but we have extended the concept with the work here. That is one of the other reasons why the latent period between a health input and a health output is going to be long. If the harm to a child in utero is translated into poor health when that person is an adult, you

have a 20-, 30-, 40- or 50-year latent period built in. I do not want any of that to be misinterpreted. We have to act as soon as we possibly can and we have to be driven by best practice and by our best understanding of these issues and not be hindered by any mistaken notions that you have to show that this particular expenditure now is going to translate into an improved outcome tomorrow, next week or next year.

In some circumstances with some of the short-term outcomes that is true, but with some of these long-term outcomes we are now just understanding in relation to our work with Aboriginal people, something that our great-grandfathers intuitively understood three generations ago when these problems were still happening in the Western world, and because the change was so slow they did not fully understand what was happening. Now, with the wisdom of hindsight, we can translate what we know now, look back historically and understand things better.

Research is important. With the sort of research that needs to go forward and the sorts of things that we are doing under the umbrella of the CRCs, how can we get better communication between the domain of Aboriginal culture and the domain of Western knowledge so that partnerships develop? The CRC is working very hard there. We have an Aboriginal majority on the board. Lois O'Donoghue is chair of the board. We have cooperative projects in education and health areas, health services areas, public health areas, the communication area, and biomedical research.

We have very highly motivated researchers, because there are fascinating problems to be unscrambled, but when you are thinking about the practical benefits, you have to keep coming back and saying, 'What comes out of the research that will drive policy most directly towards improvement?' Clearly, with the umbrella of the CRC, we are trying to get as much of that policy relevant research done as possible. Through NHMRC, it is possible to fund research that is more interesting for the scientist but is not necessarily directly relevant to rapid improvements in health outcomes.

The other thing is that, in terms of the partnership with the Tiwi, we have now got to a stage where the Tiwi were genuinely concerned about the amount of research being done with them, despite the fact that it had led to very direct benefits. For instance, the coordinated care trial which would improve their services was going to be done with Tiwi people, but because of their concern about the amount of research, we have now just negotiated a legal agreement with the Tiwi that will give legal force to their control over the research that we have been doing.

We believe that that is a first in Australia. It may even be a world first as far as we are aware. That is important because, from a researcher's point of view, a researcher would always want to think that what he was doing was justified in terms of the benefit to health, but clearly a researcher always has a conflict of interest because he wants to publish what he finds as well. That potential conflict of interest has made researchers a bit vulnerable to people from other walks of life who can say that because of the conflict of

interest maybe researchers are not being as punctilious as they might. Certainly, despite our great attention to detail in relation to ethical matters, rumours have been circulated about our work. As far as I can ascertain, those rumours are totally unfounded, but nevertheless, in developing this legal agreement, the way that we have negotiated it with the staff is that it is going to help protect them against any unfounded allegations.

Mr JENKINS—So it is more than just the protection of information and privacy concerns, it also goes to—

Prof. Mathews—We have always acknowledged that clearly because you cannot do any research without anyone's consent and because Aboriginal people have a communal approach to those issues as well as an individualistic approach. It has always been the case that we would never be able to think about a piece of research without negotiating it with the community and since 1991 that has been written formally into the NHMRC research guidelines.

We have gone one step further than that. We have put it into a legal agreement to make it very clear that the community do have that. The protection researchers get helps protect them against any unfounded rumours but also, once the community has agreed to a particular proposal, the only circumstances under which the proposal could not be finished are if we breached the agreement that we have made or in the circumstance of an Aboriginal person dying, then their next of kin would have the right to request that the samples and data from that person be taken out of the study. So that agreement we believe is an important stage in our partnership with the Tiwi. One of the reasons we have been able to develop that agreement with the Tiwi is that because of the coordinated care trial they have more infrastructure and resources than they would have had a few years ago.

I mention that because you would be aware that, going right back to the 1970s, a lot of Aboriginal people have been very critical of research. It is very easy to see that the research that was done up until the 1970s was totally for the benefit of the researcher—curiosity based research. We believe the sort of research we have done has not been of that kind and the legal agreement we have negotiated gives expression to that.

CHAIR—They still say to us that they have been questioned, surveyed and swotted out, and they are tired of it.

Prof. Mathews—That is right. That is one of the reasons we said to the Tiwi, 'You control it and here is how you control it.' If they say to us once the agreement is in place that they do not want any more research done, then we have to live with it. They also understand the benefits that have flowed in the past and the benefits that might flow in the future but the final decisions rest with them, as they always have done.

I have also had to make sure that all my researchers understand what ought to be very clear to them, that a research association with Aboriginal people is a privilege, not a

right. That is particularly hard for some of the medical people because when doctors are working in a health service capacity they get into the habit of thinking that whatever they do is totally justified; it is for the benefit of the patient.

What the doctors have to relearn when they move from a service environment either full time or part time into a research environment is that suddenly the balance of proof flips over. Instead of them automatically assuming that what they want to do is justified because it is for the benefit of the individual patient, when it is a research thing there is a much higher ethical standard. I have managed to, if you like, reprogram the young enthusiasts when they have come to work with us, but one of the other consequences of the legal agreement is just to make it very clear where the control lies.

Mr ALLAN MORRIS—Firstly, I would like to draw attention to the fact that the four pages of references that you have indicates that an awful lot of stuff has been written and, yet, on page 5 of your submission it makes reference to there being 'strong circumstantial evidence' to suggest that low birth weight—amongst other things—might lead to kidney disease. On page 7, it says that adults and adolescents tend to consume a diet high in sugar and saturated fat which may lead to non-insulin-dependent diabetes. Further on there is the suggestion that vascular diabetes related to kidney damage and other things may be related to GAS infection. All those amaze, and it is fairly clear that we do not actually know. On page 14 you say that:

> Until the arrival of Dr Wendy Hoy in 1994, there was no community based approach to the early diagnosis and treatment of renal disease.

I guess I find all that a bit perplexing. There has been an awful lot of stuff written, an awful lot of anecdotal evidence and an awful lot of conjecturing.

Prof. Mathews—Let me tell you the story. There was nothing being done in renal disease until we got support from NHMRC in 1989. We documented the problem. Wendy Hoy came on a part-time basis in 1991-92 and in 1994 she came on a full-time basis. We began lobbying the government as early as 1990. We organised a review of dialysis services at Nguiu in 1992. The report from that has been sitting ever since, with both the Commonwealth blaming the Territory and the Territory blaming the Commonwealth for nothing having happened. We fed all this information back into the public health sector. Wendy Hoy has worked with the Tiwi people to help get the Tiwi for life program going, which is going to work on nutrition, improvements in hygiene and living conditions and improved control of infectious disease and so forth. So it is not true to say that nothing has happened.

To come back to your statement that all those things are conditional, we think all these things are important, but we cannot prove it. But we believe it is so plausible that it is now driving the public health interventions. If we were to sit back and wait until we had proof, that would be a perfect excuse for not doing anything. The definition and the

demarcation between public health and science is that, all the time in public health, you use the best available scientific evidence, but you still have to take action before you are totally convinced of what the causal connections might be. If we waited for final proof, we would never do anything.

Mr ALLAN MORRIS—If we were to say that about any other serious epidemic in this country, we would be a world laughing stock.

Prof. Mathews—No, not at all—it is the wrong way round.

Mr ALLAN MORRIS—Let me put it to you another way. When the AIDS epidemic started and people first started being diagnosed with this previously unknown condition with unknown causes, we turned heaven and earth to try to get a scientific basis for the condition. Here it is all still circumstantial and anecdotal.

Prof. Mathews—I do not think you actually understand.

Mr ALLAN MORRIS—You do not have to defend what is happening. The figures from the department suggest that there will be 662 people on dialysis, and the fact is that we do not even know why.

Prof. Mathews—We believe we know why and we are taking action. None of the actions we are taking, as far as we are aware, has untoward consequences.

Mr ALLAN MORRIS—Tell me of one program that is trying to prove why. Is there one?

Prof. Mathews—It would not be ethical to withhold the public health interventions that we believe are important.

Mr ALLAN MORRIS—No, do not get it wrong. There are two separate issues here: the issue is—

Prof. Mathews—When one believes the causes are operating on a time frame that is measured in years, one has to take action without being able to test the hypothesis rigorously.

Mr ALLAN MORRIS—I am not arguing about that; that is not the argument. I will come to the action in a moment; that is a separate issue. What I am suggesting is that we are facing an epidemic. We have hundreds of people who are facing imminent death unless there is massive technical intervention, which, in many cases, will be impossible because it would mean removing them from where they live to somewhere artificial. We are a First World country and we do not know why and no-one is trying to prove why. I am not saying it is your responsibility.

Prof. Mathews—With respect, we are closer to understanding why than anyone else in the world.

Mr ALLAN MORRIS—But tell me of the program that is trying to give us a scientific basis as to why—

Prof. Mathews—But you do not understand. If something is acting over a period of years, the only way to get a rigorous proof of cause and effect would be to randomise people in intervention and non-intervention groups and see if in the intervention group it disappeared and in the non-intervention group it did not.

Mr ALLAN MORRIS—That is one way.

Prof. Mathews—It is totally unethical—

Mr ALLAN MORRIS—It is one way; there may be dozens of other ways.

Prof. Mathews—There are a lot of other circumstantial ways but there is no—

Mr ALLAN MORRIS—Medical research is based on hard science.

Prof. Mathews—Medical research is based on hard science, but we can only draw inferences about things which operate over periods of years. We are better situated to unpack this than anyone else in the world and we are trying to do it.

Mr ALLAN MORRIS—Please do not be defensive; I am not holding you responsible. Is any hard science being done to show biological reasons—

Prof. Mathews—Yes, there is a lot of hard science being done. One of the projects that the Tiwi are looking at at the moment is to see whether there is a genetic basis to renal disease. They are very anxious about the idea of genetic research because it is has been abused by people from outside. If there is a biological basis to their susceptibility, it might be genetic in origin. On the other hand, it may be that the infectious and nutritional insults in the mother are damaging the foetal development both in the kidneys and in other parts of the foetal body.

Mr ALLAN MORRIS—Which means that we should be able to establish that biologically right now. We have foetuses now in which some mothers have had bacterial infection and in which some have not. Is there a difference in their biological make-up?

