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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

MONDAY, 22 FEBRUARY 1999

CANBERRA

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Monday, 22 February 1999

Members: Mr Wakelin *(Chair)*, Mr Andrews, Mr Edwards, Ms Ellis, Mrs Elson, Ms Hall, Mrs De-Anne Kelly, Dr Nelson, Mr Quick and Mr Schultz

Members in attendance: Mr Edwards, Ms Ellis, Mrs Elson, Ms Hall, Mr Quick and Mr Wakelin

Terms of reference for the inquiry:

In view of the unacceptably high morbidity and mortality of Aboriginal and Torres Strait Islander people, the House of Representatives Standing Committee on Family and Community Affairs was requested, during the Thirty-Eighth Parliament, to conduct an inquiry into Indigenous Health. The Committee was unable to complete its work due to the dissolution of the House of Representatives on 30 August 1998.

Consequently, the Committee has been asked by the Minister for Health and Aged Care to complete this inquiry in the Thirty-Ninth Parliament, reporting on the same terms of reference as follows:

(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

Committee met at 9.05 a.m.

DUNLOP, Ms Marion, Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Aged Care

EVANS, Ms Helen Norma, First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Aged Care

McDONALD, Ms Mary, Assistant Secretary, Program Planning and Development Branch, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Aged Care

CHAIR—I declare the public hearing of our indigenous health inquiry open. I am pleased to advise that this is the first day of public hearings in the 39th Parliament, as referred by the Minister for Health and Aged Care, Dr Michael Wooldridge, with the support of the Minister for Aboriginal and Torres Strait Islander Affairs, Senator John Herron. The committee is looking at improved coordination, planning and delivery of indigenous health services and is aiming at shaping improved Commonwealth policy.

I would like to stress that the committee is seeking to conduct this inquiry in a spirit of collaboration and cooperation with Aboriginal and Torres Strait Islander people. Obviously, it is important to consult communities directly and combine the collective experience of everyone who has worked in this area to arrive at the best possible practical strategies to improve the state of indigenous health.

The committee has set aside several weeks in which to conduct inspections of remote and rural communities, to continue to experience at first-hand the living conditions of indigenous people around Australia. These will take place over the next two months, with visits to rural New South Wales and Victoria, central and South Australia, Western Australia and the Northern Territory. Today's hearing in Canberra provides another opportunity to engage in discussions on the public record with the major national organisations who have responsibilities in this area.

I welcome the officers of the Department of Health and Aged Care who are appearing before us this morning. Last Thursday, I think, we saw each other. As you would have heard many times, before we proceed I point out that, while this committee does not swear witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the proceedings of the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament. This also serves to protect you in the evidence which you give, which is covered by parliamentary privilege. Would you like to make an opening statement, Ms Evans?

Ms Evans—I think that the department and the Office for Aboriginal and Torres Strait Islander Health's overall approach to Aboriginal health is contained in the submission that we made to the committee some 12 months ago. While there have been some changes and updates, the overall approach outlined in that submission and that which we discussed with you the other day still very much holds. We feel that consolidating primary health care

services that Aboriginal people will and can access across the country is a key plank for improving Aboriginal health, and that is the major approach of the department.

Mr QUICK—In your submission—on page 220 of the volume of submissions—under 'A strategic framework for improving Aboriginal and Torres Strait Islander health outcomes', you say:

Implicit in this strategy is the recognition that there are no easy or quick solutions in the Aboriginal and Torres Strait Islander health area and that it is important not to develop more ad hoc or quick fix solutions . . .

Can you give us some examples of ad hoc or quick fix solutions in the last few years? Is this a generalisation of what has been happening the last 20 years or are ad hoc and quick fix solutions still jumping out of the ground and being funded?

Ms Evans—I think it is a generalisation. If you would like us to provide some examples, we could come back to you on it, but I think it is a more general statement on the approach to Aboriginal health over the last many years, a rather stop-start approach with bursts of interest by various levels of government, committees and inquiries but, unfortunately, not a sustained, continuing and coordinated approach across all levels of government and with the community. In the last three to four years at least that is what we have been trying to move away from. We have been trying to move forward so that it is more coordinated and coherent rather than ad hoc. Some of those ad hoc approaches had the best intentions, but I guess what we are really wanting to focus on is a comprehensive approach and a sustainable approach.

Mr QUICK—Will the framework agreements that have been worked out between the Commonwealth and the states mean that in future we will not have any ad hoc or quick fix solutions?

Ms Evans—I would not like to give an absolute undertaking that there will be no ad hoc or quick fix solutions, but I certainly think that that is the intention of all parties, yes.

Mr QUICK—Having access to the agreement between the Commonwealth and the Queensland government, I assume all framework agreements are basically in the same format for the other states?

Ms Evans—They are basically the same, but they have some variations. I will ask my colleague Ms Dunlop to comment on this. She has been involved from the beginning with the agreements.

Ms Dunlop—Yes, they are basically the same. The main difference with the Queensland one is that the community controlled health organisation was not a formal signatory to that agreement.

Mr QUICK—I understand that Tasmania and the Northern Territory had not signed at the time that this submission was put in. Have they signed since?

Ms Dunlop—Yes, they have both signed.

Mr QUICK—In light of the framework agreements, where does the Army infrastructure project fit in? Is this another ad hoc thing that jumped out of the ground or is this part of the great scheme by the department and the government to work out a sensible coherent strategic plan for progressing Aboriginal health issues?

Ms Dunlop—One of the elements of the agreements is to achieve greater cooperation between ATSIC and the Department of Health and Aged Care, and you will be talking to the ATSIC representatives later. I think that part of the arrangements with the Army is about working on some of those areas where there are problems with water, sewage or housing and trying to get a more coordinated effort. So the whole approach of what is trying to be achieved with the involvement of the Army is very consistent with the outcomes sought by the framework agreements.

Mr QUICK—So where does it fit in within the framework agreements? The Minister for Health and Family Services agreed to contribute $5 million to the program in December 1996. Who chose the six remote communities? Was that done in consultation with the states and under the framework agreements or was it just something that John Herron decided to do in consultation with your minister?

Ms Dunlop—There was considerable consultation. ATSIC took the prime running on the consultation on the locations and there had been a lot of work previously done on trying to identify priority sites that needed housing or infrastructure projects.

Mr QUICK—Can you give us the names of those six communities so, in the likelihood that we might visit them, we can actually see what has happened in the last three years?

Ms Dunlop—I can either provide you with the list or read the names out, whichever you would like.

Mr QUICK—If you have got them now, I would appreciate them if it is possible.

Ms Evans—We have a list which we can probably table with the committee.

Mr QUICK—That might be easier, Mr Chair.

CHAIR—All right.

Mr QUICK—Ms Dunlop, where does local government fit into this? A lot of the responsibilities for what the Army is doing in the provision of infrastructure are surely the prime roles of local government in the various states and territories, so are they getting an easy out?

Ms Dunlop—No, but it might be useful to have the discussions jointly with ATSIC because they have a lot of dealings on the infrastructure projects. They are primarily their responsibility, with the involvement of Health.

Ms Evans—Could I suggest, Mr Chair, that we either defer this or that the ATSIC representatives, who are here, join us at this point?

CHAIR—Perhaps the representatives would like to join us.

[9.17 a.m.]

BAXENDELL, Mr Noel, Officer, Housing, Infrastructure, Health and Heritage Branch, Aboriginal and Torres Strait Islander Commission

TAYLOR, Mr Peter, Acting Assistant General Manager, Housing, Infrastructure, Health and Heritage Branch, Aboriginal and Torres Strait Islander Commission

CHAIR—Thank you for joining us a little earlier than you probably expected to. This will be quite useful. I have already read out the general process about witnesses, which you would be well familiar with. I will not do it again because you would be aware of that. Would you like to make an opening statement? Perhaps that would be useful and then we will move forward together.

Mr Taylor—I have no intention of re-presenting the submission. It was made some time ago. As with OATSIH, our general comments stand. I would be happy to take any questions or comment on issues you see arising.

CHAIR—And thank you, Ms Evans, for your most practical suggestion. I am sure we will get more out of it this way.

Mr QUICK—Mr Taylor, you have obviously heard some of the questions. Is this a case of more ad hoc and quick fix solutions?

Mr Taylor—The area of housing and infrastructure provision is not strictly falling within the framework agreements which related primarily to primary health. There is a range of coordination mechanisms that extend beyond the framework agreements to housing and infrastructure. In relation to AACAP, ATSIC runs a nationally targeted environmental health priority program targeting needs for capital in housing and infrastructure. That program is around $90 million a year. Generally, the AACAP program is delivered as a small component of that general approach to targeting the backlog of housing and infrastructure need in indigenous communities.

Mr QUICK—So is the way to solve the indigenous housing situation to pour money into AACAP?

Mr Taylor—AACAP is a very specific initiative. It was initiated by the Prime Minister and the Minister for Aboriginal and Torres Strait Islander Affairs. It is a matter of policy for government as to AACAP's contribution to the overall housing and infrastructure effort. As I said, we are currently running in excess of 120 major capital projects around the country. AACAP, over the last couple of years, has contributed project management and construction and related expertise in five communities out of that total. It is a matter for government as to whether or not that particular approach is expanded.

Mr QUICK—The Department of Health and Aged Care submission mentions identification of good practice in service delivery and the fostering of innovative models of service delivery. We understand that the Pitjantjatjara homelands housing practices are some of the best in Australia. How do you work with the department and, for example, those people to promote good practice in service delivery and the fostering of innovative models?

Mr Taylor—Some years ago the commission took up a lot of the key messages about good practice from a long-term research study that was conducted at Pipalyatjara in the western Pitjlands. You would be familiar with the *Housing for Health* report and Healthabitat's work generally. For some years the commission has been promoting the general principles and approaches advocated in that research with state governments. We have funded a number of workshops for housing and infrastructure bureaucrats around the country to familiarise them with the principles of that kind of approach.

More broadly, ATSIC has been involved for some years in negotiations on bilateral agreements for housing and some related infrastructure. The general approach in those bilateral agreements is to try and achieve some reforms in how housing is delivered on a state by state basis, including building-in principles of good practice in the delivery of the capital side particularly of housing and infrastructure. Our submission refers to a number of other examples of ATSIC's approach to good practice in both the capital and recurrent management of housing and infrastructure.

Mr QUICK—But we can still go to various Aboriginal communities and see people living traditionally alongside besser block houses that have been totally neglected. We have not really done much at all in lots and lots of communities.

Mr Taylor—Certainly there is a substantial number of communities who have overwhelming housing and infrastructure needs. The commission has available to it around $210 million a year through its Community Housing and Infrastructure Program. The latest available estimates of the backlog of capital need for housing and infrastructure in Aboriginal communities is around $4 billion.

Mr QUICK—$4 billion?

Mr Taylor—Yes. Certainly there is a lot of outstanding need. ATSIC has taken a fairly pragmatic and hard-nosed approach, I think, to targeting those communities in most need. Our targeted national capital program is based on a process of targeting environmental health needs based on community level assessments and we are systematically working through a very long list of communities which have outstanding need for housing and infrastructure. It will be some time yet before we can say that there are no communities which have outstanding needs for capital works in housing and infrastructure.

Mr QUICK—So is it a 20-year program?

Mr Taylor—At this stage our program is working on a planning cycle of three to five years. We are about to enter the next planning and delivery phase for what we call our National Aboriginal Health Strategy program, which is the targeted capital program. There

are a number of variables in terms of how long that kind of approach is needed. My personal judgment is that we are talking in terms of decades, yes.

Ms Evans—It is a sustained approach we are taking in the primary health care area and that ATSIC are taking in the housing and infrastructure, and indeed our colleagues this afternoon from Family and Community Services are taking in the housing side too, because there is an Aboriginal Commonwealth-State Housing Agreement that I am sure Mr Whalan will talk about. Part of that is systematically identifying need. I think that in the last several years there has been much greater collaboration between the three portfolios in systematically identifying need. The Army project has contributed to that too.

CHAIR—I want to talk about the housing stock and the current maintenance of the housing stock. Where do you think that is in terms of the housing stock? Is it stable, is it reducing or would you think it is getting slightly ahead?

Mr Taylor—I think we need to be clear which housing stock we are talking about. Far and away the largest form of tenure for Aboriginal people is public housing, so the majority of rental people live in public housing, and that is picked up and through mainstream public housing arrangements for repairs and maintenance and management. A significant percentage of Aboriginal people live in community owned stock, particularly in rural and remote areas. In general terms, the responsibility for repairs and maintenance for that stock rests in a range of community organisations which own land and hence own the houses that are on it.

Jointly with the states and territories, ATSIC has been working for a few years now on a national strategy to improve repairs and maintenance and housing management performance of community based organisations. We have funded some strategic work on improving community housing management training strategies around the place, and also on investigating the issues of levels of recurrent funding that are available to community housing organisations. You would be aware from mainstream public housing that there are some subsidy arrangements that underpin the rent setting and provide the resource base for recurrent management and repairs of public housing stock. It is not clear that the levels of resources that appear to be available to community based organisations, including to ATSIC, are actually adequate to maintain an extended life cycle for a significant proportion of the housing stock.

CHAIR—What I was endeavouring to get at is that I have heard anecdotal evidence—with some reliability, I believe—that the average life of a house might be seven years. I accept your point about it being difficult to generalise public housing in remote, rural and metropolitan areas, but I am interested in this. I do not intend to pursue it now but maybe later in evidence I will try and get a picture of where that housing stock is at. You mentioned a figure of $4 billion. If in fact we are at best stable or possibly going backwards, and relating to that the issue of whether the average life of a house is seven years, this is a significant issue. You might want to make a brief comment about that, but I will pick it up later. While Mr Quick had mentioned it, I just wanted to raise it.

Mr Taylor—I am not too sure where you get the figure of seven years from. The only place that I have seen it mentioned is in a document on community housing management good practice from the Northern Territory government. I am not aware of any research that

would give you a reliable estimate of the average life cycle of an indigenous community controlled house in remote Australia—

CHAIR—I would expect it to be quite difficult or almost impossible, but I was trying to gauge whether ATSIC had any idea of where the housing stock was at.

Mr Taylor—To give you that simple figure, no, I cannot say exactly how long.

CHAIR—That is fine. I will pass over to Annette Ellis.

Ms ELLIS—Can I just say to the people from ATSIC that I want to revisit the issue of the Army project and a few other questions, but I will do that later on in your own time. I want to refer back to the department and ask a couple of general questions. You mentioned in your submission the poor linkages, the poor coordination, between different components of the health system and the impact on the delivery of good quality health care to indigenous people. Can you give us some examples of what you mean by that and what sort of behaviour you believe we need to start to incorporate to address those sorts of issues?

Ms Evans—I think that, with the linkages within the mainstream health system generally, there are continuing issues on the linkages between primary, secondary and tertiary health care, essentially between GPs, specialists and hospitals and the flow between those, which is being worked on as a general issue. It is probably exacerbated for Aboriginal people. As we said in our submission, Aboriginal people do not use GP services in anything like the way the mainstream community use them and their patterns of primary health care use are therefore very different. There is a lot of use of hospital outpatient services and emergency services. I think the linkages—referral patterns to specialists, follow-up, hospital, follow-up after hospital—are problems within the system.

Ms ELLIS—Just as an ancillary question to that, what to your knowledge is the proportion of indigenous health care providers across that spectrum and what sort of work is going on to address that?

Ms Evans—When you say indigenous health care providers, do you mean Aboriginal and Torres Strait Islander people who work in the health care area?

Ms ELLIS—Yes.

Ms Evans—I will make a general comment and then hand over to my colleague Ms McDonald. Our handle to date on the number of indigenous health workers is still not good. We do have some figures on indigenous doctors. I would like to provide you later with more accurate figures, but off the top of my head we have at the moment about 30 indigenous medical graduates and about another 40 in training. That is an area where there is quite a lot of attention in terms of how Aboriginal people can be attracted into medicine and supported through that course. There are some quite interesting and innovative initiatives going on. Newcastle is the one which obviously springs to mind where they have had a long program. The deans of medical schools are looking at this and have taken it on board as a priority issue.

Again, I would be happy to try to provide you with more details on the nursing work force, but there are more indigenous nurses. Once again, that is patchy. Indigenous health workers absolutely underpin the provision of services to Aboriginal people. They act as a liaison and a bridging within Aboriginal medical services and also as liaison officers in hospitals, et cetera. The training of Aboriginal health workers varies enormously across the country.

In the last six months we have gone out to tender and contracted for a work force modelling project to try to get a much better handle on the profile of the work force in Aboriginal health—not only indigenous workers but all people working in Aboriginal health, be it Aboriginal medical services, state run clinics or mainstream services—and then to analyse the needs and future projections to give us a better handle on future training needs and putting that in place.

At the same time we have also called for expressions of interest and are just about to go out to tender on a national indigenous health worker training project, which is a more detailed boring down on what the current training opportunities across the country are, what they should be and what the links, consistency and mobility across the country are for career development for health workers. That is a general answer. I will hand over to my colleague to see if she would like to add to that.

Ms McDonald—I have nothing to add to that.

Ms ELLIS—Another question comes to mind—if you can get that information for us—is what proportion of them after training return to their community to carry on their career? Do a proportion of them stay within the urban area where they got their training? How is the impact working on the ground in the indigenous communities? I do not know to what degree you have that information. Whatever you have would be useful.

Ms Evans—At this stage we do not have good figures on retention. Perhaps I can elaborate by saying that, although the training for health workers varies across the country, in rural and remote areas the most successful model has been to train people from that community within that community as much as possible. In urban areas there are TAFE or university courses; in communities, particularly remote communities, the training tends to be much more of an apprenticeship on the ground. We fund a range of large Aboriginal medical service providers, who are accredited trainers, to run the training. For instance, the Kimberley Aboriginal Medical Service runs a training program for that area. That is a combination of workers being trained within their communities on the ground and then coming in for periods of block teaching. Experience has shown that the people who best meet the needs of their community are those who come from that community.

Ms ELLIS—I have a brief series of questions in relation to specific risk factors of alcohol and to a lesser degree drugs and also poor nutrition. You mention them in your submission and they are becoming common knowledge within the community. There are really two questions. First, to what degree are we getting a handle on exactly how severe the alcohol problem is vis-a-vis what we can do about it? Second, nutrition comes up constantly in everything we read about health in the indigenous community. Unfortunately, in the majority of remote or semi-remote indigenous communities, access to decent food is very

difficult, if not impossible, and impossibly expensive. In relation to the framework agreements, to what degree are we able to address the supply of and demand for good food for nutritional purposes in those communities—both supply level and cost level—and the educational process that goes along with it? That is a bag of questions. They all tie in together. The alcohol problem is a separate but involved question. In relation to the risk factors generally, I would imagine that those two are of primary concern. Can you elaborate to us on how we are attempting to address both of them?

Ms Dunlop—I will start with the issue of nutrition. The department as a whole is developing a national food and nutrition policy and strategy. A major component of that will focus specifically on indigenous nutrition issues. We are in the process of setting up a group of people involved in the nutrition areas from both the community sector and the states and territories to work on the development of that particular nutrition policy for indigenous people.

That policy will build on a number of pieces of work that have been done to date. The AMA released a paper on nutrition and there have been some other studies. We have tried to pull all of that work together as a starting point, and we are hoping to have a document drafted by the middle of the year that will be a guide as to what needs to be done. It is important that the approach to nutrition is part of the broader national nutrition issues and policies, and hence it is an important component of that broader document.

There are a number of specific initiatives under way in states and territories around store policies, cost of food and getting better strategies in place within individual stores on nutrition, use of nutritious foods and the costs of those. The work we are now doing will bring some of that work together and highlight where things are working and where we have been successful with different policies, but it will obviously need to involve state and territory governments and the local communities.

Ms ELLIS—Will those things come into the framework arrangements? Will they be part of the framework agreements, or are they already?

Mr QUICK—No, they are not.

Ms ELLIS—When and how will they be incorporated? It seems to me absolutely basic that if these people cannot access affordable nutritional food then a lot of the other things in this little pyramid collapse.

Ms Dunlop—Perhaps I could go back a step. The framework agreements are essentially trying to set down some principles about how the Commonwealth, the states, the community sector and ATSIC should work together on a range of issues. They have set down some outcomes in specific areas, including improving access to mainstream programs, issues around resourcing, improving data and better joint level planning at the regional level.

As part of that planning process and as part of getting better access to mainstream services, we have established forums in each state and territory and we use those as a major advisory body to have input into planning and policy processes. Clearly the issues around nutrition will need to be discussed through those forum mechanisms, but the other part of the

collaborative arrangements is that, at the national level, we have an Aboriginal and Torres Strait Islander health council. The four stakeholders are represented on that national council, and that will also be a major body in giving advice. The purpose of having a separate nutrition group is to bring in the people with very specific expertise on nutrition to guide in developing that—and that is all of the stakeholders, including NACCHO, ATSIC, states and the Commonwealth.

Ms Evans—Could I just add to that. The framework agreement gives us a framework for collaboration with relevant parties and, as Ms Dunlop has said, one of the points made under the framework agreement is to get mainstream areas to cooperate. I think the nutrition area is an interesting one, because the working party that is working on the nutrition strategy is actually drawing on the public health partnerships, which are another agreement between the Commonwealth and the states. So it is actually a collaboration between the specific areas—the Aboriginal area—and the mainstream health department areas. In fact, the working party is chaired by Dr Catford, who heads the public health division in the Victorian Department of Health. So, as Ms Dunlop has said, it is not the state forum that is running this, but it is the overall collaboration that comes through the signing of the framework agreement between Commonwealth and state health departments and the pulling in of the mainstream areas. I think this is a very good example where the mainstream area has said that one of the major nutrition issues for Australia is Aboriginal and Torres Strait Islander people's nutrition. So the mainstream public health areas have taken that on in collaboration with the more specialist Aboriginal health areas.

Mrs ELSON—When we did an inquiry up in Alice Springs and we went into an Aboriginal community centre there, they had some excellent nutrition programs that they were teaching the remote Aboriginals. When I spoke to some of the Aboriginal women who were taking the programs, they understood the nutritional needs for their children, but they told us that if they went to the stores it was just way too expensive and above their means to ever do it. It was cheaper for them to buy a carton of chips and a carton of Coke, because that was all they could afford. So it does not matter how good your programs are—and these were good programs a year ago but we are still in the same situation—until you bring the price of good food down, you are not going to change things. It does not matter how good a peak body you have at the top.

Mr EDWARDS—My question is related to that, and it is in two parts. Having spent some time in some of the more remote Aboriginal communities up in the Kimberley, I was amazed to find out that many of the communities do not own or run their own stores. They are run by individuals whose main interest is the profit factor. I was absolutely appalled to see the comparison between the very high cost of fresh food in somewhere like Balgo as compared to Broome or Perth.

In your strategic planning, what work are you trying to do to address these issues? Are you looking at the issue of ownership of these stores? Are you looking at whether or not communities should be trying to get ownership of these stores back where they do not control them?

CHAIR—It sounds like a question for Peter Taylor.

Mr EDWARDS—It is more related to strategic planning. The other thing is: what work have you done to factor in the impact of a GST on food in these communities, given the incredibly high loading rates that apply, and what is the outcome of that sort of factoring?

Ms Evans—I will just answer in general terms. The point that several members have made about the critical role of the store is well recognised and, dare I say it, somewhat intractable. Certainly, in our overall strategic planning, supply and availability is a huge factor. In terms of who owns and controls them, I will refer to my colleague for comments on that. Then I might ask Ms McDonald, if she would like, to comment on the GST.

Mr Taylor—I think there are a few comments that we would like to make on store issues and the supply, particularly, of fresh food. ATSIC, through some of its small-scale enterprise programs and enterprise support programs, has provided some support to communities who want to localise ownership and management of stores. I am not in a position today to give you any hard data about how successful that general approach has been. Certainly, communities, over a number of years, around the country, have sought support to get ownership and control of local stores. Anecdotally—and I am afraid that is all I can comment on—there is conflicting evidence as to whether community ownership and management of stores necessarily leads to a sounder approach to providing a good range of fresh fruit and vegetables and other more nutritionally sound food products to communities.

Mr QUICK—Are there any examples of best practice stores or are they all as hopeless as each other? I am being serious here.

Mr Taylor—I am certainly aware of some stores that have taken some hard decisions about what kinds of materials they will make available and what they will not. We can provide some information for you separately, if you would like. It would be a smattering of anecdotal information that I am aware of. Certainly, there are other communities around the country where the store is closely located with a canteen and profits from those areas are recycled back into community management. There is not necessarily a connection between community management and sound practice in all cases.

The other general issue that I want to raise—I think a couple of members have touched on it already—is the supply issue, the high costs of getting food into remote communities. ATSIC spends a little bit of money through its own program in trying to facilitate transport related infrastructure to communities. It is not our primary responsibility, as I am sure the committee would be aware. Essentially, it is a role for the state, territory and some local governments.

Most recently in that regard we have commenced a national review of remote area airstrips—airstrips servicing remote communities around the country—jointly with the Department of Transport and Regional Services. We have done an extensive mapping exercise on airstrips servicing remote communities and tried to get a better handle on the kinds of issues that are affecting the use of air services in getting goods and services in and out of remote communities. That report has yet to be completed. We will be trying to finalise it within a month or so before reporting to our respective Aboriginal and Torres Strait Islander ministers and transport ministers. Depending on the life of this particular

review, it may be timely for us to provide that report, if ministers agree, further down the track.

Mr QUICK—Do you agree with Ms Evans that this problem is intractable?

Mr Taylor—I think it is an incredibly difficult problem. It goes to the heart of community management. It goes to the heart of the delivery of services in regional and remote Australia. I am not sure if I would use the word intractable, but I guess it is certainly a significant problem. If you are talking more generally about nutrition, yes, it is certainly a large, complex problem.

Ms Evans—Could I correct the record—perhaps intractable was too absolute a term. I think it is an extraordinarily difficult problem. I also think everybody recognises that it is one we have to do something about. I guess I would like to withdraw the 'intractable' and say that the situation is extraordinarily difficult but nonetheless critical.

CHAIR—Ms McDonald, would you like to comment on issues to do with nutrition, that general area of the stores and the GST?

Ms McDonald—The comment I want to make is in relation to the impact of the GST. There is not a lot that we can say from our department's perspective on that. As you are aware, most of the modelling work has been done by Treasury. The impact of a GST on the price of food is likely to be fairly complex, especially in remote areas where you have a number of factors that will determine what the actual impact will be. You have the addition of the GST and you also have other changes within the system that will reduce some of the costs, such as the changes in fuel prices, and that sort of thing, and the impact of compensation provided on people's individual income.

There is not a lot that we can say about where we end up because we have not done any particular modelling work within the department on that and Treasury is probably the better one to talk to. The issue we are talking about today is not across the whole range of food prices; it is about nutritious, good quality food, the price of it and the difficulty of accessing it in remote areas. That probably overrides the GST impacts. It is more a separate issue that is probably far greater than the marginal changes.

CHAIR—May I be so bold as to suggest that there may be people in another place who believe they have some monopoly on the discussion of the GST at the moment!

Ms ELLIS—I have one more question in relation to nutrition, and I am not wishing to sound flippant. It seems to me a bit bizarre that Sydney, Melbourne and Adelaide, which particularly come to mind, are the places to have restaurants for bush tucker. It is becoming the 'in thing' in Australia today. We are told in airline magazines how marvellous bush tucker is. To what degree is there an ongoing educational process, to your knowledge, within the communities out there about what they may already be able to access before we start talking about flying in tomatoes and red meat? I do not think it is a silly question. There is good, nutritional food out there, to some degree, that our indigenous communities have lived on for thousands of years. What emphasis is being put on that side of this debate?

Ms Dunlop—I think that is an important issue that is being taken into account as well. Obviously it is what is available and what is sensible to have available in local communities. Those issues will certainly be picked up as part of the indigenous nutrition strategy.

Ms ELLIS—Could I suggest that I think it is even more important than that. Rather than me going into an Adelaide restaurant and buying crocodile, I would rather an emphasis be put on what exactly can be found out there already. I am a little bit concerned with the sometimes detrimental effect of indigenous educational processes. Maybe we are missing out on something along that line as well which may be worth looking at a little more deeply.

Ms McDonald—Could I say that, across a number of communities, there are already nutritional strategies in place that pick up the value of bush tucker. I was at Gapuwiyak up in the Arnhem Land area of the Northern Territory where they have a program running, and I think it is probably in a number of other communities as well.

Ms ELLIS—Yes. If there is any information readily available for you to let us know about, it would be valuable for us to see exactly what is happening in that area.

Ms Evans—We can certainly make that available. Mr Edwards may be aware that, for instance, Fitzroy Crossing also has quite a lot of material on bush tucker—both a video and a booklet, as I recall. A range of communities are themselves promoting—

Mr EDWARDS—There is plenty of bush tucker about, but it is often a matter of whether or not people are sober enough to go out and get it.

Ms Evans—Yes, or whether those traditions are still being pushed and followed along.

Mr QUICK—Could I follow this line of thought along. On pages 21 and 22 of your submission, there is a rather large quote from the Australian Institute of Health and Welfare entitled 'The health and welfare of Australia's Aboriginal and Torres Strait Islander people', where you quote 10 or 12 lines on the consumption of healthy foods. In light of what has happened with your liaison with the Army in developing joint projects to improve the physical infrastructure of several remote Aboriginal communities, why haven't you bitten the bullet and put in place a strategy—I do not know whether it would be ad hoc or knee jerk—to actually cross-subsidise the food in specific rural communities? Could you do some pilot projects to say that, rather than 62 per cent more expensive than capital cities, it is on a par, and do some long-term strategic health studies?

I come from Tasmania where there is freight equalisation, so people in Tasmania are paying a little bit more for their groceries, but not too much more. In light of what you did with the Army to provide housing infrastructure, why can't you cross-subsidise food to, say, 29 per cent of the indigenous communities based in remote areas that are really under the hammer? Is something like that taking place? Why can't you find some money? Obviously you found it for housing with the Army. Why can't you do it with subsidised food for some of these rural and remote communities that are obviously under the hammer?

Mr Taylor—Perhaps I can lead off with a response to that. The general provision of housing and infrastructure is consistent with the rationale for providing public social housing,

welfare housing, across the board. I think it is a dramatic policy leap to talk about subsidising the basic costs of food. Clearly it is a matter for government.

In terms of the policy leap that would be involved, I might simply draw your attention to issues such as the average costs of other related housing infrastructure services—water and power, for example. In a lot of remote communities power costs three to four times the normal tariff for mainstream suppliers in rural towns. There are enormous costs that are borne by people who choose to live in those remote communities. Food is but one of those.

Mr QUICK—I can understand that, but you can have the best infrastructure in the world and a population whose life expectancy is 35. Why don't we go back and say, 'We will provide you with some decent food that won't cost you an arm and a leg so that, rather than eating chiko rolls and those sorts of things because they are a lot cheaper, you will actually eat some decent, nutritional food'? How much will it cost? Has the department done any studies—perhaps starting with Kintore, a pretty remote and isolated community we visited where food costs an arm and a leg and people are basically on social welfare payments—to see whether it could do something like that, and say, 'Okay, food will be on a par with what food costs are in Alice Springs; we will fly it out and see what long-term impact it will have'? We are doing it with alcohol and cigarettes and we have Quit programs and all that sort of stuff, but we are saying, 'You are paying 60 per cent more for your food, so you don't eat the good food, you eat the rubbish, and then you end up on a dialysis machine in Alice Springs or somewhere in the Northern Territory that costs the Commonwealth and the states millions of dollars.' Where is the thinking in all of it? Do something revolutionary.

CHAIR—Does anyone want to pick up on that? People might want to respond on the pilot program for subsidised food and the general issue of nutrition, and then we will need to move on because we have other areas we need to cover.

Ms Evans—I would like to make a brief comment. As Mr Taylor said, the policy leap and the complications of subsidising food for remote areas on a broad basis are really very major. Having said that, the suggestion of pilot programs with cross-subsidising of food and looking at the effects is an issue that has come up. As far as I am aware, there have been a number of tentative suggestions, although I am not aware of having seen any full-blown development of it. Perhaps we can take that one on notice.

CHAIR—That is fine. Could we just wind up on nutrition areas?

Mr EDWARDS—I am just a bit surprised that you are sitting on your hands and letting Treasury do this modelling on a GST when you say in your own submission that poor nutrition is one of the major risk factors that results in poor health in Aboriginal communities. I would have thought that you would have been trying to get something to Treasury to encourage them to look at the impact of a GST either positively or negatively. If you do not do it, what comfort can we take that these issues are being properly looked at—as I say, particularly in view of the very strong emphasis you have put on the issue of nutrition?

CHAIR—Thanks, Graham. Does anybody want to pick up on that one? As I have made the point, the senators are busily debating all these matters.

Mr Taylor—I might just mention for the committee's interest that ATSIC has put in a submission to the GST inquiry. A major focus of it is possible impacts of the GST on food in rural and remote communities. I am not an expert on the submission or the research that went into it, but I certainly refer it to the committee for your interest.

Ms ELLIS—Can I suggest we get a copy of that.

CHAIR—Yes. Would that be okay? Thanks very much. That will be done.

Mrs ELSON—I am quite surprised that we are even concerned about the GST. Listening to what Mary was saying before, I am not sure it is going to make a big difference—

Mr EDWARDS—We do not know that.

Mrs ELSON—But even if it is 10 per cent, when I was up there, fresh lettuces were $7 each, so if you compare a 10 per cent GST with a 600 per cent increase in lettuce because they are flown out there that is a very small component. I think we would be more responsible to be considering the fact that most of these people are on social security, as Harry said. I know from talking to the women up there that the reason they cannot eat nutritional food is that all of the money has gone on alcohol and they are left with a tiny bit of money that allows them to buy a carton of coke and a carton of chips. So why aren't we looking at the component that says, 'Okay, you can have half of your social security for that. If you use the other half for nutrition and come into the stores we will give it to you at half the price'? That might be more worth while. It might cut down the alcohol so they know what they are eating—rather than their drinking alcohol and not even looking after nutrition because they are too intoxicated to worry about what they are eating. You can throw all the money you like, but if you do not cut down the consumption of alcohol you are not going to get people to look at nutrition.

Mr Taylor—There is one broad set of issues that I think are relevant to nutrition and access, including alcohol consumption. Particularly in remote areas, one major strategy the communities themselves have initiated to try to resolve these kinds of problems is generally referred to as 'return to country'—to establish out-stations, small homelands communities away from the larger, more urbanised settlements.

That process has been going on since the late 1960s, largely, and it is still quite dynamic in Queensland and Western Australia. ATSIC's general role in relation to that national movement has been to provide targeted support to assist small family and extended family groups to relocate to traditional country away from those communities. Often they are small dry communities and often, because it is traditional country, there is access to traditional foods and bush tucker. That general movement probably comprises around 10,000 to 12,000—that is our best guesstimate of people who are moving back to country from the larger Aboriginal towns.

ATSIC has recently just adopted a national policy framework on provision of housing and infrastructure for those kinds of communities, and within the general constraints of our housing infrastructure program we do try to provide reasonable levels of support to underpin

general community initiatives to move back to country, making available those related strategies of getting away from alcohol and getting access to traditional nutritional sources.

Mrs ELSON—Did you say that that is going on at the moment?

Mr Taylor—It is still, yes. It has been going on for some 20 years.

Mrs ELSON—Well, it is not working.

Mr Taylor—I think that it has worked in some communities. There is quite a bit of case by case evidence that in many cases out-stations are providing part of the solution to the chronic problems that larger Aboriginal towns have. I am aware, for example, of a study that was done in the Kimberleys which associated some positive health benefits from out-station living. It is an area that needs more research.

Mrs ELSON—Most definitely. Unfortunately, when we asked our young Aboriginal women with young children about why they were not using the bush tucker idea for when they did not have money for proper nutritious food, they were not interested. They said, 'No, we have tasted your food and it is hard to go back to eating bush tucker.' And these are Aboriginal women from remote areas. So we were quite concerned about that. They can buy a carton of this and that and feed it to the children, which is a lot simpler than going out and eating bush tucker, for some reason. And it is very hard for them to go back to that. If studies have been done elsewhere, why haven't they been incorporated in the areas I have seen around Alice Springs and Northern Territory? It is proven that up in those areas there is a higher death rate of infants because of what the mothers are eating when they are pregnant. So if there have been studies going on for 20 years why have they not been incorporated in areas like that where they are having problems?

Mr Taylor—I think you might have misunderstood. I was not saying that studies have been going on for 20 years; I said that the general movement had started 20-odd years ago, more recently in some parts of the country. What I said was that there is some recent research that I can provide references for, if you like, which suggests that there are positive correlations with health from out-station developments.

Mrs ELSON—Do you know which areas that refers to?

Mr Taylor—I am aware of some studies that were done in the Kimberleys, and in a recent *Australia and New Zealand Journal of Public Health* there were some studies of some mortality and morbidity indicators that suggested things were looking positive for communities around Central Australia.

Mrs ELSON—Could we get copies of those? I would like to see those.

CHAIR—I think we have to complete this part. If we have time, we can come back to nutrition. We have had a fairly good run on it.

Ms HALL—I will just make one comment if I could. When we are talking about nutrition in remote communities, how much does advertising impact on people's choice of

food? If anyone wants to come in on that, fair enough, otherwise just leave it and I will move on.

Ms Dunlop—We do not have specific figures or information on how it impacts, but we do know that some of the local community development programs and education strategies do work. There was one example where a very good education program was built around the Strong Women Strong Babies project in the Northern Territory. That again is picking up on use of bush foods and educating the community on the impact that eating healthy foods has on the babies. Actually it has made a change in the weight of the babies over the time the program has been running. So from that fairly small project they have been able to demonstrate some outcomes in improving birth weights.

Ms HALL—I think you misunderstood what I meant. What I was talking about was advertising, encouraging people to eat food like chips and drink coke, et cetera—how is that impacting?—and the fact that young women are not inclined to eat bush tucker but, rather, want to continue to eat the foods that tend to create health risks.

Ms Dunlop—I suppose it depends on to what extent some of those main advertising campaigns or information can have an impact in a range of different communities. In some smaller remote communities, access to that sort of information—advertising of different foods, coke, et cetera—is probably not a major issue. There are very complex factors that result in people using foods that are not particularly healthy. They are promoted as lifestyle issues and all sorts of things. That has a trickle-down effect often through kids and their activities, and through interactions with communities. It is very different from community to community. The complexity of the issues will be drawn out in the strategy and the various agencies that we need to involve in order to make some advances in the nutrition issue. I mentioned earlier that the document was planned to be ready in June. I should have said August; I am sorry.

Mr QUICK—How much does the department spend? What is its budget on advertising—healthy promotional stuff for Aboriginal communities? Is it $2 million, $5 million, $10 million? How much do you allocate in each yearly budget on posters and things to go in stores and in various communities? You obviously must have some budget.

Ms Dunlop—The budget for those sorts of activities is primarily through state and territory governments, through the national health partnerships. They have responsibility for all of those public health education strategies. All of the community controlled services run a range of different programs utilising their health workers and development of other material.

Mr QUICK—So the Commonwealth does not spend any money at all on advertising?

Ms Dunlop—Not directly, for those communities.

Ms HALL—The first question I would like to ask is: how are Aboriginal and Torres Strait Islanders involved in policy development directly? Are they directly involved in it?

Ms Evans—Yes, in every aspect of it. Starting with the framework agreement, that is a very strong commitment to the fact that these decisions and planning have to be done in

partnership. A top-down approach has not worked and will not work. It needs to be done collaboratively. So the Aboriginal community controlled health sector are signatory to all those framework agreements. They are partners on the state planning forums and they are members of the national advisory group. We also fund NACCHO, which is the National Aboriginal Community Controlled Health Organisation, to provide secretariat support and also for a whole range of specific project areas and work very closely and collaboratively with them.

Ms HALL—I understand that; but going back a step further—is there Aboriginal involvement there?

Ms Evans—When you say 'back a step further', what do you mean?

Ms HALL—When you get to the partnership agreements, et cetera, a lot of work has gone on before you reach that stage. What is the Aboriginal and Torres Strait Islander involvement when you are looking at setting up those frameworks?

Ms Evans—The framework simply gives you a structure for then working collaboratively, so in all the various areas when we work together—

Ms HALL—Within your department, at your level—what is the involvement there?

Ms Evans—Do you mean within the office?

Ms HALL—Yes. When you are setting out your priorities, your strategies, et cetera, what is the involvement at that level?

Ms Evans—At that level, too, we work collaboratively with the community controlled sector from the beginning, in terms of developing policies and strategies. We also have a very active promotion of employing Aboriginal and Torres Strait Islander people within government. As important, we do not develop policies and strategies and then produce them for discussion; we start from the beginning working collaboratively. Is that the question you are asking?

Ms HALL—Basically. I do not think you have answered it, but that is all right.

CHAIR—Do you want to search it out a little more?

Ms HALL—No, I am not going to get anywhere with asking. A lot of the studies that I have seen, and everything that has been discussed at length, have tended to be looking at rural and remote communities. Given that 38 per cent of Aboriginal and Torres Strait Islanders live in urban areas, what sort of research has been done there, and what sorts of strategies and programs have you in place to meet the health needs of those people?

Ms Evans—It is a point that I was going to make at the end of the discussion about nutrition. In fact, the focus of that discussion had been on rural and remote areas, and I was going to draw it to the attention of the committee that a third of Aboriginal people live in urban areas. In our planning, whilst different strategies are needed for different areas, we do

not focus specifically on rural and remote areas. We focus on planning right across the board and, in terms of where the funding from the office goes to services, a significant proportion of that goes to urban based community controlled health services. Strategies are not just focused on rural and remote areas.

Ms HALL—Could you please supply some details of the types of strategies you have for those areas—not now—so I could look at them?

Ms Evans—The strategies are focused on the particular areas. You are asking whether we have a particular urban strategy. No, we do not have a particular urban strategy as such. When we look at Aboriginal areas, we look across urban, rural and remote.

Ms HALL—I notice that the research, as detailed on page 12 your document, is focused on rural and remote areas. Is there any research that looks at urban areas? It is in section 2: health status of Aboriginal and Torres Strait Islanders. It is under mortality and morbidity rates. It says that there is a significant bias towards research activity focusing on remote areas, and this makes it difficult to comment definitively on the difference in health status between the different regions.

Ms Evans—That certainly has been the case. An NHMRC research committee has been set up to look particularly at Aboriginal health. That is strategic research. Undoubtedly, until recently the focus has been on remote areas and the research specifically in relation to urban areas is not nearly as extensive. It is a priority we have given. In a funny kind of way, while there are particular problems, rural and remote areas are easy to research because Aboriginal communities are more easily identified and located. Within urban settings, Aboriginal people are dispersed throughout the community and that is a problem we definitely have in planning.

I talked the other day about data. Our knowledge of Aboriginal people and their patterns of service use and their health status in urban areas is not nearly as extensive as in remote areas. We are drawing on the national data we have to conclude that there is not a significant difference between the health status of Aboriginal people across the areas but, in terms of focusing specifically on urban areas, we would agree with you that there needs to be much more research. Recently established at the University of Melbourne is the Koori Health Research Unit, which the Commonwealth is contributing to, and one of the focuses of that research unit is going to be urban areas.

Ms HALL—Given that the issue of Aboriginal and Torres Strait Islander health is very complex, looking at dispossession, social, cultural, economic and other issues on the ground, what is being done to take all those factors into account when developing policies? It seems to be just a narrow health focus, not looking at the other issues.

Ms Evans—As I said to the committee last week when we met, there is a vast range of factors that impact on community health, including Aboriginal health, and we are aware of those. We try to work with ATSIC and with the housing, social security, education and employment people, but the specific mandate of the office and this portfolio is health, so there is a large, grey perimeter around primary health and all the interacting, impacting effects. But our primary focus and responsibility is health care, bearing in mind those other

factors and trying to take them into account. The danger we face right across the area is that if everybody tries to take everything into account all the time you can end up getting nowhere with anything.

Ms HALL—I would like to ask about the health councils. How effective have they been? Do they have any real input? How often do they meet? And what is the status of the advice of these committees?

Ms Evans—There is a forum in each state and territory. Are those the committees you are referring to? There is a national Aboriginal and Torres Strait Islander Health Council. It is a ministerial advisory council.

Ms HALL—That is the one I am talking about.

Ms Evans—I am sorry, could you ask your questions again, now we have established that?

Ms HALL—How often does it meet? What is the status of the advice from the committee? How effective is it? What sort of input has it had? ATSIC might like to comment on that too.

Ms Evans—It is scheduled to meet quarterly—four times a year.

Ms HALL—Has it done that?

Ms Evans—Its status is that it is an advisory council to the minister so it does not have decision making powers. It is like a range of ministerial advisory councils across a whole lot of areas: it provides advice to the minister.

Mr QUICK—You say on page 34 that it met for the first time in June 1996 and has since had a further three meetings.

Ms HALL—That is exactly right.

Ms Evans—Sorry, I will correct that. When it was first set up, it was agreed it would meet twice a year, but in reconsideration of that at the beginning of last year—not long after I took over this position—it was agreed it would meet quarterly. So the arrangement now is that it meets quarterly.

Ms HALL—And has it?

Ms Evans—Yes, it has. I can give you a list of the meetings.

Ms McDonald—There have been five meetings since its establishment in 1996.

Ms Evans—When the minister established the advisory council, he suggested that he would like it reviewed within the first 18 months to two years to see how effectively it had been functioning and to see whether the composition and the terms of reference were

appropriate. That consideration is currently taking place and is with the minister at the moment. I can keep the committee posted as to whether there is a change in membership and a change in the terms of reference. It is currently with the minister at the moment, so I cannot really comment any further.

Ms HALL—I wanted ATSIC to comment on that, too, please.

CHAIR—Would ATSIC like to comment on that?

Mr Taylor—Not in any great detail. Under the MOU that we have with the department, ATSIC has representatives on a range of bodies. A fairly significant structure has developed to provide policy advice from a range of fronts, including indigenous-specific representation. The commission has taken up those opportunities, including at the council.

Ms HALL—Do you think it is effective?

Mr Taylor—I think it would be more appropriate for you to ask that question of our elected arm. I am a bureaucrat, and the indigenous-specific perspective is, I think, more appropriately sought from our elected arm. Generally, I think various commissioners and regional council chairs have been pretty active in supporting the advisory structures that have been developed under the MOU.

Ms HALL—I noticed in the submission only a fleeting mention to dental care. I see dental care as a major health issue. Would you like to comment on that, and your strategies and programs as far as that is concerned?

Ms Evans—In the services that the portfolio took over from ATSIC—the community controlled services—there were a range of services that had dental as part of their core provision. We have continued to fund those under the funding arrangements from this portfolio. As you may or may not be aware, dental services have been an area of some discussion between the Commonwealth and the states. It is the government's position that the provision of dental services is a state responsibility, and that includes the provision of public dental services to Aboriginal people.

Ms HALL—So basically it is not included.

Ms Evans—We do fund a range of dental services in a range of the Aboriginal medical services we fund. We have continued to fund those but, under the division of responsibility, it is unlikely that we would be funding any other dental services.

Ms McDonald—We jointly fund some of the services with the states, and the states provide recurrent funding in some cases for the provision of dental services in those areas.

Mr EDWARDS—Helen, what is your relationship with the Aboriginal community controlled health services? Do you work specifically with them? On page 14 of your submission you state:

In Central Australia and the Kimberley, there have been significant gains in the prevention and treatment of sexually transmitted diseases. Rates of gonorrhoea infection among males was cut by two thirds between 1985 and 1995 . . .

I think there were also some very significant controls introduced in relation to other STDs. Just generally, has that good work been maintained in relation to STDs? How do you work directly with those community controlled health service groups? Is the success they had in this area a fair indication of the benefit of letting Aboriginal communities have control of their own destiny in these areas?

Ms Evans—In relation to the specific issue of STDs, one of our specific health strategies, as you may know, is the indigenous sexual health strategy, which was largely developed by an indigenous group of people chaired by Dr Ian Anderson, an indigenous doctor who, up until recently, worked with this office. That was a strategy that was developed in very close collaboration and largely by Aboriginal people. The implementation of that strategy is one of the activities of the office.

The good work in the Kimberleys and certainly in Central Australia, particularly the work of the Nganampa Health Council, has continued and some very encouraging recent results came out in a paper that was published last year from the Nganampa Health Council. Those services have developed fairly robust data collection mechanisms, so they are in a good position to be able to report on changes. Collection and analysis of data over time varies enormously across the services. Therefore, the capacity to report on change in progress varies enormously, but those two area services in particular have certainly been able to report and continue to report very encouraging results.