Prof. Mathews—We can test in the short term—what happens in a maternal pregnancy—but we cannot do experiments on foetal babies. We are doing the best we can.

Mr ALLAN MORRIS—I am not denying that. Please do not be defensive; I am

not holding you responsible. I am just trying to suggest that we—and when I say 'we', I mean all of us as a country—have an epidemic and we do not know why, and we are not doing any research or hard science.

Prof. Mathews—We are, for God's sake.

Mr ALLAN MORRIS—Well, tell me the program.

Prof. Mathews—We are looking at the relationship—

Mr JENKINS—Certainly there is all this work to read.

Prof. Mathews—You can read all the papers. I will send you a review article. The work is ongoing.

Mr ALLAN MORRIS—Which biological laboratory is being funded or is currently undertaking hard science research to try to find the biological cause? It seems to me that all we are doing is looking at evidentiary, circumstantial, environmental and generic issues and saying, 'All the things are gathered and therefore that is the case.' It may well be that the bacteria involved in streptococcal infections are in fact quite different here from elsewhere in the world.

Prof. Mathews—We know that already. We know more about streptococcal infection than anyone else. You are trying to force me into a corner which is totally uninformed.

Mr ALLAN MORRIS—I am not trying to put you into a corner. I asked you a question. I am not trying to force you anywhere.

Prof. Mathews—We know more about this than anyone else in the world. The way that the streptococcal infections may contribute to the renal disease is a matter for ongoing research. Dr Sriprakash in our laboratories is working with people at the Rockefeller Institute in New York, colleagues in India and other colleagues in Germany.

Mr ALLAN MORRIS—I put the same question to the renal institute in Sydney. Their answer was that they did not know of any. I asked them, 'What current biological research into this epidemic that we are having are we funding as a country?' They did not have an answer.

Prof. Mathews—No.

Mr ALLAN MORRIS—I am not holding them responsible either.

Prof. Mathews—No. They are not as well informed as we are.

Mr ALLAN MORRIS—We as a society are a First World country. A lot fewer Aids cases have occurred and we spent, as a country, millions of dollars in research programs.

Prof. Mathews—Sure.

Mr ALLAN MORRIS—I do not see any sign of research—except for the one you just mentioned for the first time. I have asked this question before. When I say 'we' I mean all of us. I do not see it as being your responsibility.

Let me go to the second part, which is the other side of it. We have been talking about the problems of doctors in remote areas and the difficulties of research. We have had the ethical questions and the issues that are involved there come up a number of times. We have also looked at the problems associated with the stature and reward of working in Aboriginal communities. Would it be possible to consider a way in which medical provision, medical services and research could be linked? For example, a person on contract to provide a medical service could, at the same time, be part of a research program on, say, diabetes, nutrition or skin conditions as part of a broader national program so that at the end of the contract they had not only been paid extra for the work they had done but also had enhanced their professional status because of that work.

Prof. Mathews—Sure. The contribution of Fred Hollows in the 1970s in relation to trachoma in Aboriginal people was to say, 'No research without service.' With the research programs on renal disease and ear disease with the Tiwi, virtually all our work has been carried out by people who are clinically qualified and who also help to provide service. However, there is the complex issue that you need to have a situation where the research endeavour is not submerging the service and not bending things ethically. One of the difficulties in this area is that researchers are always, in a sense, slightly at risk because what they do has two outcomes. If they are providing services there is a service outcome, but if what they do for research purposes overlaps with what they do for service purposes then they have a potential conflict of interest. That is an important potential problem, particularly in relation to research with Aboriginal people. For the reasons I mentioned before, how we resolve that is an ongoing issue.

Mr ALLAN MORRIS—Australian institutes train quite a few people, particularly from developing countries, in epidemiology. We seem to have worked out ways there where they are able to both provide a service and carry out their epidemiology research at the same time. There is no reason why it cannot be done.

Prof. Mathews—There is no reason why it cannot happen but—

Mr ALLAN MORRIS—If the committee was of a mind to say that the way to best try to encourage people to work in remote areas in Aboriginal health was to enhance their status and provide more funds, a way to do that would be via a research program—

research in a very broad sense. It would obviously need to be community agreed and owned as well as of national or international value. Would an institute like yours be an appropriate vehicle or would it best go to a university school of tropical medicine? If we were of a mind to try to explore that avenue, what would be the best vehicle?

Prof. Mathews—Clearly, a model of that kind could make a contribution but I would think that it could not make more than a contribution because if the primary motivation for someone to go was to do research, there would have to be all sorts of safeguards in place to make sure the service delivery side of it was well looked after.

You may wish to discuss some of these issues with Dr Harrison, who has been delivering health services with the Tiwi and had an association with our researchers. He could speak in more detail about some of the problems of the gaps between research and service.

Mr ALLAN MORRIS—One of the criticisms we have had from the Aboriginal community is that researchers come in for their own benefit rather than for the community's benefit. Anybody going in primarily for research is going to be suspect anyway, so even thinking about that would be a bad thing because it automatically means that the person involved is out to enhance their own career. So, because they are so specialised and educated, if the primary purpose is to help provide a service, they can actually help with the bigger picture while they are there.

For the funding stream to be professionally based and part of a national program, one could argue that it should come from one of the medical schools, the school for tropical health or, one could argue, through your CRC.

Prof. Mathews—Sure. I do not have an in principle problem with it, but I think it would have to be done in a way that Aboriginal people were comfortable with. In a sense, the reason why the Menzies school has been able to recruit good people is partly because of that. People who have a commitment to do some good but also have academic interests are the sorts of people who come to work for us.

Mr ALLAN MORRIS—We will not be finished for quite some time after today because there will be an election held in a couple of months time. Would it be possible, in your spare time, to jot down some points to take into account so that it can be looked at in more detail?

Prof. Mathews—Yes, I can do that.

Mr ALLAN MORRIS—That would be helpful so that we can at least argue amongst ourselves. Whether or not we can agree is another issue, but we have not had much on that in particular.

CHAIR—Dr Harrison is here and has been waiting. We are half an hour behind the time we allocated but, if you are happy to wrap it up there, I will say thank you to Prof. Mathews. We look forward to any information you would like to convey to us in the future.

[2.33 p.m.]

HARRISON, Dr Christopher, Julanimawu Health Centre, Nguiu, Bathurst Island, Northern Territory 0822

CHAIR—We have a submission from you. I notice it is dated August last year and came with a handwritten note on the bottom which reflected some frustration which has perhaps abated since August. Part of what we are discovering in our inquiry is the frustration amongst the people who are working at the coalface, so we would be pleased to have an exchange with you.

I have to point out to you that this is a formal committee and, although we do not swear our witnesses, these are proceedings of the House of Representatives and warrant the same respect as proceedings of the House of Representatives itself. This means that any deliberate misleading of the committee would be considered a contempt of the parliament.

Your submission, albeit brief, is already part of the published volumes of our inquiry, and there are no doubt a few things you would like to say before we proceed to questions. Bear in mind that my colleagues get a bit frustrated and want to hop in and get right to the bone early. I am particularly interested in your insights, being at the coalface. We will be visiting Bathurst Island at 2 o'clock tomorrow, so we will probably have an opportunity to follow up on some of things we talk about today.

Dr Harrison—A lot of the broad issues have been addressed by Aboriginal organisations and larger representative groups, but my focus was more on some of the practical, easier and obvious things that should be done. A lot of the points speak for themselves. One of the things I was trying to get across was to try to minimise the bureaucracy.

CHAIR—Are there any comments you would like to make? It is more than 12 months since you wrote your submission.

Dr Harrison—One or two things have happened. Dr Wooldridge has funded the vaccination programs, which is one very positive step as long as we can access the funding that is made available. Part of the problem is that the funding sometimes goes directly to state governments and is lost in the administration, and semi-independent health services do not have access to it. So I would make the point when it comes to actually delivering the funding to health services, make sure that we can access it. That is one very positive thing that has come.

CHAIR—It does describe Medicare in remote areas as a 'disaster'.

Dr Harrison—I guess that is another thing. I am involved in the coordinated care

trial now and it is a disaster in remote areas. The larger urban areas can access it with enough administrative support. BRAMS, where I have worked previously, do fairly well. But in places like Nguiu and the Top End—the east Arnhem communities—it is extremely difficult to access Medicare funds. We get about 100 clients per day at the health centre. I see 20 to 25 clients and do Medicare for them. If I were so inclined, I could bulk-bill 100 patients per day, 500 per week and generate a quarter of a million dollars per year, if that was the track we went down, which is possible. The nature of my work is looking at the public health programs, community development, training health workers and that side of things rather than seeing patients and generating income to cover our costs. I think the model for cashing out is a good model—

CHAIR—But does your participation in that coordinated care trial revise that comment?

Dr Harrison—Yes, it is quite a good model and for us it is working. There are a few hitches which we should probably talk about tomorrow. It was cashed out at a two-years-old level—not actually our current level—which is a problem and it turns out to be quite a bit of money. But with administrative resources, we do not have to do the forms every day and it is much easier for the health board to see how much money they have. They can say, 'That is the amount and that is the population.' It will not work for all health services but, for ones like ours which have a lot of health workers—we have 13 health workers, three nurses and one GP at the moment—it is a very good model, I think.

CHAIR—I interrupted you. It sounded like you had a program you wanted to run through.

Dr Harrison—No, I will just talk as we go, so if you want to just fire questions—

Mr ALLAN MORRIS—Does the coordinated care trial address the question that your submission raised in terms of Medicare? You are involved in it now, I presume.

Dr Harrison—Yes. It addresses the Medicare issue but it does not address the administrative issue. We have 10 times the number of administrative requirements to fulfil and a lot of the time of the health board is taken up with those administrative requirements. But it is much better. On the ground it is better.

Mr ALLAN MORRIS—We will see it at first hand tomorrow, but perhaps some of those requirements are because it is a trial. Do you think so?

Dr Harrison—Yes. That is why I accept it. We accepted that with a trial we would have to do all the evaluations. We have local evaluators, national evaluators, THS evaluators and evaluators of the evaluators.

Mr ALLAN MORRIS—One of the things we were concerned about when we

spoke to the department about that trial was access to pharmaceuticals and so on, because of the problem with pharmacists and there not being a channel. Is it actually doing that? Is the use of pharmaceutical medications being improved on Bathurst Island?