We work very closely with the community controlled services. The bulk of the specific Aboriginal health money that the office manages goes to the community sector. We continue to work very closely with them on the strong understanding that, unless the Aboriginal people have a stake in and a capacity to manage and make an input and participate in the planning of services, past history has shown us that we are probably not going to make much progress.

Mr EDWARDS—Is there anyone—I am talking about more remote Aboriginal communities—that you can profile in great detail in terms of health generally?

Ms Evans—For a detailed profile and data over time, I think probably Nganampa Health Council has the best documentation and quite extensive information available. Also, of its own volition, it has decided to invite an external evaluation team to evaluate it. There is a report due out any day—I thought it was going to come out for Christmas—which I understand is a very detailed analysis of what has happened over time. When that becomes available, the committee might find it very interesting.

Mr QUICK—Following on from that, on page 1 of your submission you state:

The best current evidence indicates that the patterns of morbidity and mortality are similar throughout the Aboriginal and Torres Strait Islander population . . . However, given the weakness of existing data, there is a need for caution in assessing how Aboriginal and Torres Strait Islander health status varies either regionally or through time.

Then on page 12 you state:

The poor health status of Australia's Indigenous people has been exhaustively reported upon. However there are significant weaknesses in current evidence regarding both Aboriginal health status and the reason for continued poor health.

What are the significant weaknesses? Commonwealth governments have been studying them for 20-odd years.

Ms Evans—Tony Barnes, who heads up the ABS unit on Aboriginal statistics, has much more technical expertise in this area than I do. He is probably to appear before the committee. One of the major weaknesses is identification of Aboriginal people and therefore how robust the data is. There has been enormous variation in identification. Identifying Aboriginal people in the databases, in statistics, for a whole range of reasons which have been well documented, is the major problem in giving us a robust, extensive picture.

Mr QUICK—In light of too many forums: on page 33 you state:

The forums comprise representatives of the Commonwealth Department of Health and Family Services; ATSIC; the State or Territory health authority; and the State or Territory based NACCHO affiliates.

We now have a new Aboriginal and Torres Strait Island Health Council. What are you doing specifically to address the significant weaknesses? We have all these bodies floating around in the ether, we have memorandums of understanding with state governments, but if we have significant weaknesses in evidence what are we basing our decisions on?

Ms Evans—There is a whole range of activities going on in that area, Mr Quick, with the Australian Bureau of Statistics for national statistics. There are extensive discussions at the moment about whether we should have a repeat national Aboriginal survey and whether the data is best collected through household survey mechanisms. There is extensive work going on in trying to improve that national data. In relation to the services that we fund, we have recently concluded negotiations with the community controlled sector on the provision of health service activity data. It has taken nearly two years to complete an agreement that Aboriginal communities are themselves happy to cooperate with.

Within our own department, we are looking at issues, as I said the other day, of improving our own data sets for the main programs we run. In terms of identification, I guess our number one priority within the portfolio is to achieve identification on the MBS-PBS database. So there is a range of activities going on.

Mr QUICK—Can we have a list of members of the health council and where they come from?

Ms Evans—Certainly.

Mr QUICK—On pages 39 and 40 you come up with something which interests me because I have always been mindful, since I have been on this committee and we have been looking at indigenous health, of the need for different models in light of the obvious three groups of people we are dealing with. Our fifth term of reference is about new primary health care services in remote communities, You mention on page 39:

The Department has worked closely with representatives of State Health Departments, as well as ATSIC and State affiliates of NACCHO, to identify priority communities in the Northern Territory, Western Australia, South Australia, New South Wales and Queensland.

You mention five criteria to select communities and say that to date 31 remote communities have been identified by the department. I would be interested to know what sort of strategies you are putting in place to deal with each of those communities, depending on their size and their access to visits by nurses or GPs, and so on. It was part of the 1996-97 budget. Are things very far advanced as far as that goes? Is setting up specific models for specific communities the way to go to address a lot of the issues that we have been talking about today?

Ms McDonald—The remote communities initiative, which is the initiative referred to there, was looking at analysing which communities across the country either had no access or very little access to services. They were generally communities in very remote areas. It was an interim measure to identify communities in the absence of good state-wide needs assessment and planning data which is now happening. At the moment, regional plans are being developed through the state forums to analyse across each state and territory by region where the needs for health services are—what is there on the ground and where the needs are—and then for each area to establish priorities.

In that process we have completed the central Australia plan in the Northern Territory and also South Australia. The others are in various stages of progress. But it was known that there was a huge priority in remote areas that had absolutely no access or very little access to services to get some services on the ground. So an assessment was done of those communities. I think we have about 20 sites close to being established, so we are about halfway through. Other sites have been identified, and I think we are still in a number of areas looking at where the priorities are. Some of the services have actually been established, and we can provide you with a list of those.

Mr QUICK—I would really appreciate a list of the 31 remote communities and some really specific details about what is happening and perhaps some inter-sectorial approaches. Obviously the people from some of the communities wander across state boundaries, and I would really be interested in how you come up with strategies to deal with South Australia's, Western Australia's or the Northern Territory's responsibility.

Ms Dunlop—The models that have been identified in each of those sites are very much designed around the particular community's circumstances, needs and access to a range of other related services. A range of different models, or service types, have been developed, so they are very much responding to individual community needs.

Mr QUICK—Finally, your submission says:

To date, 31 remote communities have been identified by the Department.

Do you have a guesstimate as to how many there would be overall? Are we talking about hundreds and this is just the start of the process or are 31 all we need to worry about?

Ms McDonald—I think some more have been identified since that 31, but we would have to go back and have a look at where that process is up to. It is thought that the regional planning will identify across each state and territory where all the needs are. So that is a comprehensive look across the whole country, and we should have good information from that as to where all the priority needs are.

Ms Dunlop—The 31 that have been identified in fact cover a number of out-stations as well. So, in effect, the total number of places that have been covered by access to services is greater than 31.

Ms Evans—Just as a final elaboration on that, we are not talking about 31 new stand-alone services; we are talking about in some cases extensions of existing Aboriginal and community controlled services. Sometimes they are contracted—with, for instance, the Territory Health Services—to provide an outreach service. So it is a variation on a different range of service providers. We are not talking about discrete new services.

CHAIR—So service providers might provide a whole state across a particular delivery.

Mr QUICK—But your submission says on page 39:

. . . 35 remote communities which have no, or very limited, access to primary health care services.

You must be setting up some new services if they have had none before, surely.

Ms Evans—Not necessarily, because some of the big area services can provide an outreach service or a clinic that they support, and in many of the remote areas it is actually more sustainable to have a regional or a big based service provide a clinic that it supports rather than set up stand-alone small services in remote areas. Some of them are new, though.

Mr QUICK—As well as the list, can you give us a breakdown of how the $24 million is going to be spent over the four years?

Ms Evans—Yes.

Ms HALL—I notice that you are about to make a bit of an investment in information technology. How much is that going to cost, and how effective is it going to be in actually addressing the health needs of people in these rural and remote communities and other areas? Will that be coming out of the $7 million that has been put in place for up until 2000?

CHAIR—For whatever that extra time is.

Ms Evans—To start by going backwards, no, the $7 million is for infrastructure, which is to do with buildings clinics and houses. The IT money will not come out of that, it will come out of the growth money; $42 million over four years growth money has been targeted at best practice.

The introduction of IT systems is based on a fair amount of evidence that to be able to know the health profile of the people using the service and to be able to provide individual

care plans—for instance, we are providing coordinated care trials, which are an experiment for providing individual care plans—or indeed to be able to provide any sort of recall system for constant monitoring and screening of conditions like diabetes, et cetera, ideally you need a population register.

So we have developed an initiative which started off with calling for tenders—a national tender process—which we did collaboratively with the community services for any off-the-shelf IT programs that could provide this that were appropriate. Rather than all the individual services going out and trying to find out what works and does not work, we felt it would be useful to have a standing contract with a number of packages or assessed as being suitable for services. So we started that process, and three packages were identified. We then negotiated a price with the providers and invited services to put in bids for money so that they would themselves be purchasing that but the groundwork would have been done in identifying the range of services.

Part of the funding will involve not just the buying of the program but, as I am sure you would know, there is a huge ongoing exercise, first of all, in training staff in how to use the IT packages and then in the ongoing use of them. So that is a fairly significant initiative just in terms of increasing their capacity.

You asked how this would help individual people on the ground. All services have paper records, but quite a lot of services at this stage have only a fairly limited handle on the health profiles of the people they are meeting. Providing a population register will give them a better capacity to be able to target in on, for instance, diabetics, which I think is a good example.

Ms HALL—And the cost? Maybe you could get back to us and give us a detailed analysis of the cost.

Ms Evans—Yes.

Mr EDWARDS—My question is in relation to the states. Are you happy that they are doing enough to meet their responsibilities in the provision of indigenous health services?

Ms Evans—I might ask Mary to respond to that.

Ms McDonald—I am not actually sure what I can say on that one.

Mr EDWARDS—Be truthful.

Ms McDonald—Certainly the states and territories are working cooperatively with the Commonwealth and with the community sector through the forums. I suppose how that is going varies across the country.

Mr EDWARDS—So there is better cooperation between some states than others?

Ms McDonald—I think some states are certainly more proactive in some areas than others and in those areas things are certainly moving faster—states such as South Australia

and the Northern Territory—in identifying need and developing regional plans. So there are some state-wide priorities in addressing need. Those two states have been moving very quickly in those sorts of areas, but then other states are certainly coming along in those areas as well.

I certainly think, in relation to improving indigenous health, all states and territories are committed to making inroads into that area and to working cooperatively with the Commonwealth, certainly evidenced by the fact that they have signed up with the partnership agreements and they are working cooperatively with the state forums.

Mrs ELSON—You may not be able to answer my question today, but I would like to see some information on it. How many people are actually employed in providing services—whether they are government, advisory or council—paid by the Commonwealth? How many people are actually employed in areas of Aboriginal and Torres Strait Islander health? What is the cost of the administration side of the services?

Ms Evans—Can I clarify what you are asking. Are you asking how many people the Commonwealth employs? So you are asking how many are Commonwealth employees or is it how many people are employed in services we fund?

Mrs ELSON—In other words, people funded by the Commonwealth. I just want to know how much we spend on the administration side of supplying health, how much of that budget actually goes to the administration side. The reason I ask is that I was very concerned over one particular state we went to with an inquiry. It had a beautiful building. I had a look at their annual report and I was quite surprised to find that they had a very high administration cost of supplying office workers and so forth to the building. There was a beautiful dentist's chair that had never been used since the building had been opened because they could not afford a dentist, yet I saw so much go into the administration side that maybe could have been cut back and put into actually providing services.

That is what I am asking now. I am trying to determine how much money is actually spent on the administration side of all areas that is a responsibility of the Commonwealth—how much we put into it—and how many people are actually employed in the positions.

Ms Evans—We will certainly endeavour to find as much information as we can. We can obviously provide information on the costs of the office—the actual Commonwealth public servants; that is not a problem—as related to program dollars. In terms of the administrative aspects of the services we fund, once again this goes to the issue of good solid data. We have some data and the service activity reporting instrument that we have just recently included in negotiating with the services should give us a better handle on it. So we will provide the best data we can to you.

Ms ELLIS—I have a quick question that follows on from Graham's questions of a moment ago. What status, to your knowledge, do the arrangements under the agreements or any other coordination between states, territories and the Commonwealth have at the COAG level?

Ms Evans—I'm just trying to think.

Ms ELLIS—Alternatively, when was it last discussed at COAG or when do you expect it next to be in terms of the need for coordination at that level?

Ms Evans—I would have to take that one on notice as to when it is next expected to meet. I am not sure how often COAG is meeting nowadays, but I can find that out. This is an agreement signed by state health ministers, so it is signed at the health minister level, not at the Premier level. I will have to check this, but I think it varied across the states as to whether they had to get clearance at Premier level to sign the agreement. We can follow that up.

Ms ELLIS—I guess my question then is: if the Commonwealth has the national interest level in terms of coordination of actions for indigenous health, when does the Commonwealth intend to—if it has not already—take it to the COAG level?

Ms Dunlop—I do not think there is a view that we would take it to the COAG level but, rather, that we would use the existing ministerial forums to put issues on the agenda as needed. So, for example, with the Australian health ministers, Aboriginal health is on the agenda there as more or less a standing item. The last meeting of social and community services and income support administrators discussed Aboriginal parenting and family issues. There is a range of ministerial forums, and Aboriginal health and related matters are being brought to those forums.

Ms ELLIS—I understand that. Please bear with me for just a second. From our discussions this morning and from other discussions we have had, there is a recognition of the need for coordination at the federal level of state and territory involvement and adherence to any cross-border discussions and agreements in relation to indigenous health. Perhaps you could take this on notice and come back to the committee. I am not talking about forums, meetings and agreements; I am talking about the need at a top level to coordinate across borders and through governments. Has or do you expect the COAG level to discuss it? In the meantime, what other levels has it been discussed at in terms of coordination in the sense in which I am putting the question? If you could provide us with any information on when they have met and so on, it would be very useful.

CHAIR—That is an excellent question. Thank you. I have three or four quick questions and then we will let you people go. Are you aware of where local government or ALGA play their part in the agreement? Has your department had discussions?

Ms Evans—My understanding is that it varies across the different states.

CHAIR—But through the ALGA?

Ms Evans—Local governments get involved at the state level in regional planning. Are you asking about the national level?

CHAIR—Yes, the ALGA in Canberra. Three or four years ago there was some discussion. They were getting involved in some things, particularly infrastructure. I might ask ATSIC.

Ms Evans—Last year we had a joint meeting of health ministers and MACATSIA, and local government appears in that forum.

CHAIR—We will check what that means.

Ms Evans—MACATSIA is the Ministerial Advisory Council on Aboriginal and Torres Strait Islander Affairs.

CHAIR—What progress is there at the national level on core competencies for Aboriginal health workers?

Ms Evans—They have been endorsed.

CHAIR—So that is under way?

Ms Evans—Yes.

CHAIR—I think the minister recently opened a rural and remote health centre in Mount Isa. Are they incorporating into their curriculum—

Ms Evans—Is this the university departments of rural health?

CHAIR—Yes.

Ms Evans—We work very closely with them in terms of training, support and planning.

CHAIR—Do you know who pays for the health care for prisoners in each state?

Ms Evans—Prison health services are a state government responsibility.

CHAIR—So they receive no money whatsoever under the formula in the Medicare agreement?

Ms Evans—I will take that one on notice.

Mr EDWARDS—The government can save money if there are more Aborigines in gaol.

CHAIR—Thank you.

[11.08 a.m.]

BAXENDELL, Mr Noel, Officer, Housing, Infrastructure and Health Policy Section, Aboriginal and Torres Strait Islander Commission

TAYLOR, Mr Peter, Acting Assistant General Manager, Housing, Infrastructure and Health Policy Section, Aboriginal and Torres Strait Islander Commission

CHAIR—I welcome again the representatives from ATSIC. Thank you for participating in the previous discussion. We will go straight into general questions. I will open the batting this time and talk about the sort of work that ATSIC might have been doing in recent times with local government. Maybe we can talk about the Australian Local Government Association at the state level and talk about examples of coordination with local governments themselves. So, in terms of the issue of local government, could we talk about the collaboration—that seems to be the word we use these days—and where we are at with local government.

Mr Taylor—I think it is important to set the scene a little bit. As members may be aware, the general structure of local government varies enormously from state to state. In most states the entirety of the state is incorporated in what you might call mainstream local government areas. However, in a few states, particularly the Northern Territory, South Australia and Queensland, there are Aboriginal specific local government structures that are established either under legislation or through de facto local government legislation. In terms of general discussions about roles and responsibilities of local government, it is important to bear in mind those specific legislative structures and how they feed into the general funding flows that come through mainstream local government arrangements, through local government grants commissions in each of the jurisdictions.

Having noted that, I think the committee is probably aware of quite longstanding concerns about the relationships between local governments—particularly mainstream local governments—and many urban, rural and remote indigenous communities. It is probably also aware of longstanding concerns that Aboriginal specific local governments, because of their size, may not be adequately resourced to operate effectively as full local governments. Those two broad issues have been on the agenda for quite some time.

Some time ago ATSIC embarked on a fairly long-term relationship building process with local government, primarily through the Australian Local Government Association. Some years ago we started joint funding local government policy offices with state affiliates of the Australian Local Government Association to identify issues where there was a need to build relationships, to change working practices and to improve the level of services that local governments were providing to Aboriginal and Torres Strait Islander people.

Where that is at the moment is that most jurisdictions in Australia have some fairly specific issues that they are working on. One of our major concerns, from a housing and infrastructure side, is targeting those areas where Aboriginal communities are not well integrated or related to mainstream local government structures—particularly in areas of recurrent management of infrastructure and funding of housing related infrastructure such as water, power and sewerage. Other areas of local government servicing, such as

environmental health monitoring and public health issues, are of significant concern to us in terms of building better relationships between Aboriginal communities and mainstream local government and better supporting Aboriginal specific local government structures to take on those kinds of responsibilities more effectively.

We can provide you with some information about specific initiatives that are in train around the country, but perhaps, having set that scene, you might want to ask specific questions.

CHAIR—My understanding is that there is a constant discussion about where the responsibility falls. As you say, there is variability across the states. In the state of South Australia you have the defined areas of local government and an area known as 'out of area', which is this huge area between that and the Pitjantjatjara lands, for example. I think many of us understand that variability. In terms of the division of responsibility, when ATSIC is required within its budget—and there will always be limited resources—to provide infrastructure, I wonder whether you could explain in a general sense whether you believe the current Commonwealth, state and local government funding arrangements are fairly distributing in a way which tries to define those areas where ATSIC is not unfairly asked to do a whole lot of infrastructure work which could properly be picked up by other levels of government.

Mr Taylor—It is very difficult to comment on that at a national level. The arrangements are quite different; the state of play in terms of negotiations with states and local governments is quite different in each of the jurisdictions. For the committee's interest, I might mention that within a fortnight ATSIC will be releasing a report which is an attempt to develop a national picture of recurrent funding for power, water and sewerage for around 790 discrete communities in Australia. By 'discrete' I mean those communities which are not connected to mainstream services for power, water and waste management and which, in a sense, have some local responsibility for managing those services.

The research that we are doing has tried to map the kinds of services that are present in those 790-odd communities and to outline the range of recurrent funding that is currently available to those communities. It also maps the kinds of recurrent costs that are indicative for the effective management of those services—in an attempt to identify a funding gap between both ATSIC and state government levels of funding for those power, water and sewerage services—as an information base for everyone to start focusing a little more closely on those specific issues.

CHAIR—In terms of funding generally, but particularly Commonwealth, state and local—if I can be as broad as that—going back to the earlier question of health, do we have an understanding of how much is spent on administration? Would that report bring out the administrative costs and the actual costs in infrastructure itself?

Mr Taylor—The report does not focus on the level of public sector administration of those funds. It simply tries to identify recurrent funding flows for those key services that I mentioned. ATSIC is not in a position to gather data about the level of administrative costs for state based water and power—and nor is local government, for that matter. That would be a fairly significant research task in its own right. But we can certainly provide you with

information about our own administrative costs. We have not really focused on administrative costs of other levels of government.

CHAIR—But we do know that, as you suggested earlier, the costs are extraordinarily expensive: you would go immediately to three or four times the cost in distribution of power.

Mr Taylor—Certainly the costs of direct provision are expensive; but I thought your question related to the administrative costs associated with that.

CHAIR—It did. Ms Ellis has questions now.

Ms ELLIS—With the 790 communities that you mentioned, did you say they had no town water? What was your description?

Mr Taylor—They are not connected to mainstream services.

Ms ELLIS—How are they currently managing, generally?

Mr Taylor—They often have their own locally managed water supplies, through bores or catchment or ground water supplies. In some cases, Aboriginal local councils have some formal responsibility for those. Generally, they have their own generators for electricity—either diesel or hybrid or some other form of small-scale power generation for community level service.

Ms ELLIS—How did the 790 qualify to be part of that examination? Were you looking for inadequate services? Is that what got them entered in this survey? Or were you looking at just anybody who did not have a mainstream water supply? And are you doing a grading of best practice and worst practice?

Mr Taylor—The criterion for inclusion in the work was basically not being connected to a mainstream service of reticulated power or water.

Ms ELLIS—So we may have some very successful and adequate supply services occurring within some of those 790 communities?

Mr Taylor—Oh, yes. This was a straightforward mapping exercise. It was not necessarily trying to demonstrate good or bad practice. It was really looking at a whole range of people and services.

CHAIR—It is an audit of what you have got.

Ms ELLIS—That leads me to the Army example that was being talked about in submissions and earlier on. For the sake of our records and my own information, how were the communities chosen and what liaison occurred between the bureaucracies involved and the local indigenous communities at the same time?

Mr Taylor—The AACAP program was underpinned by a memorandum of understanding between ATSIC, the Department of Health and Aged Care, as it is now, and Army. Under that MOU, we spelt out a staged process to identify communities for inclusion in AACAP. The first stage was to look at ATSIC's list of priority communities. We have since 1994 regularly undertaken assessments of communities around the country to prioritise a national list of communities in need of capital assistance to improve their environmental health standards for housing, infrastructure, water, power and sewerage. From that list we have developed a priority list towards which we target our large-scale capital programs. That was our starting point.

We then consulted with the Department of Health to identify areas they thought were priorities that would cross-tabulate with our list. We also sought briefings from Army about their capabilities and interests. Their general engineering services are targeted in certain parts of the country. Their mobile capabilities, which are what we were looking at trying to use under AACAP, are generally focused in the north of Australia. That is consistent with where they deploy their resources in terms of their defence and training profile.

Having put together that fairly large list and examined the intersections between them, we identified a number of communities who were then visited by bureaucrats who explained to them what might be involved in AACAP and sought their views as to whether they were interested in anticipating. It was very much a matter of whether the community was interested in being involved in this process—and that is pretty much how it has worked.

As I mentioned earlier, the AACAP operates as a relatively small section of our general National Aboriginal Health Strategy, which is a fairly large, nationally targeted capital program. Through that program, we contract private sector program managers for the overall program. They take on certain roles in assessing community need, in managing funds and in overseeing contractors and subcontractors in the actual construction process.

So, within AACAP, Army, through negotiation with us, took on roles in project management and subcontracting in terms of construction, but they were oversighted by our general program managers, who are contracted directly to us, to ensure that communities get value for money and oversight technical aspects of project delivery.

Ms ELLIS—What sort of audit process does your organisation undertake at the end of any one of those individual projects to assess the adequacy and success of the physical infrastructure that has been involved?

Mr Taylor—I am not sure what you mean by audit process.

Ms ELLIS—Checking out.

Mr Taylor—In terms of quality assurance processes, one of the stages in our looking at a possible community is that we ask our contracted program managers to undertake some indicative costings of private sector delivery of a project. We work up a scope of works—how many houses, how much water, what kind of sewerage system and those kinds of things, and then we get some private sector expertise to do an indicative costing of what it would cost for the private sector to deliver a particular project. The Army provides costings

and, if they are reasonably comparable, if we are guaranteed that we are getting value for money and the community is getting value for money out of Army involvement, then the project will proceed.

In terms of the general scope of works—what houses, what kind of water and sewerage systems should be needed—we jointly review with Army their capabilities in terms of delivering the technical expertise that is required for that particular package of works. I do not think Army would be too worried by a frank admission that they are probably not very strong in terms of house design. It is not an area that Army are particularly well equipped to do, particularly in indigenous housing where there are fairly specific design issues. Generally, we try and supplement Army's capabilities with private sector expertise and package out the works in that way.

As to the overall delivery of a project, once the community has accepted Army as taking on project and delivery roles in their community, at various stages a community is required to sign off to satisfaction with the progress of works. That includes a final sign off when works are completed. Under most of our large scale capital programs, we have extended what they call a defects liability period. Normally in the industry it is around six months, but, for our projects, because of the particular problems in design and delivery in remote areas, we have extended that under our contract arrangements to 12 months. So, if there are defects or problems that emerge with housing and infrastructure in terms of construction and design, for 12 months after the practical completion of the works we have some recourse. So there is that kind of review process at the end.

Ms ELLIS—The Army projects involve water, sewerage, dust control, roads and housing?

Mr Taylor—In terms of AACAP?

Ms ELLIS—Yes.

Mr Taylor—No, the Army have also agreed that they will provide a range of what they call tasks of opportunity. So the core of the work is a capital program, providing those items that you mentioned, but because—when Army engineers and construction gangs mobilise—they take medical crews, Army have agreed to provide opportunities for the related support.

Ms ELLIS—So there are flow-ons?

Mr Taylor—Yes.

Ms ELLIS—The chair mentioned earlier on this morning an ad hoc or anecdotal comment about a house having a life of seven years. To what degree does training occur between either the Army or any of the private sector organisations in relation to capital works in remote communities for an ongoing approach by the community once the operators of the program have gone?

Mr Taylor—I think there are probably several elements to my answer to that. We have made it a requirement of our contracted arrangements, both through program managers and

project managers at the local level, that training and employment and some strategy for recurrent management of housing infrastructure should be part of the overall planning and delivery of projects.

In AACAP, the Army do have trainers as part of their mobilised teams, and they have been providing on-the-job training to Aboriginal people both in the construction of houses and infrastructure and also in providing some training in their recurrent management and maintenance. In terms of AACAP projects, that kind of training tends to happen in-house.

In relation to the balance of our capital programs, with the rest of the NAHS program, which is by far the bulk of the dollars, we generally require project managers at the community level to work up those kinds of recurrent management plans and to negotiate with the community for their involvement in training and employment strategies as part of the construction phase as well.

Support for those kinds of training and employment outcomes we need to negotiate through external funding agencies such as the Department of Employment, Work Relations and Small Business, or state training authorities. That is an integral process for the scoping of a project and for establishing how it will actually work in a community. We do not force communities to be involved in employment and training during the construction phase. There is often a balancing act in terms of taking a bit longer to deliver a capital program but involving people in employment and training strategies as part of it, or doing the work as quickly as possible without necessarily trying to package it to accommodate employment and training strategies which might take some time. For example, housing apprenticeships can take three to four years.

Ms ELLIS—Sure, I understand that. But the maintenance of a pump bringing water to the surface will not take a three- to four-year training program.

Mr Taylor—No, that is right.

Ms ELLIS—What I am really getting at here, I think, is outside the housing question, although housing is a good example. If I can go back to this 790-community survey audit, when you look at that, will you also be considering not only the method or adequacy of supply at the moment but also the adequacy of maintenance in those communities and to what extent we can gauge how we are failing with the ongoing upkeep of things?

Housing is one thing, but water and sewerage are, in my view, the base of everything. When we go into a community and enhance its health by giving it a good water and sewerage supply, rather than generally as a principle encouraging, why isn't it more stringent that there has to be a lot more work put into it? With the greatest of respect, I understand the difficulties, but it seems to me almost a waste of money or a waste of value if we do not somehow, with the strongest urging, encourage the maintenance of that sort of infrastructure at that base level when it is put in as part of the installation process.

Mr Taylor—We do. As I said, each capital project that we deliver includes as part of its overall delivery the identification of the recurrent management strategies for whatever is delivered, be it water, power, sewerage or housing. To the best of our ability we try to

identify the available resources that are needed to support that strategy. The NAHS program that I am talking about is essentially a capital program. It has been designed and delivered over the last four or five years as a way of leveraging up interest and support from other agencies, including state and local governments. If you look at our annual report or various other public documents about the program, you will see that on a case by case basis we are negotiating agreements for state governments to pick up recurrent responsibility for water and power as part of an overall improvement in coordination around that community.

I think there is still a shortfall in recurrent funding available to support an adequate network of skills at the community level to manage housing infrastructure and essential services. Part of that research that I mentioned earlier was trying to identify the quantum of that broad funding gap. But it is an issue that we are working on very heavily both at the macro level—looking at the general resourcing picture—and at the micro level in trying to stitch up arrangements at the community level to ensure that housing infrastructure is sustainable.

Ms ELLIS—When is that 790-community survey going to be finished?

Mr Taylor—The report should be finalised within a fortnight. We were planning to have a public release, probably in mid-March.

Ms ELLIS—We need to see that, Mr Chair, when it comes out.

CHAIR—I think that whole topic is really very important. There are a whole lot of things you can do with pie charts and the rest of it, but I would be interested in the relative differentials for provision—this issue of three to four times cost or whatever it is—of a service in remote and rural areas et cetera. It is not just the initial capital cost, because as you know these 790 communities are those not tapping into the main lines and the costs are very significant. It is not just that; it is also the maintenance and, as you have touched on, the training and that whole issue of empowering those communities to participate themselves as well as getting those costs down. In terms of the analysis that we might get from these 790 communities I think it might be very valuable to get some idea of those relative costs. If it does not show in the report—and it may not have been within the brief—it would be very interesting to try to understand where those dollars are going, because it really is a huge amount.

Mr QUICK—In appendix D, under 'Management and Delivery of Housing and Infrastructure Programs' you refer to 'the overlap and duplication between existing indigenous housing programs'. Can you explain what you mean by the overlap? I thought there was just one indigenous housing program? Are there dozens, or two or three?

Mr Taylor—There are a few possible sources of funding. As I mentioned earlier, I think the bulk of Aboriginal people renting houses live in public housing. That is generally not considered indigenous specific; it is just general mainstream public housing.

Mr QUICK—On that, would it be more effective to hand that housing of indigenous people over totally—the 36 per cent who live in capital cities and major urban areas—to the state housing authorities and say it is their problem? For example ATSIC have lost health

and it has gone over to the Department of Health and Aged Care or to Family and Community Services or whatever the conglomerate is called these days: would it be far more effective for that 36 per cent who live in capital cities and major urban areas to give it to the states and say, ' Here is the standard we want. It is your problem. You have the infrastructure. You deal with it.' So New South Wales and Victoria, for example, would be asked to deal with it rather than ATSIC be part of a Commonwealth working group with another level of bureaucracy and all these consultations and the like? Would that be more effective?

Mr Taylor—The situation has changed quite radically in the last two years in terms of indigenous housing. All but two states have now got bilateral agreements on Aboriginal housing, which has integrated the Aboriginal specific housing dollars at a state level through establishing a single body within each of those states to deliver Aboriginal specific housing.

Mr QUICK—So what do you mean by a single body—the state housing commission or whatever the state authority is called?

Mr Taylor—It varies a little in each state. In the Northern Territory there is a body called the Indigenous Housing Authority of the Northern Territory, which administers ATSIC's housing program and the Aboriginal rental housing program provided through the state housing commission.

Mr QUICK—But it is a separate bureaucracy—separate administrative costs?

Mr Taylor—In terms of the Northern Territory it is basically a joint administrative effort between ATSIC and the Northern Territory Department of Local Government and Housing.

Ms HALL—And in New South Wales?

Mr Taylor—In New South Wales a bilateral agreement was signed last year, and legislation has been introduced to establish an indigenous housing office.

Mr QUICK—So how is that incorporated into the housing department or whatever the housing service is called in New South Wales?

Mr Taylor—I think the indigenous housing office will be considered as a funder. Their program will be administered, I suspect, by the New South Wales housing department as a contracted program manager. They will be separately supported in terms of their planning and policy advisory roles.

Mr QUICK—Should they be?

Mr Taylor—If they are going to be effective, yes, they do need to be supported in those activities. The process of integrating Aboriginal housing programs on a state by state basis has been going on for some years now. As I said, all states but two now have bilateral agreements.

Mr QUICK—Which states are those?

Mr Taylor—I am sorry; I forgot Tasmania. Queensland, Victoria and Tasmania are the states that still have not signed. In all of those states, discussions on bilateral agreements are fairly well advanced. In Tasmania I think there was a recent statewide meeting that broadly endorsed an approach for integrating housing programs in that state. Victoria has had a statewide meeting to consider a draft bilateral agreement which involved community members as well as representatives of ATSIC and the state government.

Mr QUICK—So if you are an indigenous person living in Queensland and you wander down to Tasmania, do you get the same basic level of housing services and access to housing? Or does it depend on which state you live in?

Mr Taylor—It does very much depend on which state you live in. The national picture on indigenous housing need is quite varied. There are fairly distinct aspects of housing need that inform public debate on this area, as far as I am aware. For example, in key areas in the south-east and settled parts of Australia, the primary concern is about affordability and some levels of overcrowding. In rural and remote communities, the main problem in terms of housing need is generally defined as access and appropriateness. There are high levels of overcrowding and there is still some direct homelessness. There are quite distinct problems in what you are pursuing in terms of housing policy and programs.

Mr QUICK—So if we asked you what were the housing requirements of indigenous people in Queensland in those three areas we are talking about—remote, fringe dwellers and urban indigenous people—could you provide us with a breakdown of the waiting list in each of the states?

Mr Taylor—I could not give you a public housing list, no.

Mr QUICK—The reason I am asking is this: is the need greater in Brisbane than Mount Isa?

Mr Taylor—ATSIC's view is that the most significant housing need is in rural and remote areas, in terms of direct homelessness—people still living in improvised dwellings—and in chronic levels of overcrowding in many communities. In terms of national policy debates, our view has been that we should target, as far as possible, available funds to meeting that aspect of housing need. There are people in Victoria and New South Wales, for example, who would say that that is important but we should not neglect urban housing need, that it is quite significant as well.

Since 1992, ATSIC has been doing fairly significant work in mapping the extent of housing need. I think it is mentioned in our submission, but we can certainly provide you with more information. We have undertaken a two-stage periodic survey of housing and infrastructure need in Aboriginal communities. In 1992, we started a specific survey of housing infrastructure in rural and remote areas—those discrete communities that I mentioned before. We have also commissioned research to specifically analyse census data to identify Aboriginal specific housing issues as they have emerged through the census on population and housing every five years. We see those as two stages that are complementary. The census data has no information about infrastructure, for example, and all the health

related infrastructure that is important for adequate housing, particularly in remote areas. But it does have a lot of nationally consistent data about housing needs.

We have tried to supplement the census with an Aboriginal specific survey census, as it were, to complement that picture. That work was first started in 1992. We are just in the process of finalising the next lot of research, based on the 1996 census. We have commissioned the same academic, Roger Jones, to undertake a fairly detailed analysis of the 1996 census on population and housing to identify the different kinds of Aboriginal housing needs based on that census. We have contracted the Australian Bureau of Statistics to oversight another survey of rural and remote community housing infrastructure need. The actual survey work is likely to start later this calendar year.

Mr QUICK—I am interested in one of the Commonwealth working group's main recommendations that indigenous specific housing funding through ATSIC, DSS and so on be amalgamated and delivered from one source. Which source would that be?

Mr Taylor—In general terms, in practice, it has been the indigenous control body that is established under bilateral arrangements. As I mentioned earlier, the Commonwealth, ATSIC and the state governments, in all but three states, have negotiated bilateral agreements. The general premise of those agreements has been to integrate those funds in a single pool for more effective administration.

Mr QUICK—You mention in this document the greater targeting of funding and acceleration of the reform process of the indigenous housing sector. Are we going to reach the stage where state boundaries are irrelevant and are we going to say, 'The greatest area of need is situation X and the Commonwealth, the states and ATSIC agree that it is not state funding; it is Australian housing funding for indigenous people'? Will there be a set of priorities, rather than having a scatter gun approach, in consultation with the Army, local government or whatever so we can sort out the worst and, as the chairman said, provide adequate training to indigenous people to maintain whatever is put there so that we get the best bang for the buck?

Mr Taylor—To take the first part of your question, which related to whether we are going to get to the point where we have a national focus and national targeting of priority need, I think we already have that. The bilateral agreements I am talking about are generally focusing on our regional council housing dollars and have been trying to integrate programs that tend to concentrate on fairly small scale housing provision. Separate from that, ATSIC has maintained a National Aboriginal Health Strategy program which, consistent with what you have been saying, identifies communities at a national level, irrespective of which jurisdiction they are in, against criteria of environmental health need. So 300 or 400 communities every three or four years are assessed individually for their needs for housing infrastructure upgrades. ATSIC is managing a three- to five-year rolling program of capital works in those communities against a prioritised list, to improve housing and infrastructure on a targeted basis.

CHAIR—On a needs basis rather than by what might be called body politics or whatever?

Mr Taylor—Yes.

Mr QUICK—Have we got to the stage where we have a house design that is suitable for indigenous people, that is low maintenance, or is that just a big wish and we will never do it? Everywhere we go, people say, 'The design is wrong, it is not fit for the people.' Surely in this day and age when we can send people into space we can come up with one or two basic designs so that we can say to Aboriginal communities, 'Which one do you want?' and we can mass-produce them in some format and provide some training for indigenous people so that the basic right of all people to have adequate housing is met.

Mr Taylor—I am not sure whether it is a cause for lament or just practical reality, but there are no one or two designs that I am aware of that are suitable for all Aboriginal communities. Let us leave aside urban Australia, where houses are generally connected to services. It has been our experience in managing housing and infrastructure that there are a large number of designs that are suitable for some communities and not for others. We have resisted a tendency to try to pick winners and say, 'Here is a short number of designs and layouts which are suitable.' The range of factors that impact on the suitability of a house are so varied that it is very impractical to expect that one or two designs would meet the diversity of circumstances. I am talking about climate, family formations and issues such as the nature of the ground water in certain areas—hard or soft—which requires certain specifications in terms of pipes and taps. Down to a micro level of detail, there is an enormous amount of diversity involved.

Mr QUICK—But, in our experience, the Pitjantjatjara have figured that they have come up with what is suitable for them. They are the traditional homeland indigenous people. Surely some given modification of what they have done would be a basis to say, 'There is no excuse for people living in say the central Australian area that this model, with some variation will not be effective.' If you live in the cyclone areas there are some basic givens so the thing does not get blown down every time a cyclone comes in. We have a core that we can say there is adequate sewerage, it is not lying flat on the ground so if you get eight inches of rain overnight the whole place falls apart. Then there would be no real excuse for anyone—Commonwealth departments, state departments or local government—to come up with the furphy that it is too difficult to come up with a basic house design so the people do have some basic shelter.

Mr Taylor—Our approach has been to encourage the multiplicity of housing designs, rather than to try to narrow it down to a single one or two. Maybe I can say a bit about what we have been doing. Firstly, in terms of the nationally targeted needs priority projects that we are funding, generally each of those projects will involve architectural advice provided to the community. There will be a process of consultation about the design of specific houses. In some cases it will get down to individuals and extended families being involved and consulted about house design. It will be important for us to make that kind of expertise available on a local and regional level to enable specific designs to be adapted to local need.

The other general front that we have been pushing is the oversight of construction. One of the major problems that has beset housing programs at Commonwealth and state level for quite a while has been a lack of regulatory oversight to ensure that construction standards are met by contractors and subcontractors. In a lot of remote Australia—and this is an issue that

comes back to the local government question earlier—the process of enforcing building codes and building standards is very poor.

As far as I am aware, in the top half of Western Australia it is still optional for local governments to enforce the building code of Australia. Our approach to that has been to rely on our contractual arrangements to insist on fairly rigorous approaches to monitoring standards compliance as the project is being delivered. I mentioned earlier that we have extended the defects liability period for constructed works to 12 months, as opposed to six. That is largely our response to the still inadequate arrangements for enforcing design and standards in a lot of remote communities. So that is another angle.

Mr QUICK—What model house did the Army build under their AACAP program? Who decided what went where?

Mr Taylor—As I said, the Army were quick to admit that they did not have particular expertise in house design—in architecture. I will have to tell you in more detail for particular communities, because there are five or six that we are talking about.

Mr QUICK—I think we are going to visit some of them, so I would be interested to know whether the six remote indigenous communities that we spent the money on have the same model house or, if they have different models, why.

Mr Taylor—From recollection, not all of them actually included housing. I would be very surprised if they all had the same design. Certainly, it would not have been a design generated by the Army. It would have been a separate element in the overall project delivery for consultation and design issues to be handled separately.

Ms HALL—I have three questions, and I will try to keep them brief. Firstly, I noticed when reading your submission that there appeared to be some frustration about the current model that is used for the delivery of health services. Now that you are a little further away from when you wrote that, I am wondering how you feel about the fact that Aboriginal health is now within mainstream health. Do barriers still exist which prevent Aboriginal and Torres Strait Islanders from accessing these services? Do you think that the health department is able to cover the holistic needs of Aboriginal and Torres Strait Islanders?

Mr Taylor—Are you referring particularly to the submission from Commissioner Delaney?

Ms HALL—Yes, I am.

Mr Taylor—I think it is fair to say that the significant barriers to access that Commission Delaney was talking about are still there. I do not think there are too many people who would say otherwise. So, in terms of locational disadvantage and various other barriers that are identified in our submission and other submissions as well, clearly there is still substantial work to be done to remove those.

As to whether ATSIC is happy or comfortable with the transfer of Aboriginal-specific health service funding to the mainstream Department of Health and Aged Care, the board of

commissioners was clearly not supportive of that transfer at the time it happened, and I do not know that they have revisited that decision. I understand that the administrative arrangements for Aboriginal-specific health services funding is to be reviewed and reported to government in 2000-01. A review of the administrative arrangements between ATSIC and Department of Health and Aged Care is due for review in that time period.

Ms HALL—Do you think that Aboriginal and Torres Strait Islanders are being disadvantaged by the current situation which has just the health focus?

Mr Taylor—I am not quite sure I understand your question. Are you asking whether the approach that the Commonwealth is taking—

Ms HALL—I am asking whether, under the current arrangement, Aboriginal and Torres Strait Islanders are being disadvantaged as opposed to having a situation where Aboriginal-specific health delivery is looked at by itself, taking into account the environmental, social and economic aspects and the things that are listed here—for example, looking at sewerage, rubbish removal and safe and adequate water supply.

Mr Taylor—From a Commonwealth point of view, I think the activities of the Department of Health and Aged Care and ATSIC can be seen to be fairly complementary—in the sense that we target environmental health issues, particularly housing infrastructure and those related services and Health and Aged Care deal with primary health care and a range of other health policy matters. The MOU that we have between us sets us the fairly challenging task of trying to pull those together into the most effective range of strategies that will not only deliver Commonwealth services effectively but also work well with state and local governments.

The current framework at the Commonwealth agency level and the framework agreements that have been established attempt to do both things that you are asking about: to tighten the focus on primary and to provide that broader holistic approach to indigenous health.

Ms HALL—The next question I want to ask relates to Aboriginal and Torres Strait Islanders living in urban or rural settings. I have worked in the delivery of allied health services in those areas, and I have found that there is very little difference in the relevance of those services to people who are living in the remote areas—that is, you still have the same problems with people accessing the services. What would you attribute that to and how do you believe those services can be made more relevant?

Mr Taylor—There is a whole range of issues involved in why mainstream services are still not as accessible to indigenous people as they might be. I think, on that front, it is perhaps more a question for my colleagues in Health and Aged Care. You could look to the underlying socioeconomic disadvantage that indigenous people have. That simply underscores the continuing need for indigenous-specific services to, as it were, bridge the gap.

As I understand it, there is a continuing effort to fund Aboriginal-specific services in urban and rural towns. The broader and longer term strategies have been put in place, and

they are largely to involve indigenous people more in mainstream structures through things like hospital boards and a range of other mainstream health planning and policy forums. That is one of the key elements in a broader strategy to try to improve the accessibility of mainstream provision.

Ms HALL—My final question is: how essential do you think ATSIC's role is in the provision and improvement of health services to Aboriginal and Torres Strait Islanders?

Mr Taylor—Our roles are reasonably well spelt out in the submissions that we have made in the MOU. In primary health, I think ATSIC sees its role as a source of advice and opinion about the delivery of services and that is consistent with our elected arm's involvement and the range of policy and planning forums. Certainly we see ourselves has having a fairly crucial role in the development of regional plans under the framework agreements with each of the states and territories. Essentially, it is providing a strong indigenous advocacy role within those emerging planning and delivery forums. ATSIC has a very strong focus on community based delivery as a model across a whole range of service areas. I think our continuing involvement in that area is something we will be taking up on an ongoing basis.

Ms HALL—So you would see it as essential and that Aboriginal and Torres Strait Islander people would be disadvantaged if you did not play that role?

Mr Taylor—I believe we have a fairly significant contribution to make. The Aboriginal community controlled health organisation sector itself clearly has links back to the community and has an important role in putting forward a community perspective. What ATSIC is able to bring is a community view that sees health within a broader framework of political and social issues. That is one of the distinctive things that ATSIC as an advocate of indigenous interests can bring to the health forums that are established.

Mrs ELSON—How much of what ATSIC spends actually goes to rural and remote areas and to urban areas? The reason I ask this is that it seems fairly prominent in our inquiry to date that when we are in remote areas people do not have a high regard for ATSIC, but in urban areas they have a very high regard. I wonder whether this is to do with funds going into urban areas. I am not accusing anyone; I am just interested to know why. I do not expect you to have the figures today, but could you give me the figures on the administration cost of ATSIC and where the funds go to rural and urban areas?

Mr Taylor—Sure.

Mrs ELSON—Do you know of a project that has been very successful—I am sorry to be so evasive but I was speaking to a state minister yesterday when, unfortunately halfway through the conversation, he was called to do his official duties and we did not get a chance to continue. He was telling me that there is a very successful program in Queensland. I presume it is run by the Queensland government for him to know so much about it. He said that in a pilot program—I presume in Queensland—Aboriginals were being consulted about the house designs they wanted. Apparently they did not want walls or floors in them and they had an open area in the middle where they could burn their fires, but they were protected from the elements and they had running water. He said this was extremely

successful in bringing up the morale of Aboriginal people in this community. Do you know where that program is? I would love to have a look at it. I tried to get through to the minister this morning. Were you involved in it or do you know much about that program?

Mr Taylor—Just to take your questions in order, were you first asking about our housing infrastructure program and how much of that goes to rural and remote areas, as opposed to urban, rather than all of our programs?

Mrs ELSON—All of your programs, because it was in different areas that we were getting this feeling. I have to be honest and say that they would not say it publicly, but when I talked to people personally, I was getting that feeling all the time.

Mr Taylor—I can tell you now that about 85 per cent of our CHIP program—which is about $210 million a year—goes to rural and remote communities. Our program does heavily target those rural and remote communities. As you know, 38 per cent of Aboriginal people live in urban areas and ATSIC's conscious strategy has been to target our program around what we expect should be provided by other agencies. So the fact that there is a private rental market and substantial public housing provision in urban areas underpins our targeting of rural and remote areas. Our housing and infrastructure program is heavily targeted to rural and remote communities.

I will have to get back to you on administration costs. Concerning the Queensland government project, there are quite a number of fairly innovative programs at community level across Queensland. There are several that I can think of on Cape York that would fit the description you are talking about. If you like, I can provide you with a list of the projects that we are involved in funding that are substantially rebuilding. I suspect it might be Old Mapoon up on Cape York.

Mrs ELSON—I had a feeling it was up on the cape somewhere.

Mr Taylor—There are several fairly large-scale housing infrastructure projects currently going on there. We can provide you with a list and see whether that helps.

Mrs ELSON—Thank you.

Mr EDWARDS—Did I understand you to say that ATSIC have not revisited the question of losing the health funding?

Mr Taylor—The board of commissioners has not reconsidered its earlier position, which was not to support the transfer, but that was 1994. Since then, our elected arms—the board of commissioners and regional councils—have contributed in good faith in the processes and forums that have been established jointly with Health and Aged Care. I think we have made a reasonably significant contribution through those forums. Formally, the board of commissioners have not revisited that earlier discussion.

Mr EDWARDS—But your current position is as per your submission where you say, 'It seems imperative that the time has arrived to review and reassess the decision to extricate the Aboriginal health funding responsibilities from ATSIC.' Is that still your position?

Mr Taylor—Yes, and as I understand it, Minister Wooldridge is undertaking that review in the year 2000-01. It was anticipated in the initial cabinet decision that the administration arrangements would be reviewed I think five years after the transfer.

Mr EDWARDS—From my own experience, it seems to me that the relationship between ATSIC and a number of the remote communities is not a good one. If that is the case, do you accept that, and is it not much more difficult for you to influence a number of the communities in relation to, for instance, some of the environmental health priorities that you set for various communities?

Mr Taylor—I do not necessarily accept that our relationship with remote communities is poor. I think certainly our relationship with community organisations fluctuates a little depending on a range of matters, including funding decisions that we take. It is very difficult to keep everybody happy, and certainly that is not our main goal. Our main goal is really to provide good programs and to advocate the interests of indigenous people. So from time to time there will be organisations which are critical of ATSIC and of how we do our job.

Mr EDWARDS—Okay. There is something in your submission that I might say I strongly agree with. You state:

It is the view of ATSIC that the key to improved health outcomes for Aboriginal and Torres Strait Islander Australians is the effective co-ordination of health care programs, and of all other special assistance programs for indigenous people, whether provided by Commonwealth, State, Territory or local governments.