Dr Harrison—It is. We have enough money to treat people with treatable diseases. There were issues before about access to PBS. I mentioned some of the issues with health care cards and those sorts of things. Our pharmacy budget was rising exponentially. Menzies had done a lot of research. In 1994 we had got all these great screening things and the notes for anyone who had proteinuria or diabetes or hypertension and they were not being treated yet. So during the last two years since I have been there, there has basically been a treatment program and we are actually identifying the clients, offering counselling and advice and actually treating the diseases with medication if that was indicated. We now have enough funds to cover those costs.

Mr ALLAN MORRIS—So your question about the CDEP workers is now picked up? The health care card is now—

Dr Harrison—We do not need a health care card for medications because PBS money is directly cashed out as part of the budget so we do not have to go through script writing to the private pharmacy and getting the script back. If they did not have a health care card number they would have to pay the full price of the medication—the $20 or whatever—instead of the $3.20 if they are on a health care card. That is still an issue across the Top End. If they are on CDEP, which is just a little bit more than the dole, they do not automatically get a health care card and have to do all the paperwork which most people do not do. As I have already said, I have to really chase them up. They are just the simple things; for places that access private pharmacies, that would save a lot of paperwork. More than half the population has a health care card. But, as part of the trial, that no longer holds because the money has been directly cashed out to the health board, so that we order our pharmacy in bulk and it is paid for by the health board. It has bypassed all that administration.

Mr ALLAN MORRIS—So it has helped solve that.

Dr Harrison—Yes.

CHAIR—After the trials are out of the way, with fully fledged participation, the special card for CDEP recipients would not be there.

Dr Harrison—It still will not be there, unless they have actually registered for a health care card. So, come 1 January 2000 or 2001—whatever it is—we will possibly revert to the old system. Depending on whether they decide to continue the trial, we will be back to that system.

Mr ALLAN MORRIS—Regarding point 11 of your submission, has it improved

since you wrote it? It is the Telstra one, about the actual communications.

Dr Harrison—The short answer is no. The long answer is that we have had lots of visits from Networking the Nation, and other parliamentary committees have actually come out and looked at telecommunications; but nothing concrete has come through yet, and there will not be any more phone lines to the island until next year.

CHAIR—There has been one. The Tanami project was funded through that program.

Dr Harrison—Yes. The Tanami is probably a good example of how telecommunications can be used effectively. But many rural communities have terrible telecommunications systems. We had a breakdown incident where it took Telstra five days to come out and fix the phones. The whole island went out.

CHAIR—Are you aware of any projects that have been submitted for consideration through that RTIF program?

Dr Harrison—There are a lot of projects. Sixty six communities are going to get a 128 kilobyte link which would support basic videoconferencing and teleconferencing facilities, which will be fantastic. There are four sites that have been chosen for electronic outback services and we are one of them, which we are quite looking forward to. Hopefully we will get some videoconferencing software and maybe some medical technology things to use.

We have a problem with a database which they have designed as part of this trial. You are supposed to be able to dial into each community remotely but the phone lines are not good enough to do that. When they actually introduce the new services, we should be able to dial the other islands. If someone comes from Melville to see me about their high blood pressure, I should be able to dial into their database and look at what medication they are on and what medical problems they have. That should be one definite improvement. They service the database from town and it drops out all the time, so when that infrastructure improves, that should improve things as well.

CHAIR—If you were aware of any other projects we may be able to recommend them. In one of our other reports—I forget which one it was—we came across one of these which we recommended should be funded and it was. That was telemedicine.

Dr Harrison—I think a lot of it is just the basic telecommunications. It is critical that they get the lines working, have good service and repair facilities, and have enough phone lines.

Mr ALLAN MORRIS—And enough bandwidth.

Dr Harrison—And enough bandwidth, yes. That is one of the critical issues.

Mr ALLAN MORRIS—Dr Harrison, one of your medical colleagues made a submission to us and said in it:

Most female bush nurses are anti-doctors and most DMOs are anti-Specialist.

Dr Harrison—That probably comes from the lack of recognition by more central services of the work we do and of our role.

Mr ALLAN MORRIS—But is it an accurate statement? Would you agree with that person's view?

Dr Harrison—I do not think we are anti-specialist or that nurses are anti-doctor. There is certainly some friction between remote nurses when the GP comes to the community, depending on what sort of role they are going to play in that community. I do not know if you are aware that a lot of remote communities are serviced by nurses or good bush nurses. They run many of the programs. Difficulties arise when a GP comes to the community because the nurse has actually got a GP's role. The health workers probably see the bulk of the patients. The nurse is a consulting sort of person. Then a GP will come into that community and their role will create a difficult situation. It depends on what the community wants and what the health centre wants—balancing up those sorts of issues.

Mr ALLAN MORRIS—That could be the case in some cases, but it is not universal.

Dr Harrison—Certainly not, no.

Mr ALLAN MORRIS—Going slightly further then: can you perhaps talk a little bit about how you see the hierarchy and integration of Aboriginal health workers at level two or level three and nurses? We have been told that in some places the Aboriginal health workers, often regardless of their training, are in fact treated as second-class professionals. Even if they have got level three qualifications, they are still treated as if they are—

Dr Harrison—I can talk from my experience at Nguiu. We have a health centre with 13 health workers, three nurses and one GP at the present time. It depends how you work. We basically work and see each other as part of a team with equal responsibilities. The senior health workers, nurses and doctor are part of senior management. We work by consensus. No-one is the boss or in charge or in total control of the health centre.

Health workers have certain skills and certain roles. They know the patients a lot better, are able to talk to them and communicate much more freely and can often get to

the core of the problem a lot quicker and access the patients. The nurses certainly have more in terms of clinical skills, that sort of medical background. I guess the GP is often seen as the third-line consultant. That is the way we work. A lot of the diseases are extremely complicated—multiple medications, sorting things out. Trying to work as part of a team is a critical issue, as is not seeing yourself as at the top of the pecking order, I guess.

Mr ALLAN MORRIS—You carefully avoided the question, and I accept that as okay.

Dr Harrison—I guess every place is different.

Mr ALLAN MORRIS—That is okay. I thought there might have been some anecdotal evidence around, but that is okay. It is a question that is perhaps a bit delicate. I appreciate that. It is okay.

Dr Harrison—It is certainly an issue in the bush.

Mr JENKINS—You highlighted the cost of foods. The AMA have highlighted the accessibility to nutritious food. What practically can be done?

Dr Harrison—There are two reports that might be useful in this context. A report called *Factors which influence food transport to remote communities in the Northern Territory* was done by R. G. Hughes in 1996. We have actually had our own community market basket survey. This is a really important issue. Personally, I see it as an important issue. We pay $363 for a market basket; Darwin pays $266. So it is 136 per cent more. Darwin prices are 30 to 40 per cent higher than Sydney prices. It is cheaper to transport food from Sydney to Darwin than it is to transport food from Darwin to Nguiu or to other remote communities.

There are four recommendations here. They include: setting up a food supply watchdog committee—it might work, it might not; an accreditation scheme for suppliers, which may or may not help; and a management pool for remote stores—that might help. Probably the most practical thing you could do is have some sort of tax rebate for suppliers, transport operators and store owners. By the time fruit and vegies get to our store at Nguiu, you might be paying $1 for an apple. It might cost 5c to produce in Sydney or somewhere in New South Wales.

Somehow we need to link a tax system to the amount of fruit and vegetables that are sold, with the stall getting X dollars rebate for every kilo, or whatever it is, of healthy food they sell. It is expensive to run stores. There are freight costs, diesel, the whole works. The problem at the moment is that the economics are not there. People cannot afford to eat healthily. They have less money to spend and food is more expensive. The cost of living is much higher and we are asking them to buy very expensive fruit and

vegetables that are a bit off or a couple of weeks old. We need some sort of incentive scheme. I do not know how you would do it. Maybe the financial people can work on some sort of tax rebate scheme for stores in remote communities.

Mr ALLAN MORRIS—They could give them a GST instead.

Dr Harrison—Another 10 per cent. Instead of taking 10 per cent, give them back 20 per cent which they could use for development or staff, whatever. I do not know how you would do it, but it is a really critical issue. We are asking people to live and eat healthily and they cannot afford it.

Mr QUICK—Major food chains may be interested in doing something with a social conscience, even to some of the less remote communities within close proximity, perhaps within 100 or 200 kilometres of Darwin.

Dr Harrison—If you rely on social conscience, then you usually get second-grade stuff and it is not sustainable in the long term. You need economic impetus to make it viable. They transport between the major centres. When they come from Sydney to Darwin, if you ask them to stop at Elliott along the way to drop off one load, I do not know—

CHAIR—Has anybody done some real work on how that cost is broken up in terms of the extra margin needed to retail when there is less volume, or the transport cost? If you can identify it, then you can rebate, compensating for whatever that difference is. One of the tragedies with food is an accumulation of all different sorts of tax as it comes through the chain and you cannot identify it. It would be good to get a handle on what the differential is.

Dr Harrison—This goes into some of the specifics, but part of the problem is that every community is different. They are all in different locations. Other islands probably have a totally different system of freight and transport from our system. If you go to the Kimberley, it is totally different again. It might come from Perth or from over in the east. A place like Kununurra might buy from Sydney or Perth, or it might be grown in Kununurra.

CHAIR—For example, for people in Tasmania—Mr Quick would know all about this—we have a transport compensation rebate scheme operating.

Mr QUICK—Freight equalisation scheme.

CHAIR—Freight equalisation—we have done it for Tasmania. It is easy to assess as long as it is identifiable. If it is the freight, it is dearer because it has to be airfreighted out to Bathurst Island when you cannot get it by ship.

Dr Harrison—Is it a state scheme in Tasmania?

CHAIR—Commonwealth to state.

Mr QUICK—Yes. The Commonwealth compensates Tasmania for its isolation. It is a couple of hundred kilometres across—

CHAIR—For example, the way it operates is that my pig producers who send their pigs to Tasmania get it to pay for their freight, so that the price in Tasmania is less.

Dr Harrison—That seems like a very sensible scheme.

CHAIR—Yes.

Mr JENKINS—We might go back to Dr Harrison's point about pressure groups.