I think that ATSIC does some great work in relation to that. In relation to housing, you quote from the World Health Organisation's document *Formulating strategies for health for all by the year 2000*. It states:

Measures have to be taken to ensure free and enlightened community participation, so that, notwithstanding the overall responsibility of governments for the health of their people, individuals, families and communities assume greater responsibility for their own health and welfare, including self-care.

I raise that because I just want to go to the issue of environmental health priorities—sewage, rubbish removal, safe and adequate water supply, et cetera. From my own experience last year I found that there are, for instance, absolutely no rubbish removal programs in place in some communities. What strategies are you using to encourage—either with a big stick or with some incentive—local communities to do such basic things as having effective rubbish removal programs?

Mr Taylor—A few things are happening. You are probably aware of the Community Development Employment Project scheme.

Mr EDWARDS—Yes, I am.

Mr Taylor—In a lot of remote areas the CDEP scheme is in communities that are resourcing local management of municipal services. It is one of those longstanding issues in terms of relations with local government. In many cases communities do want to undertake their own municipal services. They are not necessarily interested in having mainstream local

government services come in and take over those roles; they would rather localise the management and control.

In terms of our targeted capital program, we do look at rubbish and waste management systems at a community level. Where there is a need for some capital upgrade—the provision of new tips; a whole range of local infrastructure that would support a community management regime—those are provided, and we assist the community in working through a management regime.

One of the difficulties that we have is the issue I raised earlier about the recurrent funding streams that are available for community management. It is a question of arguing the toss about whether it is fair for CDEP to be undertaking essential services work, given that it is essentially converted income support funds, or whether that funding should come from a separate funding stream that is provided as per normal local government services.

But, generally, our strategy is to work from the community's point of view—how they would like their arrangements best to work locally. In a number of the major projects that we have funded around the country, waste management, landscaping, community layout issues and fencing have all been important parts of providing the base infrastructure for community managements to deal with rubbish collection in a sustained way. To a certain extent, as with mainstream local government, performance is going to fluctuate depending on how focused and successful community managements are in maintaining those local arrangements. From our point of view, for most of the communities in remote areas there is no alternative but to better resource local management to achieve the effective delivery of basic services.

Mr EDWARDS—If you are not sure about the value or the worth of having CDEP moneys go into infrastructure programs, which areas do you think the Work for the Dole money should be put into?

Mr Taylor—No, I was saying that there is an ongoing debate about the merits and ethics of using converted income support to provide essential services. It is very clear that a lot of communities around the country have voted with their feet in saying, 'Yes, we will use local labour to undertake these kinds of things.' It is, from an ATSIC point of view, entirely their right to do that. If there were other structures available to fund essential services on a community by community basis then, theoretically, that would enable the CDEP projects to focus on other work—land management issues; a whole range of other work activities that would be of net benefit to the community on other fronts; community service work; a whole range of things. But our general view has been that it is for each community to work those issues through for themselves. If they see CDEP as a way of localising control and management of essential services then generally we have supported them in maintaining that as a significant focus in their work program for CDEP.

CHAIR—Thank you very much for your contribution. We will, no doubt, be seeing you again about April. While we are changing witnesses, there is a matter to attend to. Is it the

wish of the committee that the three-page list of Army infrastructure projects, provided by the Department of Health and Aged Care, be incorporated in the transcript of evidence? There being no objection, it is so ordered.

The document read as follows—

[12.15 p.m.]

LARKIN, Mr Steven Raymond, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation

MAYERS, Ms Naomi, Deputy Chairperson, National Aboriginal Community Controlled Health Organisation

CHAIR—I welcome representatives of the National Aboriginal Community Controlled Health Organisation. I am sure you are aware of the general requirements for appearing before the committee. The proceedings 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 be regarded as a contempt of the parliament. This also serves to protect you in the evidence which you give, which is covered by parliamentary privilege. Do you wish to make a short opening statement?

Ms Mayers—I was just thinking whether you had read the evidence that we gave before.

CHAIR—I should have said that the committee has already authorised your submission's publication in the volumes of submissions in connection with the inquiry. Is there any update to it or any additional things you would like to say today? Otherwise we can go straight into questions from the committee.

Ms Mayers—I wish to add that our submission was done in late 1997-early 1998, almost 12 months ago. There are a few problems with coordination and I think there needs to be a change in the way things are being decided at a national level as to what programs get funded and so on. That is causing problems within our communities.

CHAIR—Thank you very much. That is what we are all about.

Ms ELLIS—In earlier evidence, in your submission and in the executive summary of your submission as well, you raise concerns about the commitment of some of the states to the spirit and the process embodied in those framework agreements. Now that all of that time has gone by since your first submission, is this still the case? Are things improving? How effective do you believe the agreements have been in involving the community controlled sector in the planning and delivery of health services for indigenous people?

Ms Mayers—I think in some of the states there is the relationship between the states and the state Aboriginal bodies—at the state level we have a body like NACCHO is at the national level—and I think some of the partnerships have been signed. At the time there were a couple of states that had not signed partnerships and they had been given money that should have been given only if they had signed the document. So there were a few problems over that but I think that has been rectified.

As far as I know, there are a few problems in Queensland. There are also problems in Western Australia with how the northern part reacts with the state government at the city level, and I am not sure how far they have gone in sorting them out. But I still think that the Commonwealth government should be taking great note of the Aboriginal health spending by

state governments because, historically, they have been given money but nobody has kept them to what they are supposed to be doing with it.

Ms ELLIS—Are you in a position to elaborate a bit more? When you say that there are problems in Queensland, are you in a position to say what you mean?

Ms Mayers—Under the partnership arrangement, they were supposed to do more coordination and more talking to the Aboriginal health services in those areas. More community controlled health services were supposed to come on board, which they have not done. I think there are problems with how they decide where the programs are going to be and how they decide to fund them.

Ms ELLIS—In the first part of that answer, you spoke about more community health services coming on board, which has not happened. Do you have a view why that is the case?

Ms Mayers—I have no idea. OATSIHS gave quite a substantial amount of money towards a peak body right up in the gulf. The peak body actually covered Queensland government run and funded services, so they were not really community controlled services at all; they were Queensland government programs. Part of the thing that should have happened was that some of them were going to go community controlled, but I do not think they have to date.

Ms ELLIS—So would it be fair to say that there are two levels of problem here—one of them is whether or not a state has actually signed up to these framework agreements and then the sincerity thereof?

Ms Mayers—Yes.

Ms ELLIS—Is that what you are basically saying?

Ms Mayers—Yes. Most of the states have signed. Queensland has signed.

Ms ELLIS—But what you are now saying, since your submission, is that there is also this problem about the ones that do it in a more meaningful way than others.

Ms Mayers—Yes. That is what it is—although they have signed the agreements and they have signed a partnership, it is not really a partnership at all.

Mr QUICK—We heard from the department that yet another body has been set up—the Aboriginal and Torres Strait Islander Health Council. Do you have any members on that health council?

Ms Mayers—It is being reviewed at the moment. From what I understand of the recommendations, I think they are cutting down the membership of our organisation—which was one from each state—to three or two. We all have a problem with the national council because we thought it was going to be part of the coordination and of forming a policy and so on. But we really have not participated in new policy coordination at all at that level. It

has always been after the fact. We have not had any meetings since last year—in June, August, July or something like that.

Mr QUICK—In your view, how many bodies need to advise the federal health minister on Aboriginal health issues? To my mind, there seem to be a hell of a lot of them at the moment.

Ms Mayers—That is the way it was before we did the National Aboriginal Health Strategy. There was advice given in that health strategy as to what should be the membership of a national organisation, that it should be the people that make decisions at the state level and at the national level. We also based it along the lines of the National Health and Medical Research Council. One of the problems being mentioned is that it is too big, but at the time that we first did the representation on the NAHS the NHMRC had about 46 members, and I think they represented quite varied interests right across the health sphere—all medical type stuff.

When we did the national health strategy, we tried to get it so the person that made the decisions within each state from the state government attended those meetings, plus the peak bodies in each state. In New South Wales at the time it was the New South Wales Aboriginal Health Resource Committee, and there were three from that state representing the three ATSIC regions. That was agreed to by all the ministers at a meeting in June 1989 when we first presented the national health strategy to them. That is how it started off officially.

But then in the second round it came down to one from each state plus the director-general and representatives of ATSIC and OATSIHS, so we went with that. We have only had three or four meetings and it is being reviewed again. This is what happens in Aboriginal affairs. This is why we never get ahead, because we keep taking these steps forward and then steps back. The governments change and people within the bureaucracy that make decisions change. I have been involved in health for quite a long time, about 30 years, but at Redfern Medical Service in the community control area since 1971. It is very frustrating.

Mr QUICK—In the department's submission, they are talking about how they work closely with representatives of state health departments, as well as with ATSIC and state affiliates of NACCHO, to identify priority communities in each of the states, and that state forums provided a framework for this collaboration. They mention 31 remote communities. Have you really been involved in that process?

Ms Mayers—There was a joint planning committee in place in 1994 when OATSIHS first took over from ATSIC with the health funding. They had a committee to work out between OATSIHS, ATSIC and us, NACCHO, where the services should go and to do it in a more coordinated fashion rather than submission based, to work out a plan so that if a community missed out one year they would know that down the track they are going to get a service, that their turn was the year after next or whatever. Some of that is being done, but on the whole a lot of the health services still on the ground are very underresourced.

Mr QUICK—We talked earlier this morning about the problem of the provision of nutritional food in stores in remote areas, and the thought of subsidising it to enable people on their limited budgets to purchase the right food, therefore being in a way a preventive medicine. What would your solution be to this problem?

Ms Mayers—When we first set up the health service in Redfern, there was a problem with nutrition. There still is in a lot of communities, and that is why there is a lot of diabetes and so on. We started up a breakfast program for the kids and we also did a fresh fruit and vegetable run, which we still do out of donations. We supply people that are considered to be at risk, babies and so on, with fresh fruit and vegies. We also supply the schools at Redfern, Darlington and Cleveland Street with boxes of fruit. That is for all the kids, not just Aboriginal kids, but there is a high proportion of Aboriginal kids in those schools. One of the things that we helped do initially was help the people at Cabbage Tree Island to put in vegetable gardens and stuff like that. I think that is what could happen out in those remote communities so that they can grow their own fruit and vegies, and the stuff that is brought in that costs such a lot of money for them out there could be subsidised.

Mr QUICK—Are you aware of any best practice at remote communities like the one 700 kilometres from Alice Springs? They might not have the climate. I know some communities have hydroponics and they grow things.

Ms Mayers—Is it the community at Roeburn or Pintubi—

Mr QUICK—I am not sure. Should we subsidise so that, while they are setting up something, rather than it being 60 per cent more to buy lettuce and carrots and whatever it is, we take that lateral thinking step to say that we will subsidise the food that comes in; it is the same price at Alice Springs as it is out at Kintore or Yuendumu or wherever else it might be.

Ms Mayers—It could be done as cooperative. People have tried to do that as cooperative and go and bulk-buy the food and they all put in. It has been done before too. A lot of the things that were initiatives in the 1970s have kind of gone by the wayside, but it can be done. It can be done through cooperatives.

Mrs ELSON—I heard this going around the place but I saw it in a comment here in the report, that, when you hear of another inquiry, it is the general thing amongst the Aboriginal community—I heard it when we were travelling out there—to say, 'Not another inquiry.' The health and facilities do not improve for Aboriginals every time there is a new health group, then we have another inquiry and nothing seems to be happening. I know you are well respected out there. I have seen your work first-hand. You are an on-the-ground worker. Do you figure there are not enough of your people out there and there is too much administration, and that is where it gets dissected, where everybody has ideas but they do not bring them all together to see improvement on the ground?

Ms Mayers—That is one of our major problems. OATSIHS has grown. It has about 70 staff working down here in Canberra. It has many work force issues. What showed it up more explicitly was the social and emotional wellbeing stuff. The *Ways forward* report—the Aboriginal mental health report—made a number of recommendations. Out of the blue they

picked the social and emotional wellbeing centres. These are educational centres which train mental health workers and all the rest of it. While we are going along with all of this, you have to meet all the time. Everybody who is working with these things has to come in and meet nationally here, there and everywhere. At Redfern we just said that we were not going to do that. Here we are on the ground with people overdosing from heroin; we have little kids smoking dope and getting tipped over the edge. The crisis teams that were set up to handle these things will not even come near our health service. In fact, they had to sack the crisis team because they could not handle crisis.

So here we are trying to set up a treatment program to use some of this money that has finally come along for social and emotional wellbeing and they want us to go over here and have this meeting so they can work out how to review us. We have not even got the program on the ground and they want us to go to a workshop so they can work out how to review our program!

The problem is that they are not listening. These people have not had jobs before or worked in Aboriginal communities. They do not know what it is like to work on the ground in Aboriginal communities so they have to think up something to keep their jobs or whatever. So it goes on and on. It is really very frustrating. If they listened and talked more at the community level, and listened to people who have been around a long time working at the community level on the ground—and there are many of us right across Australia—their staff would be used better, the programs that came out of there would be better and they would improve Aboriginal health. We have a national health strategy. It is still not implemented. That was 10 years ago. So, what do we have to do now? Work out another one and handle all these new players in the field?

We seem to have gone back to universities getting funded from Aboriginal health money when they already get enough. We have got back to research. There has been enough research done. Everybody knows we are sick. Everybody knows Aborigines drink. Why are we still paying people to do research to tell us again that we are drinking? We know why we are drinking and why things are happening. What we need are the services on the ground—not all this airy-fairy stuff up here keeping bureaucrats occupied in Canberra. There are far too many meetings. I sit at my desk and every time I receive information about conferences or meetings I put it on the floor beside my desk. At the end of the month there is a very high stack. If we went to every meeting we would never do our work on the ground. We have major problems at Redfern at the moment. I know other communities have the same problems—kids committing suicide and all that kind of stuff. We do not want to handle that airy-fairy stuff up there; we want to do the stuff down here on the ground.

Mrs ELSON—So, you need more resources on the ground where you are rather than all these other things? That is how you see the problem being fixed?

Ms Mayers—Yes. There are far too many meetings and reviews. Now they are going to review all the health worker training programs. We have just got ours accredited. They have not even finished the first 12 months and now they are going to go around and review them all. And they spend a lot of money on reviews and consultants. We do not know what to do.

CHAIR—Thank you.

Ms HALL—I think that you have made some very interesting and positive statements. I cannot say that I disagree with a lot of what you have had to say. How do you think Aboriginal health has been affected by placing it within mainstream health? Do you think that has disadvantaged or advantaged Aboriginal and Torres Strait Islanders?

Ms Mayers—We were part of the agreement, but we never envisaged that we would end up with a big department like we have and that things were going to be operated that way. We always said that we did not want to be split up into body parts. But that is exactly what has been happening. We have different programs, like the social and emotional wellbeing and the drug and alcohol program. These are things that we handle every day within our services so we try to treat people holistically rather than splitting them up into body parts.

I can understand programs in the general community and mainstream health doing that. But it is not the way to do it in Aboriginal health. Our services treat people holistically. It is really exasperating to be split up in that way because we are trying to do it the other way—not to the medical model. We have to handle all those things. I was listening to what you said to the ATSIC people. We have to handle housing—we have to help people get housing. We even help them go to get their pensions, and things like that. We do all those things within our service. Within the Aboriginal communities it is mainly the Aboriginal health services that do that work. They do it right across the board.

Ms HALL—And that is contributing to the health of the Aboriginal people in Redfern. And you are not funded to do that. If you were to take that component away you would be impacting on the health of those people.

Ms Mayers—Yes. We had a problem with the changeover from ATSIC and the way things happened. We had just delivered the National Aboriginal Health Strategy and ATSIC came on board too. They were just starting. The National Aboriginal Health Strategy had just been accepted by the government—the ministers had decided they were going to run with it and implement it. ATSIC was just getting on its feet too. One of the reasons we asked for the change was to give ATSIC time to get where they were going and to work out how it was going to work, because at the time we had 65 regional councils across Australia making decisions on Aboriginal health—having never read the Aboriginal health strategy.

We also had a board of commissioners which were trying to get the feeling of being in the positions that they were in. We also had the bureaucracy that came over from DAA which really did not believe in the National Health Strategy anyway, but they were the ones who were saying yea or nay to any money spending. So it was really frustrating, and we wrote several times to the ATSIC board. The most sensible thing would have been for them to listen to the national organisations, taking advice from us on health—the national organisation, because of all the health services across Australia—on housing from national Aboriginal housing and so on, and they could have used that in conjunction with the bureaucratic advice that they were receiving. But that did not happen, and that is one of the major reasons why we supported and asked for the changeover. We also put a rider on it that it be reviewed properly in three years—I thought, but somebody said it is not being done until 2001. By then we thought that ATSIC would be up and going, everything would be really well organised and we would have a better chance.

Another part of the National Health Strategy was to have a separate section, like Aboriginal hostels, which is a separate entity to ATSIC. We were going to put that in the National Aboriginal Health Strategy, but the ATSIC Act was going through at the time and they did not want to put another act through. So they said, 'All right, we'll bide our time.' But it would have been better to set up a foundation or a separate section rather than have it under the Department of Health and Aged Care because it gets lost in the mainstream.

Ms HALL—Your service operates within an urban area. Do you think enough emphasis is placed on looking at the needs of Aboriginal and Torres Strait Islander people living in the urban setting and delivering the services?

Ms Mayers—Our service is very underfunded, although I am not really here to talk about our service in particular. We have the largest population in the country, and I think the Deeble report showed that we are one of the most underfunded services. That is only because we are in Sydney and we are supposed to have everything in Sydney. We have a very large community, and when they did surveys they found out that we have a shifting population of about 10,000 people who constantly come and go to the inner city. A lot of the problem is to do with drugs, alcoholism and all the things that are in other communities, except probably the heroin, although it is getting into the rural areas. There are other things that they do in the remote areas—petrol sniffing and all that. So we have the same problems.

I do not know where they think all these people come from who come to Sydney. All the original people were murdered, so they come from all around the place. We have the biggest lot of people from other states.

Mr EDWARDS—Where do they come from?

Ms Mayers—When we see patients, we put their postcodes and so on, and the majority of people who come to Redfern come from within 20 kilometres. About 10 per cent come from New South Wales country and so on. That is talking about people who actually live in Queensland. We have not actually done a survey of who actually comes from Sydney or who came from Queensland to live in Sydney. A lot of people come from interstate because of the organisations—the Aboriginal Arts Board, the dance companies and all that kind of stuff. They have all come to Sydney wanting to act or do something—the same, I suppose, as people from New South Wales might go to Victoria or Queensland. Our population has grown since the 1970s, and I think they did a lot of reorganising of people—people going from little country towns down to Albury or moving them all around the place, but a lot of them end up in Sydney.

CHAIR—Do you think it is stabilising or do you think it is still growing steadily?

Ms Mayers—You can tell by the people who come and use our service how many new patients we see. We have so many patient files that we have to go through them all and, if somebody has not been for five years, we put them somewhere else because we keep running out of room. Then when they come back we have to put them back in. This goes on all the time, so we know that there is this shifting population. Also, when functions or conferences are on, we get people from the Northern Territory and everywhere.

Ms HALL—You mentioned coordination. Would you like to elaborate on that a little bit for us? You say that you are disappointed with the way that is going.

Ms Mayers—Yes. I think there is a whole chapter on it in the National Health Strategy—it was called intersectorial collaboration. It still needs to be done, so each sector that impacts on the improvement of Aboriginal health can coordinate the social environment, housing, employment, education—the lot. It all needs to be coordinated, because it does have an improvement on Aboriginal health. I think that is the only way you can look at it.

In some states the coordination is getting better. I know there is a state-wide body in New South Wales, and that is what it is intended to do. It is health, housing, land and so on, and that is the kind of peak body the government will take advice from on particular things that come up, even though they have the health peak body that they take their health advice from. I think they are doing really huge things in Kempsey at the moment, and they are doing it in a collaborative way. It is working because all of those bodies are sitting down and talking about it, planning it and doing it that way. So it is working out. They are doing it in conjunction with the health service, the land council, the legal service and local government.

Ms HALL—I look forward to seeing what is happening in Kempsey. My last question is picking up a little on something that you have already said. You talked about the funding, the devolution of funding to states and the delivery of programs through states and it then going out to the communities. Are you saying that the states are actually keeping it within their budget and that that devolution is not happening, that it is not going out to the communities? If that is so, what do you think needs to be done to make those states more accountable?

Ms Mayers—The reason I said that, and I have said it before, is that if you look at the figures over the years of what state got what you will see that the Northern Territory got the bulk of the money. You will find that New South Wales got the least with Victoria and so on. If they added up all of the money that has been given over the years—I know Aboriginal health money has been identified has been identified since 1970—they could have had all of those services on the ground, they would have been properly resourced and so on, but that has not been the case. That is why we have this problem with those remote communities out there that are really the direct responsibility of the state government. What have they done with the money that was given to them for those communities? What did they do with it?

When Malcolm Fraser was Prime Minister the trachoma program report came out. It showed how really terrible it was for all of those remote communities and it really showed up the Australian government and the state governments. He authorised a really high-ranking report to be done on where the money was going. Although it never hit the ground—one fell off the back of a truck—it showed up exactly what was happening with the money. They were not spending the money in the areas where they were supposed to be spending it. They were spending it on mainstream and not on Aboriginal health programs. The same thing happened with housing and all of that across the board.

We have to account for every single, solitary penny. I think the state governments have to be made accountable for every dollar that they get and where it goes. Usually, they just

give them the money and they say, 'We did this, that and the other,' and it is not even true half of the time.

Ms HALL—So you would not be supporting untied grants?

Ms Mayers—No.

Ms HALL—Would you say that it is those community groups that can write good submissions that are getting the funding rather than those community groups that have the greatest need?

Ms Mayers—I am not sure how they do it these days. One of the big recommendations that not only came out of NAHS but also out of the joint planning committee was that there be a proper plan and that those communities that really needed the services would get them and that that would not be submission drawn. That is what should have been happening.

Mr EDWARDS—Can I compliment you on what you have had to say this morning. It is very important, in my view, for the committee to hear those things. Can I say, too, that I think all of the committee members would hope that whatever we come up with is going to be worth while. What layer of bureaucracy do you think would help the cause of Aboriginal health on the ground, if it was stripped away? What level of bureaucracy would you do away with?

Ms Mayers—I think you always have to have a national one to coordinate the policies because of the way in which government operates. You have to have that national policy set-up. It needs to be done in conjunction with people on the ground. The Aboriginal health services have set up those structures so that information is able to come up from there to the national policy makers. The national policy makers have to include Aboriginal people who work on the ground in those communities. I think we are going back a little to the medical model. You must remember that we have always had doctors, psychiatrists and all of that. If doctors only were going to cure us, we would be in really good health now and we're not. The Aborigine has been overresearched—50, 60 reports, huge. If that was going to cure us, we would be in good health. It has to be a partnership, as I said, intersectoral collaboration, and people have to listen to the communities. All of those communities out there know what will correct what is going on in their community. They know how to improve things.

CHAIR—How often does NACCHO meet around Australia? What is your structure? How do you operate?

Ms Mayers—In each state the health services meet together as a body. In Western Australia, for instance, it is called WACCHO, Western Australia Community Control Health Organisation. They elect their representatives to represent them at the national level. It is all of those services sitting down together that do that. In New South Wales, we have split our mob up into 11 regions. Each of those regions elect a representative onto the state executive. The full body meets twice a year and they elect our national representatives, which is three from the states. I was elected as deputy chair at a national meeting and Puggy was elected as the chair. That is when we all come together as a national body, once a year.

CHAIR—Does the meeting go over a few days?

Ms Mayers—We usually go for a week because there is a lot of stuff to get through.

CHAIR—And you canvass all of those issues—

Ms Mayers—Each state brings up their problems. We also talk about the national policy stuff. Most of the states have already done that stuff at the state level.

CHAIR—Just on local government, you would be well aware that in remote communities local government just does not exist. There are different models around the states. But in the urban area there is obviously quite a strong local government involvement. How do you find the urban local government approach to the issues that we have been talking about this morning?

Ms Mayer—Some of the problems that we have had, for instance, in Redfern, at the moment, because of the needle exchange being closed down and the heroin and all this kind of stuff, is to do with local government. It depends on the council: Marrickville Council and South Sydney Council are very supportive. They have advisory bodies set up to advise them. I think that goes on in other states, too. In the remote areas I know—

CHAIR—You would be generally quite pleased with the support from local government in the urban areas.

Ms Mayer—You do have your fights with them but, on the whole, you can have a fight, which is the main thing.

CHAIR—And you have seen that collaboration improve over the years.

Ms Mayer—Yes. Some of the councils have been really excellent. They have reconciliation things set up now and so on. It has come out of the meetings that Aboriginal groups have had with the councils. I think there are now Aboriginal people running for the local councils.

Ms HALL—Does that vary between local government areas?

Ms Mayer—Yes, it does. South Sydney has a high incidence of Aborigines, and I think there is a good arrangement out at Mount Druitt where there is also a high incidence. I do not think it is so good at Campbelltown—I am not sure about that—because we have had a few problems there.

CHAIR—In terms of the cultural issues of Aboriginal and Torres Strait Islander people, and the influence on health, if there were one or two things that you could identify within a cultural context which might improve the situation from an Aboriginal perspective, what would they be for you? In terms of the attitude to health, to their own self-help ownership of health issues, in the Aboriginal context, is there something that you could help the committee with which perhaps we should know in that sense—if you know what I am trying to get at?

Ms Mayer—I think a lot of the things have to do with their social and emotional wellbeing—things that have happened previously like the stolen generation, the impact of loss of land, dispossession and so on. If policies are set to rectify some of those—as I said last time, pay the rent—we would be able to correct them ourselves. I know that is not going to happen. One of the things we have to do is break the cycle with our kids. Everything that is funded is the end result; they are not funding programs for children.

In the urban areas some of the communities have centres and football ovals where kids can go. In Redfern and in the inner city of Sydney they have absolutely nothing. Kids are around on the street and hanging around outside pubs and so on. It is even in the back of the national health strategy. We did a survey with the kids. We took them away and asked them to work out what they needed and so on. It was a centre where they could go after school and do all these things. We still do not have one in Redfern.

The needle exchange that was closed down—I know it wasn't really a needle exchange; it was a needle supply service—was in full view of Murawina, our preschool, and of people living on Everleigh Street. All those kids could see this going on and are growing up thinking that that is the norm. They think that shooting up the arm is the norm. It is as though everybody living on the block is a drug addict. There are only nine who live on the block that you could call a drug addict. The rest of them are coming in on the train to that community. The powers that be that wanted that service there—it was like, 'It doesn't matter because they're only blacks and it is hidden down there; we can hide it away.'

Even though we had big fights with them three years ago, we were really happy when it was closed down because every day at the medical service we could see the damage it was doing to those kids. There were kids being sexually abused, kids nine years of age smoking dope and all the rest of it. It is in the vested interests of the pushers and people like that.

If we do not start doing something with the kids now, we are continually going to have ill health all the way through. It is to do with self-esteem. That is where the cultural stuff comes in with an economic base. It is all of that. If we could have money, we could decide what we are going to do with it, decide the programs, build a youth centre and do whatever needs to be done to protect these little kids that are growing up and ending up in Minda and so on.

Our two drug and alcohol workers spend most of their time handling youth. They go up to Mount Penang—Aboriginal kids from the inner city—and Minda. They are all there for either selling stuff or pinching stuff to go and buy dope or whatever used by the dope addicts down there. It is all around; it is not only just in Redfern. It is Waterloo or wherever there is a large contingent of people in housing estates.

Mr QUICK—Have you ever had a chance, when you are not going to meetings, to sit down and figure out a per capita grant that you think would be adequate? If you are dealing with X number of clients times X number of dollars, would you be happy with that? Could you get down to saying it is $57 per annum per person that will provide a basic service that will cover most of the requirements of the people you are servicing? Could you get down to that sort of thing?

Ms Mayer—I think there has been a big review done on that. Steven probably knows.

Mr QUICK—Compared to what you are getting now?

Ms Mayer—You mean in Redfern? No, we have not done that in Redfern.

Mr QUICK—Perhaps that could be extrapolated. As Graham said, if we could cut out some of this bureaucracy and the money that has gone to that, we could provide it to community health organisations and ask them to identify the problems.

Ms Mayer—For instance, because we have been going so long, we are doing programs that we were never funded to do—but we do them. New services get funded to do those programs and that is why they are per head of population. Ours is so low, and some of the new services have far more money than we have. We have never sat down and worked it out, apart from working out what a whole youth program would cost. We upgraded it again last year to handle all the things to do with the kids.

Mr QUICK—What would your suggestion be for ways to attract and retain trained health professionals, especially doctors and dentists, to service your communities?

Ms Mayers—You need better salaries and, out in the remote areas, you need better housing and that kind of stuff.

Mr QUICK—So it is just as simple as saying to Dr X, 'We will give you another $150,000 to go out to'—

Ms Mayers—The royal college was trying to do something where we work with them on getting Aboriginal health into some of the curricula as a postgraduate thing. There needs to be some kind of a plan like the Family Medicine Program where doctors go and work. We use that program too, but it needs to be where they go and work in the remote areas too. Even in Redfern we advertised for a doctor and I think we got one application. That has never happened before. We usually get a lot of applications, but I do not know what has happened over the last few years. It is really hard inland. It is all right along the coast of New South Wales but inland places like Walgett, Brewarrina and Bourke find it extremely hard to get doctors and dentists. They could have some kind of plan through the royal college, because there are so many doctors in the city it is ridiculous.

Mr Larkin—We are often competing against state and territory governments for the same people and, because a number of our services are not able to pay the same rates, understandably the health professionals are making a choice to go the other way. One thing that really impacted on us was the removal of the movement to award wages money, because now we are having to try to find that money from within.

Mr QUICK—You say that one of the barriers to accessing mainstream programs and the like is the problem of indigenous people carrying current Medicare and health care cards. How big a problem is that?

Ms Mayers—That has always been a problem with bulkbilling.

Mr QUICK—So how do we solve that?

Ms Mayers—We used to keep the numbers at the medical service on cards.

Mr QUICK—So what bureaucratic change needs to be put in place so that it is no longer a problem?

Mr Larkin—There has been a major report done on this—the Keys Young report on the Health Insurance Commission with respect to Medicare cards and identifying some of the administrative and systemic barriers. I understand that resources have been made available within the HIC to put some communication packages and the like in place to pick up on some of the real structural systemic barriers. For example, people are not always enrolled and people do not always carry the cards around, so it becomes very difficult to administer. There are a number of suggested reforms which are probably better explained in that report that the committee can refer to.

CHAIR—I accept that the date of the submission we have is November 1997, so we are going back a while. In your executive summary you talk about a range of issues, one of which is the incidence of cost shifting. Everyone has been playing these games for a very long time, no doubt, but do you have something specific that you can identify in this cost shifting exercise? You may have already done it before, but I am not aware of it. Can you identify something that is obvious to you in cost shifting?

Mr Larkin—Not off the top of our heads, but certainly we can provide that. I can gather information from our member organisations of instances that they have observed.

CHAIR—Thank you very much. It has been very good. We really appreciate your contribution.

Proceedings suspended from 1.04 p.m. to 1.34 p.m.

BUCKSKIN, Mr Peter, Assistant Secretary, Indigenous Education Branch, Schools Division, Department of Education, Training and Youth Affairs

GREER, Mr Tony, First Assistant Secretary, Schools Division, Department of Education, Training and Youth Affairs

KARMEL, Dr Tom, Assistant Secretary, Operations Branch, Higher Education Division, Department of Education, Training and Youth Affairs

SPARKES, Ms Lois, Acting Assistant Secretary, Quality Schooling Branch, Schools Division, Department of Education, Training and Youth Affairs

CHAIR—I welcome representatives of the Department of Education, Training and Youth Affairs to this public hearing. Before we proceed, I wish to point out that, while this committee does not swear witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives itself. Any deliberate misleading of the committee may 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. I understand, Mr Greer, that you would like to give an opening statement.

Mr Greer—Thank you. Constitutionally, the state and territory governments have responsibility for all matters relating to schools and vocational education and training. However, the 1967 referendum gave the Commonwealth special responsibility for indigenous affairs. The Commonwealth government, together with the state and territory governments, recognise that Australia's indigenous people are the most educationally disadvantaged group in the community. Indigenous people participate in and obtain significantly less from education than the rest of the Australian population, and this impacts adversely on their economic and social wellbeing.

Many factors contribute to the educational disadvantage of indigenous people and, in particular, it is well recognised that poverty and ill health can limit the ability of many indigenous people to participate in education. In 1969 the Commonwealth introduced Abstudy to help indigenous students with the costs of education and to assist in the education of indigenous Australians to a standard equal to that of non-indigenous Australians.

In the 30 years since 1969, some significant progress has been achieved. Greatly increased proportions and numbers of indigenous peoples of all ages are now undertaking a full array of education and training options available. Participation in early childhood and primary schooling has improved dramatically, the year 10 retention rates have shifted from single digits 30 years ago to about 30 per cent in 1997 and the involvement of indigenous parents and communities in education has increased, with over 3,500 ASPA committees in 1995 covering about 98,000 or over 90 per cent of indigenous school students.

Indigenous participation in any kind of university course has risen from under a hundred 30 years ago to over 7,000 in 1997. The participation rates of indigenous 15- to 24-year-olds in vocational education and training have actually reached levels about the same as for other

Australians. While substantial progress has been attained over the last three decades in improving equality of access to, and participation in, education and training for indigenous people, inequality remains. There is still an enormous amount that needs to be done.

The results of the national English literacy survey in 1996 showed that 75 per cent of indigenous primary school students failed to achieve the minimum literacy benchmarks. Indigenous students to year 12 in schools was only 30 per cent nationally in 1997, which is much lower, of course, than the 70 per cent year 12 retention rates of non-indigenous students. Indigenous Australians are almost three times less likely to have a post-school qualification. Similarly, there is a greater tendency for indigenous year 12 students to delay entry to higher education until later in life and, when they do, they are far more likely to enrol in a diploma or enabling course rather than a degree. Although indigenous people are well represented in the vocational education and training sector, it remains true that they tend to be in the lower level or shorter courses compared to other Australians and are often doing vocational education and training courses to help them catch up with other Australians. While these indicators show that there has been some significant improvement in the levels of educational achievement by indigenous Australians over the past 30 years, there remains clear evidence that indigenous students remain disadvantaged in attaining equality in Australia today.

The national Aboriginal and Torres Strait Islander education policy of 1989—otherwise known as the AEP or the Aboriginal education policy—was endorsed by all Australian governments through the Ministerial Council of Education, Employment, Training and Youth Affairs and has the objective of achieving educational equality for indigenous Australians. While the AEP does not specifically refer to health related issues, it establishes the standard for indigenous Australians—that is, the level of educational access, participation and outcomes achieved by non-indigenous Australians. This benchmark has not yet been achieved.

The Minister for Education, Training and Youth Affairs, the Hon. David Kemp, publicly stated recently, ‘It remains the goal of this government, and it will be my personal goal, to drive as far as possible the achievement of educational equality.’ The minister further observed that there is a need to strengthen the links between the Commonwealth’s own indigenous education, employment, health, housing and community development programs, and to pay particular attention to specific communities. In addition, the minister has called on the state, territory and local governments to likewise establish and build on their own cross-portfolio programs to target indigenous communities in most need.

The Commonwealth government currently supports the AEP through a number of identified supplementary programs—the Abstudy income assistance scheme; the higher education support program; the VET sector funding arrangements; the Indigenous Education Direct Assistance Program, IEDA; and the Indigenous Education Strategic Initiatives Program, IESIP. In 1998, the Commonwealth provided about $330 million in funds under those programs.

Turning specifically to the inquiry’s terms of reference, in relation to terms of reference (c) and the need for improved education of medical practitioners, the Commonwealth has provided funding to establish a number of indigenous higher education centres. The centres

are expected to encourage the development of research skills and academic excellence within the indigenous community. In relation to indigenous health, centres are being developed in indigenous health, law and environment at the University of Newcastle; indigenous research and development at Curtin University of Technology, specialising in professional education and training in health education, science and technology; a Centre for Excellence in Indigenous Higher Education at the University of South Australia, specialising in indigenous curriculum and research development, executive training and holistic health; and an indigenous higher education centre specialising in indigenous public health to be administered by a consortium of the University of Queensland and the Queensland University of Technology.

Again, in relation to terms of reference (c) and the need for improved education of health workers, you would be aware that the responsibility for the training and ongoing professional development of employed health workers rests with the health services. If the training undertaken by employees is accredited by the appropriate state accreditation body and conducted by a registered provider, the training provider may receive supplementary assistance under the Commonwealth's Indigenous Education Strategic Initiatives Program, IESIP. In addition, the student may be eligible for tutorial assistance under the Commonwealth Aboriginal Tutorial Assistance Scheme—ATAS—and some benefits under Abstudy, subject to means testing. In addition, DETYA is working with the Commonwealth Department of Health and Aged Care in its national review to develop a strategic approach to health worker training at the national, state and territory levels.

In relation to the inquiry's overall terms of reference, you should be aware of a number of other strategies in place to address issues affecting the level of educational access, participation and outcomes achieved by indigenous Australians. Since 1997, all education providers in receipt of funding under the Commonwealth Indigenous Education Strategic Initiatives Program—IESIP—have established annual targets in relation to a range of performance indicators, which include improving the level of educational participation and attendance by indigenous Australians.

Funding under that program is based on an enrolment per capita rate and provides providers with the flexibility to design locally appropriate strategies to improve participation and attendance. In 1998-99, the Commonwealth budget provides $118.4 million under the IESIP program.

Also under the IESIP program, funding of $36 million has been provided for a series of strategic results projects. Those projects launched in December 1997 are designed to encourage innovation in addressing the range of issues that affect educational access, participation and outcomes achieved by indigenous Australians. A number of these projects specifically address the hearing impairments of indigenous students and provide local intensive support arrangements for at-risk students, as well as providing transport, teacher housing and upgraded health related facilities in non-government preschools and schools. A considerable number of these projects are in rural and remote localities.

Under the Aboriginal student support parents' awareness element of IEDA, the Commonwealth provides funding to school based parent committees to enhance educational

opportunities for indigenous students. These activities can include nutrition and health education programs.

Finally, the Commonwealth government and all state and territory governments, through the Ministerial Council for Education, Employment, Training and Youth Affairs, MCEETYA, has undertaken a number of collaborative activities in school health education, in particular the national school drug education strategy and the national blood borne viruses, STD, HIV, and sexuality education in schools project. These projects promote ongoing collaboration across the health and education portfolios and provide guidance on curriculum, content and appropriate teaching approaches.

CHAIR—The inquiry was first referred by the minister to the committee in June 1997. The committee notes that you have not been able to get a submission in. Is there any particular reason for that?

Mr Buckskin—It was probably an oversight with the change of government and the agenda that Dr Kemp has set for the department. We have worked with the secretariat and suggest that we would have a submission in by 19 March.

CHAIR—So we can expect that within the next three weeks?

Mr Buckskin—Yes. The minister is currently overseas. Otherwise, we probably would have had a draft to look at on the weekend.

Mr QUICK—Can we get a copy of what Mr Greer read today?

Mr Greer—I will make that available.

Mr QUICK—It is rather difficult for us to try to remember all the acronyms. Most of us would like to have something in printed form in front of us.

CHAIR—That would be very practical right now.

Mr Greer—My copy is heavily annotated at this stage. Could I provide it later in the day?

CHAIR—If you had a clean copy, we could get some copies for the committee to glance at.

Mr Greer—I have a statement here which is broadly the same context.

CHAIR—That may suffice for our purposes. Concerning the link between poverty, literacy and all the general issues—they are well documented—there would barely be an Australian around who, if he were half interested in this issue, did not know the basics of it. In the context of health, if you had a specific about education and how we might improve the health of indigenous people, would you be able to give the committee two or three main points? What would you see is the main focus of improved education for health?

Mr Buckskin—I suppose it goes to the priorities that the government has already identified, that is, access to appropriate education, and to start at the preschool sector to ensure that there is appropriate access to preschool education, then to formal primary schooling and, indeed, to secondary schooling to which a majority of rural and remote indigenous Australians do not have access today. It is through access to that type of education that indigenous communities will understand how they are to participate in the wider Australian community and to have the skills to do that and to engage themselves in better literacy outcomes.

Mr QUICK—So is the Northern Territory government's decision to cut back on bilingual education part of this ad hoc approach to education and health that we see in Australia and has been operating for the last 50 or 60 years? Mr Greer said it is the basic responsibility of the states and territories and we have duck shoving between one group and the other. Surely to goodness, for something as simple as that, for a small amount of money, considering the budget of your department, how do we get state, territory and Commonwealth agencies to come up with a coherent strategy? You are doing one thing and they are doing something opposite.

Mr Buckskin—As Mr Greer enunciated, the Commonwealth is in partnership with states and territories and, indeed, with any education provider that delivers services to indigenous Australians under the auspices of the national Aboriginal education policy, called the AEP. That is not a Commonwealth policy; it is actually a national policy signed up by every state and territory government, including the Northern Territory.

Mr QUICK—So, when the minister responsible made that decision, what was the view of your department? Did they throw their hands up in horror or did they say, 'Typical bloody Northern Territory government, they are putting the spoke in the wheel'?

Ms HALL—Did the Commonwealth have any ability to force the Northern Territory to keep that in place?

Mr Buckskin—As I talked about in Senate estimates the other week, the Commonwealth's response to that is that clearly education and training is the responsibility of the states and territories. However, under the AEP we do have an agreement in place whereby one of the 21 goals—I think it is goal 14 or 17—talks about the maintenance of indigenous languages. We have monitoring arrangements in place whereby there is due to be a meeting on 2 March, which Mr Greer and I will be attending, in Darwin with the executive of the Northern Territory Department of Education. We will be talking to them about how they will be meeting that particular goal of maintaining Aboriginal languages in the Northern Territory—through, say, the schooling sector—considering the decision that they have just taken.

You would appreciate that bilingual education is one of many strategies that educators use to accelerate English literacy outcomes for indigenous Australians. English as a second language is another methodology. It is our understanding, having spoken to the Deputy Secretary of the Northern Territory Department of Education, Ms Katherine Henderson, that the Northern Territory government is concerned about the level of literacy in Aboriginal communities, especially in the area of year 3 outcomes and, indeed, outcomes after people

have been through the Northern Territory school system. As every report has indicated, they are way behind that of the rest of the Australian community.

Mr QUICK—On that point, Mr Greer mentioned annual targets for the states and territories. Can we have some evidence about the levels of numeracy and literacy for each of the states for their indigenous population, so we can say when we visit the Northern Territory, 'Why is your rate X compared to Queensland, Western Australia, South Australia, Victoria, New South Wales?' Do we have these sorts of figures? My understanding, from when I was on another committee, is that no indigenous child in Katherine has ever graduated from year 10. Do you have those sorts of figures?

Mr Buckskin—We would not have them school by school, but I imagine we would have them by year cohort—for example, of the people who graduated from year 10, those who went on to year 12 or those who have transferred between primary school and secondary school. The types of data that you are seeking will be very much part of discussions that we will have on 2 March because of the lack of that type of data coming forward since the outcomes agreements were put in place in 1997. We appreciate that it takes a year for some systems to develop the instruments to measure thing such as access and attendance, to identify literacy targets and specific performance indicators and then to fast-track that through identifying strategies to achieve those.

The Commonwealth is concerned that there has been a lack of progress in the monitoring of the targets, which we do not think are too strenuous for the Northern Territory, because they have yet to report on a few of those targets from 1997 data. On 31 March this year the Northern Territory government, like all other providers, will have to report on the 1998 performance indicators. So you can see already that, if the Northern Territory have not reported on 1997, they will have difficulty reporting on 1998—hence the cause for concern and the reason why we are going forward.

Mr QUICK—What are the performance indicators that we are talking about?

Mr Buckskin—There are performance indicators across a whole range of areas. We specifically have identified a number of areas such as—again—access, attendance, retention, literacy and numeracy targets. We have set professional development targets for indigenous and non-indigenous staff. We have set employment targets for indigenous staff across the department—from being an education worker, a para-professional, to being a professional teacher; being in leadership positions in the schools; or being in the administrative sections of the central office or the regional offices of an organisation.

Mr QUICK—Are there any sanctions in the allocation? As you say here, the 1998-99 Commonwealth budget provides $118.4 million under IESIP. Are there sanctions if the performance indicators are not met?

Mr Buckskin—If the indicators are not met, the Commonwealth through the department tries not to use punitive measures—that is, not to deny states and territories funds that they are entitled to through the per capita process—but to actually identify through the monitoring arrangements alternative strategies to achieve an outcome if the current strategy they are

trying to put in place is failing. For example, if they have not reached their year 3 literacy target, then we would expect them to examine the reason why.

Clearly the Northern Territory government has decided that the bilingual approach to teaching and literacy outcomes has failed and, therefore, they are going to try another strategy. They have decided that the English as a second language methodologies are more appropriate. We can argue that. I am not a linguist, so I am not that informed about the processes, but there always has been in the area of indigenous education and English literacy outcomes the debate between the academics about the best possible approach—bilingual education or English as a second language—and that continues. Our only concern is that there was not a lot of research done before the Northern Territory government came to the conclusion that bilingual education methodologies have failed in the Northern Territory context. There is lots of research on bilingual education failing around Australia but not in the Northern Territory context. So we will be seeking some support from them on how they will be continuing that process in the action they have taken to disband the bilingual program.

Mr QUICK—So how long a piece of rope are you going to give them? I do not want to say this in a disparaging way, but one of the words I would not associate with your department is 'flexibility', considering the cases that come to my electorate office about Austudy and Abstudy. There does not seem to be much flexibility, and I would be concerned that we would be giving the states and territories a rather large amount of money.

There does not seem to be much in the way of sanctions, and we have an absolutely appalling record when people are talking about 30 per cent compared to the national retention rates. I know Dr Kemp's concern—and I share it as a former teacher—that there ought to be some sort of sanction in there to say, 'We give you so long and after that we start pulling the money out,' or, 'It is a territory; we assume some responsibility ourselves,' because, as Mr Greer said, under the 1967 referendum the Commonwealth does have sole responsibility.

Mr Buckskin—Members of the committee might not be aware that the national Aboriginal education policy came in in 1990. We have taken, since the AEP has been in place, retention rates from a single digit to a double digit in a matter of less than 12 years. Given the cultural, social and economic issues that impact upon indigenous communities, I think we have done extremely well considering that it has only been since 1967—as you have rightly stated—that there has been some strategic Commonwealth interventions to ensure that we are fast-tracking some outcomes.

People seem to be concentrating on the Northern Territory. The Northern Territory has a whole range of diverse factors that clearly impact upon the education of the young people within that territory. They are clearly the social and infrastructure aspects of communities—that the majority of those people live in remote communities where there is little access to preschool or post-primary education. They therefore would have to go away to school, although the majority of them do not, to places like Kormilda College in Darwin and Yirara in Alice Springs.

Therefore, the Northern Territory government clearly has to have some strategies in place and some type of framework for what it is going to do with those numbers of children. We believe that the Commonwealth, in terms of lack of access to preschool and, say, to post-primary education—whatever that might be, considering that you have just stated that the majority of people do not have literacy standards which allow them to do a full secondary curriculum offering— cannot say that money in itself is going to create change; it is about getting the communities to understand what the Western education system is there to do and then trying to convince them that their participation in that is not to assimilate them into the Western world at the expense of their own culture. I think that is a very long-term proposition to put to communities.

What I am trying to put to the committee is that, with the Commonwealth national framework in place since the AEP, I think moving the retention rates from a single digit into double digits—considering we are only one of many players involved in this—is an achievement of the policy and shows that, after a generation of children going through, say, seven years of schooling under the current outlays, we are seeing indicators of success. I know that retention is only one of those. In terms of retention growing, we have been concentrating, since this government has been in power, on outcomes. In the first nine years of the policy, we concentrated on inputs and we looked at outlays. Since the coalition government has been in power, we have shifted it to the outcomes approach.

We have then shifted it from the strategies to actually identifying those areas that I talked about—literacy, numeracy, attendance and access—and saying to people, 'Here's an indicator and here's a target and we want a national target which we have set across those areas,' and then saying to the department, 'Could you please give us a target that you are going to aim at too which will contribute to that national outcome?'

Mr QUICK—You mentioned, in relation to term of reference (c), the need for improved education of health workers. I cannot believe that we are still means testing Abstudy. How many people of indigenous origin are earning money to the stage where we have to means test them out of a benefit? Surely we should be providing encouragement in any form whatsoever, rather than a hindrance, by saying to these people, 'Look, we've got an appalling educational record. We will put whatever you need in the way of benefit and opportunity in place.'