Dr Harrison—I guess someone has to run with it. From a local point, it is very difficult to take on a state government or the federal government. It is very hard to know which way to—

Mr QUICK—When you become a state in 2001, if you are going to do something like Tasmania, irrespective of which political party is in power in Canberra, you should argue that this is sacrosanct and that it should be put in legislation so that it is always there. It is something that the Aboriginal communities should say ought be part and parcel of the Territory when it becomes a state—that this is legislated for because of the isolation, not only for indigenous people but for white people.

Dr Harrison—For everyone. That might be a good point to bring up when they come to statehood.

Mr JENKINS—Dr Harrison, what is the role of traditional bush foods? Is that pie in the sky?

Dr Harrison—If you are looking for a cure in the long run in terms of the amount of disease, it is probably the wrong place to look. Periodically, we have had a bush holiday where everyone goes out and lives bush for four weeks, which is fantastic. We go out, do the run and check everyone's blood pressure. No-one has high blood pressure because they are all eating bush food, eating fish and doing lots of exercise. I guess the community cannot spend the whole time out bush eating bush food, unfortunately.

There is a lot of evidence that it is definitely a very positive thing. It is up to the communities to work out how to introduce bush foods into stores. Most communities know bush foods are good. Medically we know bush foods are good. It is a practical matter of getting people to choose that food, putting the energy into getting it or having

time in the modern world to spend out bush eating bush food. Practically, I cannot really talk to that. In some ways it goes back to the communities, but medically it makes a huge difference.

Mr JENKINS—Is it the actual food itself or is it the lifestyle?

Dr Harrison—I think it is both. Fish has fish oils which prevent heart disease. A lot of the nuts and seeds are excellent nutrition and fibre. People are actually going out physically, walking, hunting and digging it out of the ground and men are walking through the bush with guns or spears, whatever. So it is both; it is lifestyle as well as the food itself, I am sure.

Mr JENKINS—I think I know the answer, but I must ask this question. Why can there not be commercial development of the gathering of that food?

Dr Harrison—That is a good question. The actual question might be the answer in that, if you commercialise it, then it might lose its value. It is certainly tied up with culture. What sorts of resources you need to run a commercial operation getting bush food is difficult to say. I know in a place like Kakadu at the hotel they sell emu meat—the whole works. You can get some fantastic food at some restaurants in cities, but to make it commercially viable requires a commercial discipline with large farms or large groups regularly collecting bush food. That infrastructure to support a business may not be there to start with. Some of the grants for starting bush tucker industries are certainly quite worth while. It often depends on the community.

Mr JENKINS—That was the next point. You could set up the scheme but the community must have control of what they are doing. It has to be attractive.

Dr Harrison—Yes. Some of the legislation also works against it. I had a fellow who wanted to sell small quantities of fish to the store but the fisheries department would not let him because he did not have one of the right licences for salmon. It is a very complicated business. Some of the legislation also works against that.

Mr JENKINS—You are here for the discussion about research.

Dr Harrison—Yes.

Mr JENKINS—Is there anything you want to add from your involvement on the ground?

Dr Harrison—On the Tiwi islands, there is a bit of a love-hate relationship between the research people. I am not a great fan of research because there is so much work to be done to get the basic services—nurses, health workers, doctors—on the ground running the basic programs. I guess the Menzies team for us provided a service model,

which is very important to remember. It was not just people doing research. A nurse and two or three health workers were employed. They would do the check-up and talk to the patient about diet, exercise, lifestyle, smoking and alcohol. Then, if they had a treatable disease such as proteinuria, they would be prescribed the ace inhibitor. They also work with us fairly closely. I am the one who writes all the scripts, so they defer to me when people need to start medications. We have that service model with a dedicated nurse or health workers running the program.

They are a bit isolated from the acute care in the clinic, so they are not always caught up with people with sores or some drama that has happened in the camp or trying to fill out some form. They are isolated from that and protected so they can have devoted time for those chronic disease programs. That is one reason why it works. It is a good service model and it is actually providing treatment. There are 250 people on treatment on the Tiwi islands. Physically, I could never hope to do that amount of work, to see all of those people every three months focusing on those sorts of chronic diseases. That work is actually isolated in the clinic.

They put all the copies of the results in the patient's notes. All reports come to us. They ask permission to publish and now it is formalised in that legal agreement, which, I must admit, is quite a good agreement. They have proposed another four projects in our health centre. Some of those we have said no to. It is a love-hate relationship. At the moment there are more benefits than there are cons. We are running with that for the time being. I would also note that we do not have control of the funding. It is funded from external sources. They have an NHMRC grant and now they have money from CRA to run it as well. There is a slight personal ambivalence with that control resting outside the community.

Mr ALLAN MORRIS—Couldn't you be doing research?

Dr Harrison—I could, but there is so much. A lot of the evidence is already there basically. Unless the research is actually delivering some sort of service that is needed, I do not believe it is a valuable type of research for me. Research for research in Aboriginal communities is a bit unethical when there are not basic services on the ground.

Mr ALLAN MORRIS—It seems that in many ways we can train doctors to do epidemiology for other countries but not for Western Australia. We do not see doctors in Australia as researchers, yet other people do seem to see their medical practitioners as potential researchers as well. They do not see a difference between the two. We have somehow created this new separate breed of researchers only. Aboriginals have been saying to us for a long time, 'These people come in and do some research and go away and who cares. We don't care and they don't seem to care.' It seems to me that it does not have to be that way. I do not see any reason why a good doctor could not be part of a research effort.

Dr Harrison—I tend to agree with that. There have been some proposals recently for public health training programs to be integrated into health services. If you are going to do research, the best people are the people on the ground: the doctors, the nurses or the health centres themselves. We respond to what the community council or what the Tiwi Health Board wants. If they want to do research or they want to know about issues such as renal disease, suicide or whatever, then we can gear our work to follow that path.

Mr ALLAN MORRIS—But you have to be owned by the community or there has to be agreement and you have to be part of some broad approach, not some mickey mouse thing of its own.

Dr Harrison—Yes. It is a much better model in many respects rather than a researcher coming in, unless they have been specifically invited in to look at a particular problem.

Mr ALLAN MORRIS—As part of what you are doing? It seems to me that you can have someone come in and help what you are doing, and these may be a dozen different visiting doctors who are also doing research in a similar field and taking it to another level. It seems to me that we have this great vacuum. We cannot even get a doctor in there, yet we send in researchers and doctors but we do not seem to realise that perhaps we might want to do the same together.

Dr Harrison—I think certainly you can. I guess part of our problem is also there is so much of an acute load that we often do not have time to do that basic research. That is where Menzies' role for us has come in. They had a dedicated program to be able to do it and the Tiwi people were happy with them being there. That has worked well for us, but, in the future, if you look three or four years down the track, then maybe the model should be integrated on the ground.

Mr ALLAN MORRIS—I think this is the change you have. You drafters would know what model you think would work and you might help. We will not change the world—don't get me wrong—but I think the answers lie out there with people like you rather than with us as to what may or may not work. I am really suggesting that following today you might have a think about that. We need to find some way of getting doctors working in the communities. We need some way of getting better information and a better understanding. We also need to do it in a way which is compatible with the communities, their culture and their long-term interest. I think you may have a better answer to it.

It seems to me that the researching profession is always going to be under suspicion. The politician is always going to be under suspicion. The people working in the field are probably the most credible. Perhaps you have some thoughts on how it might work, whether it is diabetes, nutrition, renal failure or heart disease. There is a whole range of areas. The circumstances are unique in terms of both the history and the environmental circumstances that it really has to be done out there. It cannot be done

somewhere else.

Dr Harrison—It is an interesting area. I think the two newer models—the coordinated care trial and the CRC—have a lot of value in some of the ways that they are working. They are certainly bringing the communities in with the researchers to look at going forward rather than both looking off in different directions. They are quite good models to run with. Certainly having those agreements is a good idea as well.

Mr ALLAN MORRIS—If you have any thoughts on that, perhaps you could send them on later when you have had a chance to think about it. We would be grateful.

Dr Harrison—Sure.

CHAIR—I am interested in what you could possibly suggest to deliver on point 9 about liquor canteens in communities. It recommends that all liquor licences have community control over licence hours. We have been in communities where elders, particularly the women elders, have pleaded with us. It is almost politically impossible to deliver, unless the community itself does it. A 50 per cent GST on profit sounds like a good idea, as long as the community controls it. It is something the community could do itself in its own managed shop.

Dr Harrison—I have worked in about three different places. In Nguiu, where I work now, the club is actually owned by the community and there is a committee. All the profit goes back to the committee and they decide what they spend it on. They might buy a new play centre for sport and recreation or give us $5,000 for the kids' Christmas party or buy the school a car or a computer. It does not go directly to the health service, but that works really well. So the committee actually decides where the profits from the community go. The community sets the hours and what sort of beer they can sell. We have access to a board where, if everyone agrees, people who have health problems go on it. That is quite a good model.

Halls Creek is the other extreme. There are two licences owned by two people who live out of town. They make about a million dollars a year. All that money goes directly out of town. It is never seen again in the town. The community has absolutely no control. There was a hearing about five years ago where they cut the hours back by about four or five hours—from 24 hours to about 16 hours.

CHAIR—Presuming that they do that by a liquor licence, would it be controlled by the Territory government?

Dr Harrison—Yes. It was the Western Australian state government, but it is extremely difficult to go through. There was not actually any money taken from that profit towards any of the health services. I do not know how you do it from a federal level. In the NT they have the wine cask levy, which funds alcohol programs. That is fantastic. It is

a very big plus. But there are a lot of remote communities or towns where they have no control and there is a huge amount of profit taking. I do not know how you address that. I do not know whether it is a state issue or a federal issue, but it is obviously a hot potato. It works well at a community level. Where we live it is a very good model. As to whether a whole country town can benefit, I would say there is no reason why not. The problems are similar with alcohol addiction and the profits. In terms of health services generally perhaps the federal government could look at it as a way of funding some of the health services.

CHAIR—Dr Harrison, thank you for coming along. We will catch up with you again tomorrow. If there is anything at all that you think you should have said or if you have some more ideas on something, just drop us a line because this is an ongoing inquiry. We do not want everybody waiting for our report before we move to the next stage. It is pleasing that some progress has been made even since the frustrating experience when you made your submission. We are trying to encourage that as we go along. We will leave you with that option.