We have got a letter from a medical student who happened to pick up a bursary from Queensland and, because there is no consultation between Abstudy and various states, he then got a magic letter signed by the department to say he had an overpayment. The person is trying to become an Aboriginal medical practitioner and all he gets are bureaucratic letters and hurdles to hinder whatever he is trying to do! Why can we not have some flexibility and some encouragement, rather than hindrance, for these people? Why do we have to means test Abstudy? How many indigenous families are earning over the limit?

Mr Buckskin—I will take that on notice. I wouldn't know about that, but clearly this is a matter of government policy that has been in place with the previous government.

Mr QUICK—But surely the department can advise the minister? That is what the department is there for—to say, 'We have got this appalling record,' and then you put some

strategies in place. You can get the basics—the year 3, the year 6 into secondary colleges and then into senior secondary colleges—and then you belt them over the ears with some prescriptive means test. Because they get a benefit from one state, why can't they get both?

Mr Greer—The government has recently reviewed the provisions of Abstudy. The principle that underpinned the changes that the government announced towards the end of last year was that benefits payable to indigenous students will be the same as those paid to non-indigenous students, except in cases where the youth allowance did not cater effectively for the particular disadvantages faced by many indigenous students. So I think the degree of flexibility or recognition of the particular educational disadvantages faced by indigenous students is reflected in the current Abstudy policy.

Mr QUICK—How flexible is Abstudy in light of what incentives state governments provide in the way of scholarships for indigenous people to access higher education in related health fields? If it isn't very flexible, should it be? We do not have many indigenous dentists in Australia and we do not have many indigenous doctors. We are talking about a holistic approach; that was the word used by Mr Greer. I find it difficult to have a holistic approach when we have got a departmental straitjacket and there is not that flexibility between states and Commonwealth. I would like to see, as Mr Buckskin said, this expanded rather than constricted. I think there is a constriction there, because we cannot talk to each other.

Mr Greer—In responding to the committee, I think I am limited to saying that the government has in fact very recently reviewed its policies in respect of Abstudy and income support and supplementary arrangements. The outcome of that was enunciated towards the end of last year, again premised on the fundamental, underpinning principle that the benefits payable to indigenous students would be the same as those paid to non-indigenous students except in cases where such alignment clearly did not cater effectively for the particular disadvantages faced by many indigenous students. Arguably that principle accommodates a good degree of flexibility.

Mr QUICK—I know for a fact that the department in Tasmania is doing an aboriginality check on students who have already been in receipt, for many years, of Abstudy. They are doing it on hearsay because various sections of the Tasmanian Aboriginal community do not recognise various members, even though the Commonwealth department has recognised that. Those people are being put through the heartbreak of having their aboriginality questioned by the department. Is this just a Tasmanian occurrence or is it happening around other states in Australia?

Mr Buckskin—A point of clarification is that the Department of Education, Training and Youth Affairs looks after the policy through me, being the branch head and responsible for the Abstudy policy; it is Centrelink that delivers the Abstudy program and it is Centrelink that makes those assessments. If it is being done, again by Centrelink, it is probably because they could be lodging a new application; I do not know the reasons why. But it is really a Centrelink issue rather than a DETYA issue.

CHAIR—We need to talk to Centrelink about that. Thank you very much. Just a couple of quick questions from me. I am interested in the apprenticeship and training area and this

whole issue of infrastructure health issues and all the well-known issues. Can you give some enlightenment to the committee on this matter? Please bring the state arrangements on training into play with it as well. I do not want you to limit it to apprenticeships but include traineeships as well, in terms of indigenous training programs which may enhance the maintenance of the buildings, the building of new housing and that type of thing. Have we got something there that is a bit holistic and relates back to infrastructure health issues?

Mr Greer—Not specifically in the papers, but I am aware of some best practice projects in this area. One that particularly comes to mind is a project at Cherbourg. My recollection of that project, having visited it, is that it clearly is a benchmark project which that community has taken to other communities throughout the country. That involved an integrated program, or a cocktail of a program in a sense, of supporting indigenous young people from that community through to completion of an AQF4 certificate, or the equivalent of an apprenticeship, in the building and construction area. It exposed those young people in that learning process to the maintenance of public housing in that community, to the winning of contracts for the construction of houses in that community. In fact, there was an extension of that project. When those 15 or 16 young people graduated, there was some further assistance to enable them to obtain gold licence status such that they could as a group specifically tender. I know that that model, with the cooperation of ANTA, the state government and, from memory, the Building Industry Training Council in Queensland, is being looked at across other indigenous communities.

CHAIR—Would you be able to identify across the states a pilot program in each state with the state picking it up?

Mr Greer—We can certainly take that on notice and provide some further detail on it.

CHAIR—Thank you for that. My next question is on the issue of incarceration. We know the figures: 25 per cent of the gaol population and three per cent of the total population being Aboriginal and Torres Strait Islander people. Do we have any work being done at a national level or state best practice—I am quite open to where models might be coming from—in terms of education programs available within the gaol systems of Australia?

Mr Buckskin—Going back to Abstudy, under current Abstudy guidelines people that are in incarceration can access Abstudy to actually participate in undergraduate work. That is one strategy that we have as a response to the royal commission. The other is recommendation 185, which was a DEETYA responsibility, now DETYA, to bring together a national education and training policy for indigenous prisoners. It is not for juvenile detention centres but for adult populations in prisons. It has taken a long time, five to six years, to get it to a stage when we will be bringing forward to the ministers of justice and Attorneys-General group, through their administrators, a national strategy to address the training and education needs of the adult population. If that is agreed to at a meeting that will be held of those administrators soon—I think about June—it will go to the ministerial council.

Once that is adopted, we believe that we will be in a position to fast-track some work to address further education and training needs but also it will ensure that those people actually

have access to, say, post-release programs that lead to more appropriate or opportune employment than they have had in the past. That has taken some time because of the number of jurisdictions and because it relates to people in incarceration who go from juvenile justice centres to adult prisons and to people who are on work release or whatever. It is a very complex area and you get so many different types of ministers involved, whether it be health minister, community welfare minister, minister for police or minister for prisons, and you need to actually get that group together to come to a set of words where there will be, we hope, an agreement between the Commonwealth and the states and territories. We believe that as a result of that we will be able to further work in this particular area.

Mr Greer—I have located some further relevant briefing here on participation in vocational education and training. Would you like me to go into that?

CHAIR—Just briefly.

Mr Greer—In 1997, 2.6 per cent of VET clients identified themselves as being an indigenous Australian, which is higher than expected based on the 2.1 per cent indigenous share of total population. In that sense it is an overrepresentation. Although indigenous people may be well represented in VET overall, they do tend to be in the lower level or shorter courses compared with non-indigenous Australians. In 1997 about 28 per cent of indigenous enrolments were in AQF certificates 1 and 2, around 32 per cent were in AQF certificates 3—that is the traditional apprenticeship area and equivalent—and 11 per cent in diplomas and AQF certificates 4. By comparison, non-indigenous enrolments were 13 per cent in AQF1 and AQF2, 25 per cent in AQF3 and 23 per cent in AQF4 and above.

CHAIR—You mentioned education and that the health service was the responsibility of that particular discipline, as I understood that. State accreditation and the registered providers: do we have anything there on the general standards and how those state accreditation issues are standing up? Are we satisfied that they are reaching satisfactory benchmarks?

Mr Greer—I do not have that with me. I could certainly take that on notice and get some comment from the Australian National Training Authority.

CHAIR—Thank you.

Ms ELLIS—Without wishing to labour the point, can I add my voice to the disappointment about the lack of a submission, particularly as the election was only in October and it is very difficult. I look forward to the possibility of meeting the department again and having more information in front of us. In the copy that we have of the opening statement there are two things I want to refer to briefly. One of them, which has already been referred to, is the 1967 referendum giving the Commonwealth special responsibility for indigenous affairs. Further down there is a strong acknowledgment that poverty and ill-health can limit the ability of many indigenous people to participate in education. Can you please tell me how your department liaises with health authorities in relation to the advancement of education with the health hat overseeing that question?

Mr Buckskin—Currently we are in discussion with the Office of Aboriginal and Torres Strait Islander Health and I had a meeting with them late last week. The Australian Health Ministers Advisory Council has set up a review into Aboriginal and Torres Strait Islander health worker training, and we have been talking to them over a number of years about the number of courses that we support through Abstudy away from base activity. One of the supplementary benefits for Abstudy in terms of flexible arrangements is that we provide funds to institutions where people can come from communities to that institution or the institution can go out there.

You would be aware of changes to that that Senator Vanstone put in place when she was minister. The government has decided to exempt the health worker away from base activities from those changes for another year, which is the end of this year, where they can continue to have the level of access to those courses from those institutions. I understand there are about 741 students taking up the away-from-base activity across a whole range of providers such as James Cook University through to community controlled colleges. We have asked the office of health to provide us with any other provider which they think might be at a disadvantage as a result of Abstudy changes. Through our ongoing discussions with them we will be participating in that review of the health worker training and also looking at another project which they are putting in place, which is best practice in the area of workplace activity.

Ms ELLIS—Thank you, but what I am more precisely referring to is the wellbeing, in a holistic way, of general Aboriginal communities, given the participation of education at the most basic of levels. That is what I am really talking about: the health of the community as reflected by good water, good sewerage, good housing, healthy education processes and so on. That is the level that I am really aiming my question at.

Mr Buckskin—I would not know that level of detail. Our agreements are bilateral with ministers of state—the whole of the education portfolio in training responsibilities. As I said, when it gets down to strategies in terms of achieving the indicators or the targets that they set, we would only be aware of some of the processes that they adopt through our field staff visiting local communities—people like me visiting communities and being invited to communities. But we also have in place a number of SRP projects which are promoting best practice.

Ms ELLIS—SRP?

Mr Buckskin—That stands for ‘strategic results projects’. Some of the $36 million which was approved by the minister last year goes to looking at training issues of indigenous people, which include access to appropriate things like—

Ms ELLIS—You mentioned earlier that that was a 1997 decision—innovation programs. Would you be able to take on notice to advise the committee of the distribution—rural-remote-urban—of those projects within that $36 million program? Could you take that on notice and supply it to us?

Mr Buckskin—Yes.

Ms ELLIS—You made a reference a moment ago, in answer to another question, to the role Centrelink may be playing in relation to Abstudy. Can you just clarify, for my information: if you are the policy department and you formulate a policy which government then adopts, in this case in relation to Abstudy, are you basically saying that it is up to Centrelink? What checks do you have, and what ongoing relationship do you have with Centrelink as to the delivery of your policy and not a Centrelink interpretation of your policy?

Mr Buckskin—We have a steering committee in place, made up of Centrelink and the department, and ongoing officer to officer collaboration. If an officer at Centrelink's national office has a difficulty with a policy interpretation by a Centrelink office in the regions, it would be referred to our department and then to my branch for some clarification.

Ms ELLIS—So, in relation to the question that Mr Quick asked before: from whom do we seek clarification? Do we seek it from Centrelink or from you as it is your policy?

Mr Greer—In relation to the operational application of the policy, it would be an approach to Centrelink. It sounds to me as though it was an issue of proof of identity. Mr Buckskin was right: in addition to the steering committee and high level strategic forums—in which the chief executives and senior staff of both organisations meet—there is a formal memorandum of understanding or agreement between the portfolios, in a purchaser-provider context, in which DETYA outlines the parameters and bases upon which we require our policies and programs to be delivered by Centrelink. There is regular monitoring of performance against those benchmarks.

Mr QUICK—This person was paid to do a first degree by you people when you had control of Abstudy. She must have met the criteria in order to get the payment—as I said, she was in receipt for eight years—and then suddenly it goes to Centrelink, and there is a question of her aboriginality, and it is an easy duckshove to say, 'It is Centrelink's problem'.

Mr Buckskin—I think we will have to take that on notice. In any individual entitlement, we would have to look at the individual case and the circumstances that surround it before we can make an informed decision.

Ms ELLIS—I do not want to labour the point of the Northern Territory example. You have given us a lot of detail already about that, and I thank you. But I would comment that, given the Commonwealth's overriding responsibility for indigenous affairs, is it enough for us to accept that a perceived requirement for literacy in the English language is going to be accepted as overriding a literacy or other competency measure for a native language in the Aboriginal community? I find it terribly much a dilemma to accept that we are going to place somebody upon our indigenous communities—in this case the Northern Territory government—and that we are collectively going to allow that to occur, when we are talking about the health and the holistic wellbeing of indigenous communities. I find that anathema, and I am wondering if you would care to comment on what else can be done, except for it to be brought up at a meeting some months down the track with probably—the cynical politician in me says—no change to the outcome.

Mr Buckskin—As I stated before, goal 17 of the policy, which the Northern Territory is a signatory to, talks about the need to develop, support the maintenance of and the continued use of Aboriginal languages. We will be seeking from them an absolute guarantee that they have in place strategies to, first of all, respect and maintain the language.

The Commonwealth is not of the view that Dr Kemp's pursuit of English literacy outcomes should be at the expense of the vernacular. As we all know, that goes to levels of self-esteem, and the bilingual program—as we also know—was about much more than just literacy outcomes. It was about employment, developing self-esteem and empowering indigenous people in the schools to be the owners of knowledge which non-indigenous people have and to actually reverse the power base within the schools in terms of a more equitable partnership.

We will be seeking to know how the territory would do that under that particular goal. In terms of the holistic ' approach to education, we have used the $36 million to ensure that there are air conditioners in the schools, appropriate shaded areas, appropriate playground equipment and that transport requirements are met—that buses have seatbelts, for example. There is a whole range of holistic approaches. When Dr Kemp talked about an outcome in terms of access or attendance, he was very clear in his mind that one of the things that he needed to put in place was basic infrastructure. The majority of that money went to the community controlled schools or to remote or rural areas. We would be pleased to give you that breakup. But we have clearly seen that this interventionist money is not just about the activity that happens in classrooms; it is about the social infrastructure of communities and how we can contribute to that.

Ms ELLIS—Sure. We cannot have English as a second language when they have lost their first. That is the point I would make.

Ms HALL—That is right.

Mr QUICK—We have a copy of the agreement on Aboriginal and Torres Strait Islander health between the Queensland minister and the Commonwealth minister. Can we get examples of the agreements or memorandums of understanding between Dr Kemp and the various state and territory governments?

Mr Buckskin—Yes, we can certainly give you the IESI—or indigenous education strategic initiatives—program bilateral agreements.

CHAIR—Thank you very much.

Ms HALL—I would like to join with my colleagues in expressing both my disappointment about this and my hope that there will be some actual action in ensuring that the Northern Territory does respect people's native language. Whilst the states are responsible for direct delivery of services, the Commonwealth does play a role in providing funds which, to a degree, deliver those services. If they are not going to deliver the appropriate service, then the big stick approach can be used.

You were talking about students who were prepared to undertake Western education not being forced to assimilate, and I cannot think of anything that could be a greater disincentive for them than to be forced to learn in a language that was not their own. I just make that comment. Everybody has said a lot about it and there have been a lot of questions asked, and I am sure that you will be pushing that at your meeting.

You detailed some of the really good courses that are actually in place at the moment, and then you said that the ongoing education of employees of state health departments was up to the states. So basically—correct me if I am wrong—you were saying that in the universities there are a number of good new initiatives in place which are promoting the right sort of approach to health; but, for those people already employed in the services, it is up to the state health services to see that they get such education. I suppose my question links in a little with what I said before. What strategies has the Commonwealth, and your department in particular, in place to ensure that those state health services continue to update those skills, particularly in the area of Aboriginal and Torres Strait Islander health?

Mr Buckskin—We do not have any bilateral agreements with departments of health at state or territory level. Our bilateral agreements are with the education and training authorities of the state or territory or, indeed, with any independent trainer—such as the Institute of Aboriginal Development in Alice Springs, Marr Mooditj, which is an Aboriginal health program in Western Australia, or with places like Curtin University or Pundulmurra College—that delivers health services. We would expect or understand that people who access those programs are sometimes the employees of departments of health or of the independent aboriginal medical services. We do not necessarily fund the in-service training of another department's employees.

Ms HALL—No. I agree that that is the role of the department itself. But, for ongoing accreditation of services—and I know the Commonwealth has input into the accreditation of various services and into the ongoing accreditation of people working within those services—could some strategy be developed to ensure that those employees actually undertake ongoing training in those areas?

Mr Buckskin—Yes. One of the decisions that came out of the Abstudy cabinet decision was to ensure that in the indigenous health area of Education and Training we maintain our efforts in that particular area and, indeed, that we improve our services to that particular part of the government's agenda. We will progress that through the implementation of the cabinet decision this year, through the term of this government.

Ms HALL—Looking at the Abstudy issue and the changes in policy, who and what determine whether the means tests can be put aside? What determines the level of disadvantage? Are there are set guidelines, or is it decided on an individual basis by a person, depending on the mood they are in?

Mr Buckskin—It is based purely on the income test, the actual means test.

Ms HALL—Previously it was stated that that could be put aside if a person were deemed to be particularly disadvantaged. What determines that particular disadvantage, and how is that assessed?

Mr Buckskin—There are two parts to the Abstudy decision. Clearly, there was a concern from the wider Australian community, as well as from the parliament, that there were two sets of income testing arrangements and that one was more generous for a group of people called the indigenous Australians. When the government wanted to bring the common youth allowance into play, they started to look at the types of allowances that Abstudy provided.

Abstudy provides wide ranging types of income support arrangements for the under-16s, for the over-20s and for the over-25s, as well as complex assessment arrangements and different pay arrangements. They wanted to bring those allowances into line, to be the same as for all other Australians. What they essentially did in the cabinet decision was to bring the living allowances for 16- to 19-year-olds into line with the common youth allowance, and the rest into line with the Newstart allowances for the over-20s. So everyone who is on an income support program from the Commonwealth—and it does not matter which program they are in—has the same income testing and payment arrangements.

Ms HALL—What I am pushing is the special disadvantage where you can fiddle at the edges.

Mr Buckskin—There are the 10 or so supplementary benefits which the cabinet agreed need to be maintained, based on what Mr Greer talked about—specific indigenous disadvantage, that is, that the majority of people live outside the metropolitan areas. Those people that live outside metropolitan areas do not have access to appropriate post-schooling or tertiary or VET sector type arrangements and therefore they decided to keep in place the fares allowance for secondary students so they can access those because of the level of disadvantage and lack of access, and also the fares allowance for tertiary students. The school term allowance is paid because the average income of indigenous Australians is far less than anybody else, but they changed arrangements so that that term allowance be paid to the school rather than the individual, so there is tighter targeting of that.

The school fees allowance for secondary students approved to live away from home because of the home situation again is based on the socio-economic status of indigenous Australians. The masters and doctorates awards were maintained, but were also streamlined in terms of eligibility requirements because of the lack of people that are studying for masters and doctorates. The government saw that as an area of disadvantage. Incidental allowances were retained for mature age students and tertiary students, again because of the low socio-economic status of the people at the time.

They are the decisions that the minister took in preparing his cabinet submission. He clearly was able to convince the cabinet that all these allowances needed to be maintained—but certainly needed to be tightened—because of the level of disadvantage, either socio-economic or cultural.

Mr Greer—There is a summary of the changes that we certainly can make available to you which goes through the living allowance and the supplementary benefits.

Mr QUICK—To follow on from that, with the forms, can you imagine an indigenous couple in Alice Springs or in a township? How relevant are the forms that they have to go

through? My electorate staff have hassles advising people about how to fill out some of these forms. How relevant are they to the benefit, and what cultural sensitivity is there in the department to enable people to go through a bureaucratic form that is designed for an Anglo-Saxon Australian with probably at least a year 10 educational equivalent?

Mr Greer—My understanding is the design of the forms and the administration of forms design is the responsibility of Centrelink. In designing and redeveloping those forms, Centrelink has engaged—and I will confirm it—in a consultation process with indigenous communities to get more culturally sensitive applications of that.

Mr QUICK—So it is Centrelink's responsibility, not the department's?

Mr Greer—That is correct.

CHAIR—We will undertake to bring Centrelink in as well. Any assistance there would be appreciated.

Ms HALL—The issue of health for Aboriginal and Torres Strait Islanders to a large extent is about access and socio-economic and cultural issues. Into that comes employment. There is probably no group that is more disadvantaged in the community or that has higher per capita levels of unemployment than Aboriginal and Torres Strait Islander Australians. That then impacts on health, housing and all other areas. Unless the issues of employment and education are addressed, then those other areas—including health that we are looking at—will never be solved.

I know in the past there were very definitely programs that were designed for Aboriginal people. Are they still in existence or have they changed? I know Barry was talking about apprenticeships and traineeships within communities but, overall, are there jobs that are targeted for Aboriginal Australians? What support mechanisms are in place for them to help them adjust during their training periods, and are there any Aboriginal-specific programs? I know in the past there were training programs for nurse assistants within the general community, and that is honing in on just one particular area. Are there any programs in place for Aboriginal and Torres Strait Islander Australians to do nurse assistant courses?

Mr Greer—The responsibility, following the change to administrative arrangement orders for indigenous employment, is now the responsibility of our colleagues in EWRSB through their indigenous employment branch. My understanding is that indigenous employment responsibilities really are a policy and operational responsibility of that department. Notwithstanding that, we have a memorandum of understanding between both of our portfolios in this important area, such that initiatives, policies and strategies that we are pursuing through our programs for indigenous education are cognisant of the employment strategies that are being progressed through our colleagues in EWRSB. There are regular meetings of the officers and policy people involved in that.

Mr QUICK—Can you get us a copy of the memorandum of understanding?

Mr Greer—Yes.

Ms HALL—You asked for a copy of the memorandum of understanding. Could we also get some details of what is in place? You could maybe liaise with the other department and see that that information is passed on to us.

Mr Greer—We will certainly take that on notice.

Mrs ELSON—Mr Greer, in your opening verbal statement I believe you said that we have had an encouraging increase in the numbers of indigenous people taking up further education. I have been on this inquiry for about 15 months, and the thing I have noticed most when I go around to indigenous communities is that the most disadvantaged group are the dark-coloured disadvantaged people in the community. I do not mean to say that light-coloured disadvantaged indigenous people do not qualify for the assistance from this $330 million under the programs to help them. It appears that the dark-skinned indigenous community would like to see their people in further education as role models to allow the young ones going through our school system to see that you can achieve in Australia in the system and get assistance for it. I am all for that—I have to be honest. But when I have seen some of the programs and talked to the people taking the indigenous programs, I have been quite surprised to see that in one group we had three dark-skinned indigenous people and the rest were light skinned. I repeat that I see no problem with that. They are entitled to the assistance, because they are disadvantaged people, but do you have figures at all that show how many dark-skinned disadvantaged indigenous people are actually taking up further education? I am not in any way being derogatory but it concerns me that the people who should be encouraged are not and that they are maybe not taking advantage of the $330 million that we are putting into the system each year.

Mr Greer—I think I mentioned as a supplementary answer recently in relation to vocational education and training, which in some cases is described as further education and training, that in 1997 2.6 per cent of vocational education and training clients identified themselves as indigenous Australians. That is higher than the indigenous representation, so the message coming through is that the participation rate in vocational education and training or further education and training is, you could argue, overrepresented. But when you look at that representation, indigenous people tend to be represented more generally in the lower areas—that is, in the AQF1 and the AQF2 outcomes rather than AQF3, AQF4 and beyond, diplomas and so forth. In 1996 there was relatively little difference between the participation rates of indigenous and non-indigenous 15- to 19-year-olds in the VET sector, with 26 per cent for indigenous Australians and 27.5 per cent for non-indigenous Australians. Those rates were also mirrored when you looked at the cohort 20- to 24-year-old group. The completion rates for indigenous apprentices and trainees are broadly similar to those for non-indigenous apprentices and trainees. Unfortunately, our aggregation does not go—

CHAIR—How is that, Kay?

Mrs ELSON—I would like more answers on that, because I am very concerned that—

Dr Karmel—I could add to that in higher education. I have some data here on indigenous students. It would be possible to cross-classify according to whether the students come from remote or rural areas, which might provide some information.

Mrs ELSON—That might be a better way. With the outlay of funds, do you have a breakdown of what gets spent in rural and remote areas compared to urban areas?

Mr Greer—This is out of the $330 million?

Mrs ELSON—That is right.