Dr Harrison—Thank you for having me. Some of those programs are very good, especially the vaccination programs. I commend them. I will see you tomorrow.

Proceedings suspended from 3.11 p.m. to 3.28 p.m.

GLASBY, Dr Michael, Top End Primary Health Care Network and Top End Division of General Practice, PO Box 2052, Katherine, Northern Territory 0851

CHAIR—Welcome. Do you have anything to say with regard to the capacity in which you appear?

Dr Glasby—Although the submission was written on behalf of the Top End Primary Health Care Network, that project as such has ceased to exist under the auspices of the Top End Division of General Practice so I am essentially speaking for myself as a public health trained GP and a reasonably long-term resident in the Katherine region with some experiences from my time as the project manager for the Top End Primary Health Care Network.

CHAIR—Whilst this committee does not formally swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the proceedings of the House of Representatives itself. Any deliberate misleading of the committee may therefore be regarded as a contempt of the parliament. This also serves to protect you and the evidence you give, which is covered by parliamentary privilege.

As you have mentioned, the committee has received the submission you referred to and it is part of the published volumes of the inquiry. The committee is very much interested in talking to you as someone who has been at the coalface. I am particularly interested to talk about your experience and how you actually came to work in the Top End and, contrary to popular opinion, the difficulties you had in getting a position as a new doctor. That is the kind of thing I would like to pursue with you. In fairness to you, though, we will give you the opportunity to make an opening statement to canvass the sorts of things you would like to submit to us—it is nearly 12 months since you wrote your submission. I give you the commitment that your evidence is as important as any other evidence we have received, and we have heard from people all over Australia.

This is an unusual inquiry in which we have broken a few of the normal traditions. We have had Puggy Hunter from NACCHO accompany us on our inspections. Jim Kennedy has been seconded from the department to spend time with us as a parliamentary committee. We have a strong bipartisan resolve amongst the committee members to make some progress on this matter and keep the politics out of it. That is how we feel.

Mr ALLAN MORRIS—Give up the GST.

CHAIR—There is time for that as well. You have met the whole of the committee. I have not taken the trouble to introduce the committee today because we have been coming and going. Harry Quick, the member for Franklin in Tasmania, is the deputy chairman; Allan Morris is the member for Newcastle in New South Wales; Harry Jenkins is the member for Scullin in Victoria; and I am the member for Mallee in Victoria, which

is a large rural electorate. We have a very diverse group of people and there are another eight or nine members who cannot accompany us for every visit.

That is us, so now it is over to you. You have as much time as you like as there are a few witnesses who have not shown up today. It is your opportunity to indicate some of the frustrations you have felt and for us to try to get them on the record and try to do something about them.

Dr Glasby—Thank you very much for your welcome. When I look at my paper in relation to some of the others, the amount of work people have put into this is fantastic. It is really good to see the expertise that you are being exposed to.

As an introduction, I was project manager of this primary health care network because I was one of a few GPs working in a bush community who could take it on. The previous project manager, who lived in Gove, wanted to hand it on to somebody who worked in the community to maintain this rural aspect of it. When my wife and I—she is a medico too—were living in Daly River under an RIP grant, I was able to take up this job as part of my part-time work. My wife and I were job sharing that position so I was able, in the other part of my time, to take on the project work associated with the primary health care network, which is in front of you.

It attempted a multi-disciplinary approach, primarily involving Aboriginal people. As GPs working in the bush, if you do not have a health worker working with you, most of the time you are severely handicapped. This project was actually an initiative of GPs working bush who said, 'We need a team around us. We can't function without the Aboriginal health workers and the nurses. We believe that the current situation', as it was, and is again, 'is inadequate to provide us with the supports required to work effectively in those situations.' This was a Commonwealth funded project which has now, through the evolution of the divisions and project grants, become something different. In that brief introduction you might pick up a degree of dissatisfaction with the existing services provided by the local health department.

I also want the committee to understand I am very positive about the things going on within Territory Health Services. In this area I believe Territory Health Services is not adequate in being able to provide resourcing or planning to really provide for Aboriginal people out bush. I probably do not have as much experience working in bush communities as Chris, but I worked within Aboriginal medical services before in Daly River for a few years. I was trained in public health before we came back to the Territory. I was an intern in the Territory and I also worked in Alice Springs. We lived in Melbourne prior to that. That really did not suit us and we either had to go back to India, where my wife and I both grew up, or stay in Australia. I have two brothers in the Territory so it seemed a good place to come back to and be able to be useful. I think that is where we stand. The social justice issue of working amongst Aboriginal people is important. That would be our aim basically.

We came to the Territory to work amongst Aboriginal people, preferably in an Aboriginal community, and we had to wait three years before a suitable opportunity came up to be able to work in the bush.

CHAIR—So much for the shortage. What year was that?

Dr Glasby—It was 1993, 1994 and 1995. In that time three other positions came up. Two that we applied for were taken up by other people or were offered to other people, and one was only offered after we took the job that I took in Katherine at the time of Wurli Wurlinjang. So there was not a real shortage in the Top End. But, again, I believe that is because Territory Health Services really did not collaborate with the Commonwealth in the rural incentives program. If the Territory had taken up the rural incentives program and really promoted it and supported it, I believe it could have facilitated the placement of GPs in communities far more than has actually happened.

I have worked intimately with the Territory Health Services for the last few years as a doctor in Daly River—I had to, because we were intimately connected. The doctor who had been there before us at Daly River was a DMO and worked for Territory Health Services. The nurses all worked essentially in the same model as Territory Health Services nurses work, although they were employed by the community in a grant and aid situation.

What I tried to set up in the first paragraph of my inadequate submission was the fact that I believe the Territory Health Services—even though I appreciate so many things that they have done—do not have a handle on being able to provide Aboriginal people with what they really require. Also, the Commonwealth needs to get a very clear message from people on the ground about the adequacy of health services. I do not believe state and territory funded health services are adequate. This is backed up by international reviews of indigenous health funding which all suggest that, if you want to go ahead with indigenous funding, you have got to stay with Commonwealth or federally funded activities.

Earlier somebody asked the question of another person who was sitting in my position: how did the Maoris and the Indians manage to improve their situation more than Aboriginal people have improved their situation? Kunitz—I am sure the committee is aware of that name; it has probably been mentioned on a number of occasions—very clearly showed up in his work that the differences are partially, at least, if not more importantly, due to the fact of Commonwealth and federal funding for indigenous health services in those countries. I believe that our country has no other good model to follow at this stage.

That is a bit of an introduction. When I read my submission again now I find myself cringing in terms of some of the points I was trying to make. Although I am public health trained and I am a medical practitioner, I found it tremendously difficult to try to grapple with the jargon in ads placed in the paper. Most of my colleagues very sensibly

disregarded the jargon and just answered the questions, saying what they thought were the problems with Aboriginal health. I believed that I should try to address them, so I made a series of comments. It is fairly hard to pick the guts out of them if you want to.

The point I want to make again is that, if you want to look at a funding pattern that makes sense to people on the ground, you have to stick with a Commonwealth funded program, although there are arguments for and against that. People in Queensland seem to be working very effectively together—I am not sure how much. Western Australia has a reasonably good record. The Territory is a very immature place in terms of the development of services. They will not have told you this morning how many reviews of the Territory Health Service have been performed in the last 10 years and how many recommendations of those reviews they have managed to carry out to make health services more appropriate in the Territory. But I will tell you for certain that they have not been aimed at rural activities. We will come back to that later, I am sure.

Mr QUICK—If we said to the Territory, 'Okay, we are going to pull out X millions of dollars and it is going to be a Commonwealth responsibility,' the Commonwealth does not have representatives out in the areas so there is no-one necessarily in Darwin, Katherine or Alice Springs, so do we have to replicate another bureaucracy which in lots of cases is probably just as inefficient as the Territory's or a state's?

Dr Glasby—I am not as pessimistic in terms of another bureaucracy. I think that health boards around the Territory have indicated the possibility of independent health services being able to operate without another layer of bureaucracy too much above them. Nganampa Health Service is a model. I am sure it has its faults, but it has been operating now for a number of years and is a good regional model of health service delivery to Aboriginal people separate from states and territories, as I understand it. I stand to be corrected.

Mr QUICK—Do we say that its $57.63 per person should provide an adequate health care cover for one year and that, multiplied by X number of patients, health board A gets $1.7 million for all the indigenous people in Katherine, and we then leave the health board to sort out priorities? Have you seen a model that is approaching the ideal that you would like to run?

Dr Glasby—All of the Aboriginal run health services manage without an extra layer of bureaucracy. I am not sure whether I am speaking out of turn here but, essentially, the independently run health services are granted moneys and they operate health services. Congress is a very large operation that has no extra layer of bureaucracy above it, and it is directly funded by the Commonwealth, as I understand it.

At the moment I am working as the public health adviser to the Katherine West Health Board. I believe, with the model that is being generated there, we are struggling to

come up with something that is at least as effective as Nganampa is. We would see this as very important developmental work in terms of health service funding. In terms of models for actual funding, it is likely to be more beneficial than any funds that you direct through to the Territory now, half of which get gobbled up in the bureaucracy. Actually, it is more than half.

Mr QUICK—Following on from that, you need money for housing, which is not necessarily in the health department, and you need access to money for education. So how do we marry in all these departmental boxes? As well as getting health money, you get educational money, you get transport money and you get housing money to give to community A so that there is a holistic approach to health, so they have got adequate housing, sewerage and roads and all that sort of thing for the community? It might be easier to deal with health, but how do we get all the others? Do we say to the Territory housing department, 'Look, we're going to take money from you that previously went to Aboriginal housing and put that back into this new basket of money and the Territory transport department, or local government, because you are not adequately servicing the roads and things'? Do we pick all this money out of all these baskets?

Dr Glasby—One has to be factual in these matters. Lots of communities have reasonable roads to them and, more importantly, they have bitumised roads within them. That is the issue in terms of roads, more often than not. But, once we are talking about those more general infrastructure areas, any one person to speak on that would have to be careful to know where the bubbles were coming from.

I think you have to go back to community control. This has been said a thousand times before, and I have written it again, and where I am working at the moment I focus on it. You have to have community control as a requirement, and then you have to actually educate the community to be able to participate effectively as a community controlled organisation.

When you go to the Tiwi islands and when you come to Katherine, you will find out about the amount of effort that has been put into educating people to be able to function as board members. When people talk about education—and you are well aware of the problems inherent in most Aboriginal communities in terms of eduction—that is not going to change overnight.

Mr QUICK—In his PS, Dr Harrison said:

I have just received a nice glossy 100 page document from OATSIS on reporting requirements.

He is struggling with that, and he is frustrated.I am not being disparaging, but what will Aboriginal people—who might have had a grade 7 or 8 education—make of this 100-page, glossy OATSIS document that they, as a community, have to work through? As Dr Harrison says, the state health department put out a similar sort of thing but, quite often,

they do not even talk to each other.

Dr Glasby—I do not believe that is a real barrier in some ways. I work with an Aboriginal administrator who eats those things for breakfast so there are varying levels of skills. What you are actually setting up with regional health bodies is enough resourcing to provide Aboriginal people with expertise to be able to cope with these things. I believe that that is the model that Nganampa works on; that is the model of the organisation I am working in at the moment and these are working models.

We have established within Katherine West health board that we want to work in an action research way—which is a little bit up in the air—but, essentially, you do certain actions and you look at it. This follows Mr Morris's suggestions about how you incorporate research into your clinical activities as a GP out bush. We are developing a working model and I think that that has to be something that we actually struggle with, this whole area of going forward as a GP working out bush. You get deskilled out bush; you are removed from a lot of professional contact in other ways and these kinds of incentives may—I have not read the recent reports that have come out of the GP Review for Rural Activities, but I have not seen anything that looked as sensible in terms of your career opportunities as a person working in those situations. I am not sure. Chris, have you read those?

Dr Harrison—Just generally.

Dr Glasby—Action research provides a basis for this.

Mr ALLAN MORRIS—The perception has been that it may well hurt your career to have worked in the bush: that you may well have done it because you could not get work somewhere else and because you were somehow a bit off the planet.

I will tell you a story about a student I knew once who took a year off medicine and came and worked in the Northern Territory as a fourth year medical student. When he got back I said to him, 'That was a really strange thing to do.' I asked him about it and said, 'Won't it hurt your career?' He said, 'All my colleagues think I'm mad. They think I've wasted a year's income.' And I said, 'But how about your studies?' and he said, 'That's easy. That's not a problem.' All of his colleagues at university thought he was stupid because he took a year off, which meant he lost a whole year's income as a doctor in two years time. That was the perception and it probably still is. You go bush for a few years and it looks like you have gone to live like a nomad and you have gone backwards while you have been away.

Dr Glasby—There is an element of that but there is actually a large body of medically trained people in the Northern Territory who have worked bush.

Mr ALLAN MORRIS—But there are no psychiatrists. Look at all the specialities

you are missing out on.

Dr Glasby—There are psychiatrists. There are not many but there are a couple of psychiatrists.

Mr ALLAN MORRIS—Are they permanent?

Dr Glasby—They live here.

Mr ALLAN MORRIS—I have a recollection particularly that when we were looking at youth homelessness, there were no psychiatrists here then.

Dr Harrison—I do not think it was said that there were none.

Dr Glasby—There is a great paucity of all specialities, certainly.

CHAIR—Dr Glasby's wife is also a medico so that is even more unusual.

Dr Glasby—That is not necessarily so unusual, Mr Forrest. There was another team at Maningrida who also made a submission. Mike Dawson and Margaret Niemann were at Maningrida for a couple of years. It is not so uncommon for medicos to marry but still, we are not necessarily the commonest folk.

CHAIR—I did not mean it like that; it has been a long day.

Mr ALLAN MORRIS—In terms of your career path in the sense of a career as professionals, the fact is that for you to progress your career as such you have to leave the Northern Territory.

Dr Glasby—As I was trying to say before, there is a large stable body of general practitioners in the Northern Territory who work collectively and recognise each other as professionals. There are, of course, idiosyncrasies amongst that group of people as there are within any group.

Mr ALLAN MORRIS—But if you are going to get funding for research or from the National Health and Medical Research Council or the national institutions, then the accreditation that you need and the professional standing in which you are held by your peers will not be augmented by staying here, I would have thought. That would be gained somewhere else. Isn't that the history of things?

Dr Glasby—There is an element to that but, as Professor Mathews mentioned today, they have a body of researchers there who have been general practitioners. That is the only option.

Mr ALLAN MORRIS—I am trying to look at a different paradigm. We have to work out a way to move forward and I am pressing all of you with these questions. The model has failed to date. There are all these pages of research and we still do not know what has caused kidney failure. All that work that has been done still does not have a result in a professional, medical and biological sense.

I am trying to suggest that somehow we have to find a new way of doing it. Medicine is as faddish as anything else, if not more so. Black health is not exactly fashionable right now. How do we try and give it status and significance? In any other Western country an epidemic such as is facing us here would be a major front page national story; yet here it is backwoods, backyard, off budget, 'let's not talk about the war' stuff. This is all of us. This is a national problem, not a Northern Territory problem.

Dr Glasby—To focus on the issue of taking it forward and career structures for those of us who are interested in working in those situations, I believe your suggestion of involving research as part of your duties in those positions is a reasonable activity in terms of career advancement and the placement of GPs in communities, but I will qualify that. I am not sure that putting GPs in communities is necessarily a workable a model in a short-term framework. We have been trying to put GPs in communities for the last four or five years.

Mr ALLAN MORRIS—And we have failed, yes.

Dr Glasby—But we need all kinds of input as to what kinds of incentives can be generated which are more satisfactory, because the current incentives do not seem to be.

Mr ALLAN MORRIS—So far we have had two options raised, not today but at other times. One has been to pay them more, in other words a financial conscript, and the second one is a career option by saying that they must do two years service in the bush. That is like the Queensland teachers or the old New South Wales teachers bond model. You do not get accreditation or you get faster tracking for your Medicare numbering if you spend a couple of years in the bush. Those are the two models that we have been given so far. To me both of those are very unprofessional and very bad for the people in the bush who are being treated by them.

Dr Glasby—It misses the fact that what you have got is an interaction with an Aboriginal community which is not considered in both of those incentives. To qualify that even further, I believe all of these programs need to have a multipronged approach. You cannot rely on one or two incentive type programs. You have to have a range of incentives depending on the individual and the situation. Particularly in Aboriginal communities there needs to be certain other infrastructural work done so that the community can own the health programs, rather than the doctor being expected to be the boss.

Mr ALLAN MORRIS—We were told in an inquiry two years ago that temporary medical admission was the only way they had a medical service at Halls Creek. We had a hearing in Darwin on access and equity. We were using overseas doctors who would not be professionally recognised in Australia otherwise. That was the third model.

I think they are all wrong. All the models we have used are not good for the people involved. They are all good for the person who is providing the service. In other words, a visiting foreign doctor gets a higher wage while they are working in Australia for a period of time. With the other two get career enhancement for themselves, but none of them is good for the people actually being treated.

I have raised one model today, which is GP research or the service provider, and questioned that as a possibility. Do you have some more for us? We need more than one, but how many more are there? Do you have any more you could put forward?

Dr Glasby—Again, there is no single one I believe will be successful.

Mr ALLAN MORRIS—There is Dr Harrison's coordinated care trial where the doctor is part of a team which is cashed out and where the financial situation is different. That is another one.

Dr Glasby—Indeed. The whole idea that Medicare in the Territory is inadequate needs to be supported.

Mr ALLAN MORRIS—Yes, I agree with you.

Dr Glasby—There have been several other submissions which have made it very clear that Medicare is a major problem here. I did a rough calculation before as to how many GPs are working on salaries in the Top End only. There are more than 10. I counted about 15, and that is not counting the district medical officers, who are salaried officers under the Territory Health Services. We have got close to 15 GPs who are essentially working under a salary type structure and Medicare is a component of it in one way or another. If you asked those GPs whether they would be happier to work in a decent kind of salaried position, I know what their answer generally would be.

Mr ALLAN MORRIS—I am sorry, I do not know the answer.

Dr Glasby—They would be very happy with a situation that clarified what their income was going to be, without all the hassles associated with Medicare.

Mr ALLAN MORRIS—We had a submission from somebody else that suggested the idea of a private company type basis.

Dr Glasby—There would be a number of models. Mike Owen—

Mr ALLAN MORRIS—It was stated:

Private, multi-doctor, sub-regional practices should be supported as viable private enterprises, even as Aboriginal Enterprises, to avoid creating more politico-health qangos.

I thought about that and I am not sure that I agree with either of those, actually. Of course, the coordinated care trial could be seen as a politico-health quango. On the other hand, a multi-doctor private practice could be equally seen as being not much different. But you are saying the salaried doctor would be a workable model for the Territory?

Dr Glasby—I would qualify it by saying the Top End. I can only speak for myself. But I am telling you that there are 12 to 15 GPs who are primarily working under salary based conditions in the Top End.

Mr ALLAN MORRIS—And there is some uncertainty as to salary value?

Dr Glasby—Yes. There are quite variable packages involved.

Mr JENKINS—You made reference to something that Michael Owen said.

Dr Glasby—Yes. Michael Owen proposed that you have variable Medicare rates depending on isolation and so on, so that you would get a different rebate for working in different places. That has probably been proposed before, but this morning was the first time I have read that, when I got a chance to get my hands on the paper. I think your job is to look at all the various options.

Mr ALLAN MORRIS—That is not an option. We should be about equity for people when they need the care, not—

Dr Glasby—If you are talking about salaries as an issue, you have raised the issue that, if you pay them too much, then they are going to come, but they are not going to be really committed. I do not believe it is going to make that much difference. I think that GPs who are interested in a social justice issue will come whether you pay them $100,000 or $180,000, because you are not going to get them here if they are not interested.

Mr JENKINS—What about the peer group and professional support? Should we be looking at that?

Dr Glasby—That has been addressed by a number of the reviews that have been done in rural situations. You are probably aware of most of that data. Of course, it is a major issue, not just for us, but also for the health workers in those places where we are working. You will be visiting them, and you have probably visited other Aboriginal communities. The status of Aboriginal health workers in those communities is unfortunately low. We rely on them as core health people to be able to interpret the

situations that we are working in. All of the doctors working in those situations look at how we can improve that situation. But it is caught up in the whole issue of their training, their situation, their inabilities, the barriers to their being able to come to work, and all of the other issues and situations which have been well documented and written about.

All I can say is that all the GPs working in the Top End are all committed, as sensible people, to working towards a solution to involving Aboriginal health workers in our work. The Top End Primary Health Care Network struggles—and I emphasise 'struggles'—with the issue of how we involve health workers, not just in the daily work, which they actually do very well, but in developing a professional body, which they do not have, and in being able to design their own ongoing learning programs. Essentially, this has all been under the Territory Health Services' umbrella. Although they have done some important things with career structure in the near past, it has not really gone far enough to improve the situation of health workers' participation in the workplace.

Mr JENKINS—Could you tell us what took over from the health care network? What has happened now?

Dr Glasby—When I was managing it I was only doing it for six months while we were tying up the ends to get the next submission approved or otherwise under the divisions program. In that six months the divisions program went to outcomes based funding and all of the previous submissions for funding were then wiped away, and each individual division had to decide what it was going to go ahead with. That was being finalised at a time when the Daly River flood happened. We could have possibly jumped back in on the bandwagon and really pushed this as a divisional issue but it got a little bit subsumed under trying to get some handle on the issue of outcomes based funding from a divisional perspective. What that meant for us as a division was a decision as to which things we were going to run with or not.

I have not highlighted yet the whole issue about how trying to respond to these kinds of requests for information from individuals and small organisations is incredibly difficult. The fact that you have got responses from a couple of GPs separate from any organisations in the Top End reflects the degree of importance which GPs have placed on Commonwealth understanding of the situation from our perspective as workers at the coalface. But we are just not resourced to respond to these things in a really comprehensive and clear way which can make recommendations based on the information as we see it.

The Menzies paper is a very erudite piece of information, but it does not include much information that you would get from people working at the coalface like the Harrisons and the Niemanns and so on. They are not interested in involving us at research at the coalface, because it is too difficult for them and partly because the funding arrangements for our positions are caught up in a whole maelstrom of other conflicting arrangements. So there are huge barriers for them in trying to fund us or to try and work

out arrangements with us—let alone the problem of communities understanding the documentation of how things work. We are not talking about high-powered research at the community level; we are talking about action research type stuff, which is going on in all other indigenous situations internationally and seems to be getting a bit of a backdoor step here.

Mr JENKINS—I do not want to deflect from that action research, because I know that Allan will probably want to continue it, but I am desperately interested in completing this division question. What have they funded now?

CHAIR—In other words, is there a need for this Top End primary health service network or not? There was when you were involved in it. Obviously, things may have changed now and it is not and there is something else in place. That is how I want you to answer it.

Dr Glasby—Territory Health Services have such an inadequate response to human resource management that they are struggling with the idea of trying to support their multi-disciplinary teams. In the Katherine region they have just created a position—and I wonder where the money came from for that if it did not come from coordinated care trials—to have a remote health services manager to try to coordinate health workers and nurses in the health centres that are out bush. This is another level of bureaucracy that has been added because the health worker managers do not work and the nursing managers do not work properly with the team, so they just throw in another level of bureaucracy.

This is the Territory Health Services' response to a problem. Rather than getting good management in, they add another level of bureaucracy. Yes, we do need support, we need facilitation, we need decent management. I believe the only answer to that is to have decently funded regional health services which provide Aboriginal controlled services of that nature. If you have got Territory Health Services running things, it is not going to happen, I do not think. That is trying to work constructively within a very difficult situation for the Territory Health Services. They are operating under very difficult circumstances, and they are immature and under-resourced. Look at the data that has come out of the Territory Health Services to try and justify the funding that they are applying. They have got morbidity stuff from the hospitals but, in terms of what is coming out of the health centres, we have got nurses and health workers generating data every day which Territory Health Services cannot actually analyse or feed back to them.

CHAIR—Let alone make available to us.

Dr Glasby—Does that answer your question?

Mr JENKINS—Yes, it does.

Dr Glasby—Yes, this is an important issue of facilitating multi-disciplinary teams.

The division took it up because we were GPs struggling with working in these situations. It needs to be done in a much more concerted way with the Commonwealth taking control of the situation and working towards something that is much more sensible.

Mr JENKINS—And the regional approach could also cross the state-territory boundaries which can be a problem?

Dr Glasby—People have looked at a sort of Top End, Western Australia, Queensland, Territory type of approach, but I have barely enough expertise to respond to your request for submissions but, beyond that, I really could not comment.

Mr JENKINS—I am not sure how *Hansard* could handle the gesture with which you answered that question so well. The body language said it all.

Mr ALLAN MORRIS—'He gently raised his hands in despair' would be the way you would describe it I think. Dr Glasby, with regard to that action research you mentioned. I guess I was trying to talk to Professor Mathews about the idea of GPs being not high-powered PhD students but people who are trying, by their own work, to improve the medical circumstances of the country—and how that had to be part of some other accreditation process and part of a broader program, not just mickey mouse. It had to be owned by the community so they agreed with it, and it had to be complementary to what they were doing in terms of their service provision.

Dr Glasby—Yes.

Mr ALLAN MORRIS—You called it 'action research', which I thought was a good phrase to use. You have a better picture of it than I have.

Dr Glasby—I am not sure about that.

Mr ALLAN MORRIS—Can you draw that picture a little bit?

Dr Glasby—Action research is a fairly simply concept, but basically when you are working in pioneering situations there is not a lot of data to support any one action over another and you are stuck with either doing something or not doing something. Most people who are out there are gutsy enough to do something but you have to have the resources to look at the effects of what you have done. So you have an action and you research that action and you come up with, 'Well, okay, that has or has not been very effective' at a local level.

Mr ALLAN MORRIS—How do you make that part of a broader picture? In terms of the action research you might do in one community with a diabetes case or with a particular heart condition vis-a-vis another doctor in another community with another case which may end up being of a similar nature, how would you actually relate those

within a framework?

Dr Glasby—Action research is about publishing small-time information. It is coalface stuff. It is all based on 'When we had this, we did this and this happened', so that somebody else, as you have mentioned, in the next community can say, 'I can see what you are doing and that is really practical'. It is a practically based approach to research at the coalface.

Mr ALLAN MORRIS—What kind of framework could help do that? Would it be a CRC, a university or a hospital? How could you actually develop a framework where that was known, recognised and accredited so that the person eventually achieved some professional status, standing or recognition for that work they were doing?

Dr Glasby—It has to come back to the community's participation. That involves a certain amount of commitment to resourcing and training of local people to be able to understand this stuff.

Mr ALLAN MORRIS—I am with you there. So assume the money is available, assume the Commonwealth will provide X dollars to deal with it: who would it channel through? It cannot come to the person direct, because they are just at the bottom end of it.

Dr Glasby—That's right.

Mr ALLAN MORRIS—It has to come through some intermediary.

Dr Glasby—Yes, regional health boards.

Mr ALLAN MORRIS—You just told us that it was not through the Territory Health Services.

Dr Glasby—Exactly. That is right—not the Territory Health Services. They do not have any regional boards. They do not have any health boards whatsoever. They have not managed to generate any. I am not sure about the Tiwi Health Board. Do they get supported by THS at all?

Dr Harrison—Yes.

Dr Glasby—Grant in aid—but did it support the Tiwi Health Board?

Dr Harrison—Yes.

Dr Glasby—That would be the only situation where it was able to. Regional health boards have been only Commonwealth initiatives.

Mr ALLAN MORRIS—I am looking at professional status to ensure that we are looking at both the financial support for the people doing action research but also the professional support so they are recognised and not simply GPs working under primitive conditions—not people who are out of touch with their peers but actually at the front end of medical development who are doing work which is far beyond the work of a normal GP and, what is more, is being understood and recognised.

Dr Glasby—The CRC we have here within Menzies is a potential venue for that type of activity. I am a little concerned about the consultation process between a high-powered research organisation like Menzies and people at the coalface. It is not always creative.

Mr ALLAN MORRIS—So the division of GPs has been the intermediary?

Dr Glasby—The division of GPs has got its own problems, but at this stage it would probably be the most useful forum for channelling this kind of activity and resourcing these kinds of activities.

Mr QUICK—I want to ask about something completely different. You might be aware that we did a report on telemedicine. I am interested in your comments on page 3:

Our local health department . . . has a timetable to implement their rural remote IT in health program. We cannot call it an upgrade as there has never been a primary program . . .

Can you expand a little on that?

Dr Glasby—Territory Health Services have just completed the urban second upgrade, so all health services, and, more importantly, all the bureaucrats sitting in the offices in town, are now up to Pentiums and the whiz-bang things on their desks. The clinics out bush have usually got a stand-alone computer which has a few games on it and Word—something for them to gain some skills on. They have had this IT program going now for several years, and the program that was being written for bush communities was subsumed under the coordinated care trial and has now become bigger than Ben Hur's horses and has taken another six months to a year to get it to the stage where it was going to be last year. It is the whole issue of lack of prioritisation. From my perspective of working at the coalface, we have got nurses and health workers working in clinics out in the bush who are not being resourced to a basic level of functioning that people in town would assume as being natural. This disparity between the second upgrade occurring to systems in town when they have not even got a system out bush only highlights again this issue of the prioritisation of health issues at a rural and remote level versus what is happening in town.

We are dealing with a very small population in the Territory, and that is why we have got such a big percentage of health moneys being taken into the bureaucracies. I

believe it is bigger than any of the other states: 54 per cent is the stated figure of moneys being withdrawn from any service delivery funding from the Commonwealth. The Territory Health Service takes that off the top as part of maintaining the bureaucracy, which they have to do with such a small situation. We need to be able to make it leaner and meaner because the services are not going bush. I believe the Commonwealth provides, through the working model of regional health centres, this kind of possibility.

There was one point I would not like you to gloss over. It is an issue you have also addressed, Mr Morris, of standards out bush. This is another area which needs lot of resourcing from the funding bodies. Most other health centres in the country have got some kind of accreditation program running within their doors. Territory Health Services are working towards it but, because of the situation, again there are no standards that can be applied. In fact, we do not even have procedures manuals for nurses to operate in terms of how clinics are managed out bush. We have procedures manuals for how to manage conditions but we do not have procedures manuals for how to deal with a specific situation of human resource management, personal trauma in the workplace or dealing with the community issues. Those kinds of policy and procedure manuals do not exist. This would only highlight the immaturity and the lack of resourcing for bush clinics that is operating under our current situation.

Mr ALLAN MORRIS—I would go further. In the wider community there is a view about Aboriginal health as a separate entity. At one end of the spectrum it is a massive waste of money and allows a great waste of resources. At the other end of the spectrum it allows us to accept a level of health that we would not accept in any other Western society. Those two views are argued, and that differentiation in some ways allows us to accept a standard of health which we would not tolerate in Sydney, Melbourne or Newcastle.

I do not quite know how we handle that. I think we are looking to people like you who are working as professionals in the field to make it understood by those of us who are not professionals in your field that the levels of health that are actually accepted as acceptable in remote and outlying areas are just disgraceful.

Dr Glasby—I think it only highlights the issue that, if you put money into things, it does not necessarily work—and that is separate from the fact that I am not sure whether you are talking about money into Aboriginal health or money into Aboriginal situations.

Mr ALLAN MORRIS—People say that all this money has been spent on health—in fact look at our last term of reference—and Aboriginal people are actually sicker; they have more renal failure and more diabetes. So one argument that is put to us is that it has all been wasted. The other argument that comes forward to us, particularly from the Aboriginal community, is that by having it separate, you actually allow a second-class treatment—and we do. Both are argued. I am more inclined to the former—in the sense of allowing a second-class standard—but yet all the doctors are of the same standard. Doctors

in Sydney and Melbourne and in Aboriginal communities have all been through the same medical schools and have the same professional status. So, in a sense, the profession itself allows us as a community to accept substandard treatment.

Dr Glasby—It is not quite as simple as that. It is not substandard treatment; it is the participation of people in their health service because it is not their health service. I do not believe that what you are talking about as two things are actually two things. The fact that there has been a lot of money—

Mr ALLAN MORRIS—Two extremes in a spectrum.

Dr Glasby—I do not see them as opposite ends of the spectrum. Just because you put a lot of money into something does not mean that you necessarily get a lot of outcomes out of it.

Mr ALLAN MORRIS—I agree.

Dr Glasby—The fact that you have substandard treatment or substandard health outcomes has no relation to the fact that you have put a lot of money in at the other end. ATSIC held Aboriginal health moneys for a number of years, and I believe was inadequately supported to actually take on that role—but that is a separate issue. We now have a situation of there never having been adequate resourcing of Aboriginal health—never—and we are now having to respond to the international situation where this is unacceptable. People of Australia accept, by and large, that it is unacceptable, but the solutions have not been there.

Mr ALLAN MORRIS—I should have said 'two competing perceptions'. That would have been a better way of defining it. But the professionals who work in the field are the same.

Dr Glasby—Yes, but how can you have health of a people who are not interested in going to a health centre? There are issues why people will not go to a health centre. You understand that, don't you?

Mr ALLAN MORRIS—They are the same health centres that took away children.

Dr Glasby—That is an issue, but it may not be quite as important as it used to be. One has to understand—and it is not easy to discuss this—that Aboriginal people have a lot of other health options than a health centre. It has been well documented that Aboriginal people will search for other options for health care before they will go to the health centre generally—not unlike a lot of non-Aboriginal people.

Mr ALLAN MORRIS—Yes.

Dr Glasby—The fact that money has been poured in there does not mean that the second-class quality of health care is because there is not enough money; it is because the approach is the problem. This is where the whole issue of community care, of which I am only another component—

Mr ALLAN MORRIS—Then what you are really saying is that unless Aboriginal communities approach health the way we want them to approach it—

Dr Glasby—No, I am not saying that; I am saying in the way that they want to approach it, which has not been addressed.

Mr ALLAN MORRIS—Their level of health medically is vastly lower than that of a non-Aboriginal community—massively lower.

Dr Glasby—Yes.

Mr ALLAN MORRIS—Part of the reason for that is because they do not approach health centres.

Dr Glasby—Yes.

Mr ALLAN MORRIS—We say that they must fit the centre, but a survey in 1988-89 found that 80 per cent of students at the medical faculty of Brisbane university believed that the health conditions of Aboriginals were their own fault. This is a similar perception. We have to be careful that the system should fit the people who need it. In other words, the medical centre should be relevant to the Aboriginal community. The doctors who practise in those centres practise medicine in Melbourne and Sydney in the Turkish community, the Greek community and the Italian community and they make it adaptable there. But we have not adapted it to the Aboriginal community somehow.

Dr Glasby—Doctors perform in those communities at a level not dissimilar to other places. I do not see the issue of a doctor's work as being necessarily related to the health outcome. That is separate from the fact that we have not had doctors in most bush communities. But health outcomes, we know, are not related to medical care by and large. As was very succinctly pointed out by Allan Walker and a number of other submission writers, until you have economic situations in communities so that people are able to work and educational issues are addressed by the community, you are not going to have health improvement. You are saying: 'Because you have good doctors there, why don't you have the same kind of health that you have in other places?' This is a complex, multifactoral situation.

Mr ALLAN MORRIS—I watched Dr Leed campaign for money for research for AIDS and for other major medical crises. I do not see the same kind of thing happening in terms of the crisis in Aboriginal health.

Dr Glasby—There are significant Aboriginal directors of organisations in the Territory. We need to be subservient. One has to understand this from a community control perspective. If a doctor stands up and says too much, then it is calling too much on yourself. We can respond to the situations we work in and numbers of doctors do.

Mr ALLAN MORRIS—That's a fair point.

Mr QUICK—The minister in his speech mentioned that Territory Health Services has established the Aboriginal health strategy unit, which according to him functions much as the recommended task force would. The Aboriginal health strategy unit spearheads the strategic direction of the department to ensure there is measurable and sustainable improvement in the health of Aboriginal Territorians.

Dr Glasby—Yes.

Mr QUICK—How is the Aboriginal health strategy unit working? Is it effective? Has it just started work?

Dr Glasby—You have been a politician for a long time, Sir.

Mr QUICK—No, not all that long.

Dr Glasby—I would only interpret that as politico-speak.

Mr QUICK—It says here:

The unit is a discrete division of TATS, with the assistant secretary reporting directly to the secretary as a member of the TATS executive. It is a small but focused unit comprising of two senior policy officers; one project support officer; one administrative assistant; three project officers working on three key projects, namely the Aboriginal Employment Strategy, interpreter and translators trials at Royal Darwin Hospital and remote area environmental health standards. . . Of the nine staff members, six are Aboriginal, including the assistant secretary.

So it all sounds wonderful.

Dr Glasby—It does.

Mr QUICK—But it is not working.

Dr Glasby—What can you do with six or nine people to address the resourcing required for community control? In the Katherine West health border I can only speak of the situation I am in at the moment. A year of training has gone into our Aboriginal health board to make them active as community representatives making decisions on health matters as to their region. It has required an external source of funding and commitment to that as a priority for that to happen. You know the numbers involved in the coordinator

care trials.

Territory Health Services are moving in the right direction. I have continued to affirm that and I believe that I am trying to be positive about the situation. But the Territory is a very small place, and it is still immature in terms of its development of policies and so on. It takes a long time, as you are well aware, for government activities to actually be active in the field. Who knows what might happen in 10 years if it was left alone? But it is not going to be adequate to the task ahead of it because it is so large. It is a national problem, not just a Territory problem.

Mr QUICK—Could I have your views on the patient assisted travel scheme, which assists people in remote areas to access outpatient clinics in hospital care?

Dr Glasby—Certainly. A number of your other submission writers have actually commented on this far more sensibly than I have. I made a small comment in the third paragraph on page 3. The patient travel scheme attempts to bring people in to access mainstream services. Most of the Aboriginal people coming in on those services are unfamiliar with life outside their community. Let me qualify that. You will understand the example of, say, a shy 20-year-old woman. She may be a single woman or she may have children, but she is a shy woman, and she has always lived in a small community situation with lots of her family around her; yet you want to put this woman on a plane—by herself, potentially—and say, 'Go to Darwin hospital with these other people.'

I can show you Aboriginal women of 20 years of age who, in a semi-urban situation such as in Katherine, even, where there are lots of other Aboriginal people around—let alone in Darwin, where there are a lot fewer—would operate essentially as a 12- or 13-year old would operate. This is not at all to diminish them: this is just the kind of interaction that we are talking about understanding; yet we are constrained in our patient travel scheme by the fact that anybody over a certain age cannot be escorted—and that also goes for shy men, and they exist in large numbers.

CHAIR—You mean that they are not funded to be escorted, don't you?

Dr Glasby—That is correct. I am sorry. In a sense, the scheme is inadequate to the cultural situation. Again, I would point to the Mike Dawson and Margaret Niemann submission, which spent quite a bit of time outlining the barriers associated with the appropriate use of the patient travel scheme. You will get a lot more depth out of their response.

Mr QUICK—After listening to your last comments I wonder if, where the minister says on the topic of resourcing that, over the past three years, Territory Health Services has been taking a 'leading role in Australia in introducing an economic approach to decision-making and resource allocation in the health sector', that is a case of 'enough said'.

Dr Glasby—Enough said!

Mr QUICK—No further questions from me, Mr Chairman.

CHAIR—Dr Glasby, we have been here since 8.30 a.m., and we might actually catch up with you again later in the week, I believe.

Mr ALLAN MORRIS—Dr Glasby, when you read the *Hansard*, you will have a lot of hindsight, and so you can write to us and tell us about all of the things you think you should have said. We are happy to get more material and more ideas. You were very self-effacing in your submission. You do not need to be. We think you probably have more answers than we have. I encourage you to perhaps ponder on it beyond today.

Dr Glasby—Okay. Thank you very much.

CHAIR—We will see you on Wednesday morning: is that right?

Dr Glasby—I am not sure whether I will be at that meeting.

CHAIR—All right. We will see your facility, anyway. Thanks very much. I enjoyed your evidence. It has been very good. It is good to get it from someone who is in at the coalface and has made the commitment to be at the coalface. Thank you very much, Michael. The committee stands adjourned, with grateful thanks to everybody who has given evidence today and to *Hansard*. Thank you, Susan and Jason, and thank you, Bjarne.

Resolved (on motion by **Mr Quick**, seconded by **Mr Allan Morris**):

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 4.29 p.m.