Mr Buckskin—Not necessarily. We could compare rural and remote with urban under the $36 million. In terms of the bilateral agreements, we do not ask where they are spending the money. Again, it is based on the outcomes they have identified, and they are reporting on those outcomes. We might get involved in where the money is going for the IESIP program based on, say, the department identifying some programs as being of best practice and therefore asking us to look at them or do further work through the Strategic Results Program. The only way we can actually identify whether it is remote, rural or urban is through the direct assistance programs—that is, we can tell you how many students in receipt of Abstudy are from rural, remote or urban societies. We can also tell you through the direct assistance programs about tuition through parent committees. We can also identify where people are from who are in receipt of vocational education and guidance programs, because they are driven by a direct application. The IESIP program is like a general recurrent grant made to a state, and how they spend that is really their business, as far as we are concerned.

CHAIR—I thank you all very much for your contribution. We look forward to your submission and trust that today's proceedings have perhaps assisted you in identifying the sorts of things we are interested in. I am sure we will have you back in the foreseeable future.

[3.57 p.m.]

RUSHTON, Ms Tricia, Assistant Secretary, Community Branch, Department of Family and Community Services

SMITH, Mr Barry, Director, Indigenous Policy Unit, Community Branch, Department of Family and Community Services

CHAIR—I welcome to the committee the representatives of the Department of Family and Community Services. I point out that the committee does not swear witnesses, but you are aware of the process and that evidence that you give is covered by parliamentary privilege. Would you care to make an opening statement?

Ms Rushton—Yes, and we will be brief.

CHAIR—Thank you.

Ms Rushton—We are delighted to be here. Thank you for the opportunity to make this contribution. We have already provided a submission and a further update on that submission in the context of the new department. The portfolio has responsibility for a range of services and programs which all could be seen to contribute in some way to the health and status of indigenous people. Our submission, though, is focusing on two particular terms of reference that you have: '(a) ways to achieve effective Commonwealth coordination of the provision of health and related programs' and '(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'.

Mr Barry Smith, who heads up our Indigenous Policy Unit, has been saturated in these issues and progressing them over many years, so I would like to offer him an opportunity to say a few things. We will be brief, and we look forward to your questions.

CHAIR—Thank you.

Mr Smith—Thank you very much for the opportunity, Mr Chair. We will look at these in three parts. One is looking at what FACS is doing in collaboration with ATSIC, in terms of improving outcomes in this area. We will look at the work that we are doing with the Commonwealth-state working group, which is a group set up after a housing ministers meeting in Launceston in April 1997, and the outcomes of that. Then I would like to indicate the work that is being progressed under the leadership of Minister Newman.

In terms of pursuing coordination at the Commonwealth-state level, I suppose there are two ways the department is doing that. One is through leadership in conjunction with ATSIC in the Commonwealth-state arena and the second is the provision of secretariat resources to organisations, convening activities, putting money into various research, and our funding program. This is all towards achieving better housing and better services of housing, which affect the indigenous community housing sector—more houses and greater accountability to government in terms of housing. You are aware that Family and Community Services

provides $91 million to the states and territories under the Commonwealth-State Housing Agreement—that is the Aboriginal Rental Housing Program—and those funds are to be used for housing and related infrastructure. That refers to anything within the fence line of the house.

In late 1996, Senator Newman and Senator Herron requested that an internal review be carried out because they were concerned that the outcomes for indigenous housing that they would have expected were not being achieved. The results of that internal review indicated that, at the Commonwealth level, there needed to be a single point of contact for indigenous housing, and that at the state level it was necessary to have Commonwealth-state bilaterals in place to achieve better outcomes. It also indicated that improved outcomes in indigenous housing would be achieved through better monitoring processes with the states and territories and that there should be a focus on rural and remote areas.

Over the last couple of years, Family and Community Services has been involved in conjunction with ATSIC in negotiations of bilaterals. You probably are aware that bilaterals are in place with the Northern Territory, Western Australia and New South Wales, and the one for South Australia is ready for signature now. The other states and territories are also well advanced. We are hoping that bilaterals will be in place by the end of this financial year.

A new policy direction has been struck with the states, moving away from a policy which we referred to as build and abandon to a policy of sustainable healthy housing. They are deliberately chosen words because under the build and abandon policy we provided money for housing, the houses were constructed and the people walked away from them—and those houses lasted between six and eight years if they were in rural and remote areas. The sustainable healthy housing policy makes sure that those houses stay on-line and stay in a healthy state.

CHAIR—Whose responsibility is it to make sure that you have sustainable, healthy housing? Is there a sanction within the bilaterals? You guys do not have people on the ground, for example, in Tasmania, to see that the housing stock at Bridgewater that is designed for Aboriginals is maintained adequately. Do you rely on the states to tell you that?

Mr Smith—In conjunction with the states we have an annual strategic planning process where they have to indicate what they are doing in terms of upgrades and cyclical maintenance of housing. In terms of the actual checking on the ground, the department did not have a network in place at that time, but ATSIC does have a network in place and, between both those organisations, we have been in a fairly good position to know what houses are working and what houses are not working. As ATSIC probably indicated to you this morning, they have a regular monitoring process, HINS, to see how stock is operating and not operating. The states and territories have their own stock assessment processes in place to look at the condition of the stock.

Most of the problems we have had with the condition of stock have not been with urban based stock but more with rural and remote stock. Over the last couple of years, we have done a lot of work with the Healthabitat organisation to look at the stock condition and the

work they have done in the health area. One of the things we are about to strike with the states and territories is a design, construction and maintenance framework which agrees on a set of principles and, therefore, gives us a reporting process in terms of stock condition. I will move on to that.

The housing ministers set up the Commonwealth-state working group on indigenous housing. This has been a significant change, because it is the first time after the inaugural meeting in 1997 that there has been a specific focus on indigenous housing and a specific body set up to address indigenous housing issues. As products of the work of that organisation, things which are actively being put in place and pursued, and will be endorsed by ministers, are a national policy and vision for indigenous housing; a multimeasure approach to indigenous housing need, which focuses on sustainable healthy housing; a national data agreement; national performance indicators; a national skills development strategy; a voluntary rent reduction facility; and, as I mentioned, a design and construction framework in regard to the building, construction and maintenance of houses. Built into that is a monitoring process which will be independent of the states and territory, as an honest broker, to look at those houses.

The ministers have committed themselves to environmental health outcomes and functional safe houses. Minister Newman has reinforced this through letters to state housing ministers and she reinforces it very strongly in the annual indigenous strategic planning processes. We analyse these and, if the processes are not being put into place, those plans are not automatically rubber-stamped but go back to the states and territories to reflect the Commonwealth's position in terms of housing.

From a state level, this has resulted in a significant shift to resources in the states and territories to rural and remote areas. There is in the order of 85 per cent of funds going to rural and remote areas this year. This is a significant improvement. In, say, 1995-94, there would have been about $32 million of ARHP state/territory related funds going into housing in regard to the Aboriginal rental housing program in rural and remote areas. At this current point in time, there is in excess of $100 million of ARHP state/territory related funds going into housing in rural and remote areas.

The states and territories are also seeing that they have more of a role to play and, over the last five years, they have made significant improvements in the contributions of owned funds or untied CSHA funds. About three or four years ago, they would have been contributing about $2 million and, at this particular point in time, they are actually contributing well in excess of $50 million into that area.

In addition to that, as examples of the moves towards sustainable health housing, you have states and the Northern Territory, who out of the pooled ATSIC and FACS funds of this year committed something like $6 million towards maintenance, whereas in previous years they would have committed amounts as small as $½ million to that. There have also been significant contributions or shifts in contributions in places like New South Wales, who have put significant amounts of money into maintenance; South Australia, who are looking at the transfer of maintained houses across to the indigenous housing sector; and Western Australia, who are actually putting quite a lot of their money into training in the sector. I think that probably gives a bit of a snapshot.

CHAIR—Thank you very much. That is very comprehensive. I have three or four quick questions, and then we will go to committee members. Consultation with the Aboriginal community: can you describe some of the processes, particularly the relationship or the consultative process with ATSIC in its various forms?

Mr Smith—You need to keep in mind that ATSIC primarily services the indigenous community housing sector whereas FACS primarily services the state indigenous-specific housing sector, although in the Northern Territory and Western Australia they use quite a lot of our money in terms of the indigenous community housing sector as well. In terms of consultation processes, the states and territories are responsible for—

CHAIR—Let me be a quite specific: consultation with Aboriginal people and consultation with ATSIC. They are two separate issues.

Mr Smith—In terms of consultation with Aboriginal people, we rely on the states and territories primarily to do that. This year we wanted to establish a consultation framework, and we are doing this with ATSIC. We are mapping the whole indigenous housing sector in terms of contact details so that we can directly contact those people rather than relying on the states and territories to do that. ATSIC have actually been using that system for quite some time.

In addition, we complement that by some field trips from within our own organisation. Last year, that entailed three fairly extensive field trips—two to different areas in Central Australia and one to the Torres Strait to look first-hand and be involved in consultations first-hand with them. We have also been working with the Community Housing Federation of Australia. ATSIC has funded a project there to look at the possibility of setting up an indigenous community housing peak body, and we are working closely with that.

On the question of liaison with ATSIC, we have a very good, informal working relationship with ATSIC. We do run separate programs, but when we actually attend any of the Commonwealth-state working bodies we have joint planning meetings before we attend these and we try to look at a joint Commonwealth front and share data where possible. In terms of the people working in the Indigenous Policy Unit and the housing branch of ATSIC, there is a day-to-day informal relationship.

CHAIR—So it is as close as that? It really is quite significant day-to-day or week-to-week contact, is it?

Mr Smith—It is not always on a formal basis.

CHAIR—No, I understand that.

Mr Smith—There is a very personal sort of contact in regard to officials.

CHAIR—I have three other questions. I am very interested in the needs analysis. From the Commonwealth perspective—and not having had an opportunity to look at it in any depth—does that imply that, nationally, you would be able to advise the committee pretty much where the weak spots are and where some areas are stronger than others across the

breadth of this country? Does that imply that we would have a fairly good picture across Australia of all the needs?

Mr Smith—At this particular point in time we have what are referred to as 'experimental estimates' of that need.

CHAIR—Experimental?

Mr Smith—They need to be confirmed. We would actually like to have another source or two to look at the data. Because the multimeasure approach looks at homelessness, overcrowding, services, the condition of stock and affordability as the five measures, we rely on a number of different data sets—the census, the Supported Accommodation Assistance Program data, the HINS survey and the health survey in Western Australia. We have recently received the experimental estimates part of the paper from Roger Jones, and we would like to have a verification and validation exercise.

CHAIR—What is the time line on that?

Mr Smith—It would probably take another two months to do that.

CHAIR—On the housing stock—I was specific this morning; I will not be now because it may be a bit too anecdotal to be of sufficient significance—what is the general acceptance of the stock? Are we holding ground, are we sliding away or are we improving? The general principle which has been painted to me over the last couple of years is that the lifetime of Aboriginal housing may be shorter than mainstream housing. Therefore, despite significant investment going in, we may only be treading water or we may even be going backwards because of the stress that comes on the stock. Do you have a view about how we are going with the stock?

Mr Smith—There are two answers to the question. One is in terms of need for stock and one is the aggregate level of stock. In terms of the aggregate level of stock, we are making ground. In 1996-97 the net increase in stock was around about 700, but that does not mean that you are actually meeting the growing need because there is an increased enumeration of indigenous people and also there is this unmet need in terms of family formations and a range of other activities. So we are not necessarily keeping pace with that.

One of the problems with the stock, which we are turning around now, is that, because of the build and abandon approach, probably 40 per cent of the stock, particularly in rural and remote areas—that is, about 12,000 units—were probably in a state where they needed upgrades. Around 1,800 of those houses probably should be bulldozed. The rest of the houses were in a fair state of repair. But, with the turnaround to sustainable healthy housing when you are looking at putting more money into maintenance, habitable healthy housing is increasing as distinct from housing alone.

Mr QUICK—Can you give us a ballpark figure of the unmet needs? Do we need 20,000 houses or do we need 30,000? You mentioned that there are a whole lot of things that you need to put in place over the next couple of months, but you must have a ballpark figure of unmet needs nationally.

Mr Smith—I would prefer to provide that after we have done the validation exercise.

Mr QUICK—You mentioned as part of that process 12,000 houses. We have seen them as we have visited communities where people are living in traditional accommodation and there are 20 or 30 besser block houses just sitting there and falling apart. Do you have a list of those that ought to be bulldozed, state by state and territory by territory?

Mr Smith—ATSIC has a record of those from the 1992 CHINS survey and they are about to do another survey this year—1999. Once that survey is done, we will have an exact figure community by community because all the indigenous community housing sector will be included.

Mr QUICK—Can we get a copy from you?

Mr Smith—There would be no problem getting it from ATSIC. We could quite easily liaise with ATSIC in regard to that.

Mr QUICK—Thank you. That would be handy.

CHAIR—We see growth in the homelands policy, but my experience is that you can build some homes and then there may be some abandonment, some shifting in family structure or whatever. How do you feel about the homelands policy, demand for the housing stock and competition for the available dollars?

Mr Smith—The homelands and out-station side of the housing and infrastructure area really is controlled by ATSIC rather than by our department. The states and territories are less likely and less willing to put ARHP dollars into those environments. That question really needs to be addressed to ATSIC.

CHAIR—That raises the whole infrastructure issue and the cost of those infrastructures. The states would be less likely and, therefore, it tends to fall back to ATSIC. For that homelands policy, the funding will be putting the greater demands on ATSIC to maintain that policy.

Mr Smith—That is right.

CHAIR—The maintenance of the stock: you pretty well answered that with the $6 million figure that you mentioned. What might be the prognosis in the future on maintenance? Have you done any work which may extend the life of available stock, the skilling of the communities in the maintenance and those sorts of issues? Do you have anything that might touch on those issues?

Mr Smith—Again, we have been doing quite a bit of work with ATSIC in improving and growing the indigenous community housing sector. ATSIC is putting quite a lot more effort into the training side. With the Commonwealth-state working group, FACS actually funded the development of a national skills development strategy for the sector. In terms of the actual modelling of keeping houses on line, the Northern Territory government did quite a lot of modelling of what would happen if you put X number of dollars into maintenance as

distinct from X number of dollars into construction. South Australia has done some work in regard to that.

Recently we applied both of their methodologies—again these are ballpark figures and a bit rubbery, so take them on those grounds. If you took those 12,000 houses that were in rural and remote areas and continued to spend all the money on capital construction, at the end of a 10-year period you might end up with 24,000-odd. Only 14,000 of those would probably be habitable and healthy houses. Quite a few of them would not be healthy in functional condition.

If you took an approach where you put more of your money into a regular maintenance program, at the end of that same 10-year period of time you might actually have about 20,000 houses, but the whole 20,000 would be healthy houses because you are actually putting money into construction and maintenance. So your net number of houses ends up being smaller, but the number contributing to the health of indigenous people is around an extra 6,000 houses.

CHAIR—I am greatly encouraged by the focus. That is exactly what we are about. My last question is on a totally separate issue. I noticed that the issue of child abuse was briefly mentioned in your submission, and there are always the inevitable reports. In terms of the overall health of Aboriginal people, can I get a snapshot of how you see the issue of child abuse—the relativities over the last 20 years and some concept of the future?

Ms Rushton—In terms of the increase or decrease?

CHAIR—We come from somewhere; we come from 20 years ago on this issue of child abuse with Aboriginal people. I have some limited knowledge of Central Australia, and there is a whole range of issues in terms of flying people into Alice Springs or other communities and quite horrific injuries to young people. I could not call it anything other than child abuse at times. Basically, do you have a view of the overall issue of child abuse in terms of the Aboriginal people and where that is at? It is a pretty broad question, and I am still grappling with it.

Ms Rushton—I am reluctant at this stage to say anything definitive on that. There are some significant issues, I think, in statistical comparisons over that 20-year period, with an increasing number of people identifying as indigenous and vast changes over 20 years in what we call child abuse. I would like to follow that up for you, if I could, and provide something.

CHAIR—I do appreciate that it is a difficult issue, and I put it on notice that it is an issue that I will be taking up.

Ms Rushton—My very experienced colleague in this area might want to make a comment.

Mr Smith—I think I will take basically the same line. The two reports that you refer to certainly identify this as a significant issue. In the new department there is the Family Relationship Branch, which is certainly going to be focusing on this child abuse and

domestic violence area in a more coordinated way. But you can understand that until more recently that particular activity was very much one for Health and Family Services.

CHAIR—I just signal too—and I would not press it in this forum in any way because it is more of a private matter—that, in terms of the cultural differences and the pressure that comes onto the families with change, there are very significant, and some quite tragic, consequences. I will just leave it there.

Ms ELLIS—I have a couple of brief questions. Can you tell me how you quantify 'homelessness' in the indigenous community?

Mr Smith—We have quantified it in three ways. The first is the number of people living in improvised dwellings. The second is people who are living in accommodation which is normally provided for people who are defined as homeless in the normal definitions of homeless under SAAP, the Supported Accommodation Assistance Program. The third is homelessness in the sense of overcrowding. Roger Jones in his material looks at the fact that you do not have the same number of indigenous people defined as homeless in the sense of being in an improvised dwelling or out on the street because there is always a 'home', a spot to be found. That is why in the multimeasure approach you are picking up homelessness in terms of the improvised dwelling, homelessness in the traditional sense under SAAP and the hidden homelessness in the overcrowding sense. The other part of overcrowding, of course, is simply larger or extended family arrangements.

Ms ELLIS—So you would actually use a slightly different set of definitions to the norm?

Mr Smith—That is right.

Ms ELLIS—They have never been written down or quantified in any way, have they?

Mr Smith—That is one of the reasons we looked at getting this work done by Roger Jones. It is a theoretical paper that looks at how you might quantify and redefine the measurement of indigenous housing need as distinct from other measures of housing need. So it is written down in that sense. That particular paper was a product of the Commonwealth-state working group. It has not yet been endorsed by an indigenous-specific housing minister's meeting, but it certainly has been accepted by the Commonwealth-state working group.

Mr QUICK—Following on from that, in the 1993 parliament we did a report on youth homelessness. At that stage we had two definitions of homelessness—one by DEET and one by DSS—and we came to a common agreement that there ought to be one. In light of what you have said today and what Ms Ellis has elicited, in the case of overcrowding, how sensitive and culturally aware is the government going to be when people fill out 20 pages—you probably heard me having a go at the previous witnesses—of application forms and explain their homelessness to an ASO4 at Centrelink in Hobart? What about the total inflexibility of departments to understand this? I think it is great if we can get that amount of understanding into the bureaucracy. I think it would be great, but where are we on that sort of scale?

Ms Rushton—I think the chairperson mentioned earlier that you intended to bring Centrelink in. Centrelink does have a key role in explaining and in making sure that the customers of these policies do understand, and I believe there is a commitment to that.

The definitional issue that Barry Smith has been talking about is being discussed. It has not yet been taken on and turned into a program or a policy within FACS. What we are sharing with you are the kinds of thinking and the kinds of research that have been done to date to make as full a contribution as we can to your inquiry.

Mr QUICK—Thank you.

Ms ELLIS—I refer to page 5 of the paper we have got from you today and to 'Cross portfolio linkages' and the paragraph that refers particularly to your having initiated a cross-portfolio group including a range of departments and organisations. For me, one of the most frustrating aspects coming out of this whole inquiry is the seeming lack of cooperation when you are looking at indigenous health across a whole range of policy and portfolio areas, despite the full acknowledgment by everybody that they all feed into the health and wellbeing of Aboriginal communities generally. Can you elaborate for us on the group that you have set up? When did you set it up? At what level does it operate? What is its agenda in terms of collaboration? Do you envisage pulling anybody else in at some point down the track?

Mr Smith—In terms of our relationship with the Office for Aboriginal and Torres Strait Islander Health Services, we initiated the links there at a high level in the sense that one of our executive directors met with the First Assistant Secretary of that area to simply come to an agreement that we would work, wherever possible, with them on as many practical things in this area as we could. That opened the gate for us to do things at very much an officer level.

I actually have a senior officer in my unit who has responsibility for facilitating the Commonwealth-state national skills development group under the Commonwealth-state working group. She runs that. She is the person who has actually built links with people at director level over in the rural health training area of Health and Aged Care and also in the Office for Aboriginal and Torres Strait Islander Health to look at how the strategy that has been developed under the Commonwealth-state working group might be actually unfolded without us duplicating resources.

She has invited DETYA into it, ATSIC is involved in it and she has brought into it ANTA and associated people to look at what resources are around. The strategy is not the problem. The biggest problem in this particular area is tapping the resources to actually do this training and looking at whether or not there can be opportunities to offer some generic community based management and service management skills training and then offer in some way some specific modules, whether they be for health, housing or other activities. That group has been meeting over the last six months and has been looking at those opportunities. We probably cannot move a lot further at this particular point of time until, again, this particular part of our work receives endorsement from states and territories, because it does have those resource implications.

The other area in which we have been doing a lot of work—with the Office for Aboriginal and Torres Strait Islander Health, ATSIC, the Office of Indigenous Affairs of Prime Minister and Cabinet, and the ABS—is on the whole issue of indigenous data and therefore assessment of need. We have been having regular meetings to look at improving the quality of indigenous data and to improve the data not only at the Commonwealth level but also at the Commonwealth-state levels. As you know, whether or not you are achieving outcomes or whether or not you know what your need is depends on what you are measuring, how you are measuring and how many gaps are in the data.

Ms ELLIS—Would you say that to date this has been working really well?

Mr Smith—There is a lot of good spirit there and willingness to cooperate, so the processes are working well. I think the dollars are hard to find.

Ms ELLIS—I should actually say that it is not a lack of cooperation across all of the sectors; it is a frustration in operating across all sectors. We have had some examples of where that has been attempted, but with local, state and Commonwealth governments—and a few dozen departments thrown in—you end up with almost a bowl of spaghetti, trying to put all the ends together.

I wonder if, further down the track, you can see some positives coming out of this that are useful in the longer term. Do you have a measurement mechanism and a reporting mechanism—through either the ministerial or state-Commonwealth level—to take this model further? Is this something that you can actually use as a pilot model for further integration and further intersectoral arrangements?

Ms Rushton—I think there has always been interest by government, since time began, in solving the problem that you are outlining. It is not a new one.

Ms ELLIS—Absolutely.

Ms Rushton—Were we to see this as achieving things, we would certainly be willing to boast about it.

Ms ELLIS—To share it.

Ms Rushton—Yes, share it.

Mr Smith—Over the last two years, one of the notable features of this particular area has been, at the Commonwealth level, a willingness for more people to get out of their silos and do a little bit more working together. I think there is a fair bit of credit in that for both ATSIC and FACS because we have together tried to take a bit of leadership and we have actually also tried to take a fairly inclusive approach to bringing people into any of the activities and to joining with other people in joint research activities.

The mapping project, for instance, has three-way cooperation. ABS are involved in it from an expert point of view, ATSIC are providing funds to the Community Housing Federation of Australia in terms of the peak body, and that peak body has been contracted to

do the work—and we have provided the money for it—to actually do this mapping exercise. I think there are more and more examples of that type of thing happening.

Ms Rushton—The administrative arrangements we have been working under since October are focused on addressing some of these things. Even in the creation of the branch I am now running, there are some synergies. The supported accommodation program is now with me, with the Indigenous Policy Unit and with others, so there will be some natural synergies created there by those arrangements.

Ms ELLIS—Thank you.

Mr QUICK—You mention that indigenous people comprise 12 per cent of all SAAP clients. Could you provide us with a state and territory breakdown?

Ms Rushton—Yes.

Mr QUICK—In relation to children and child care, you mention that only one per cent of indigenous children access mainstream child-care services and that special services are being funded to meet the child-care and other developmental needs of indigenous children in ways which are culturally appropriate. You say that special services funded include playgroups, outside school hours care, enrichment programs, vacation care and other children's services and that these may be provided separately or as part of a multifunctional Aboriginal children's service which has been established in 37 locations in all states and the Northern Territory. In contrast to the minister's emphasis on this, which I commend her for, we have, as we raised this morning, the Northern Territory government's decision to abandon its bilingual education program.

I would imagine that, if I visited some of these 37 locations—whatever number are located in the Northern Territory—I would find that they were well-accessed, wonderful learning environments. We spend money on that and then a couple of years later we are pulling something away from that holistic approach for those children. In this intersectoral sort of thing, how do you as the department get the message over to the Northern Territory government that what they have done is in many people's eyes—mine included—culturally insensitive?

Ms Rushton—I heard the answer that Peter Buckskin gave you earlier. I do not think I can make any further comments on that, only to say that we would stay in dialogue. I do not think there is anything else I can tell you.

Mr QUICK—Do you understand our concern?

Ms Rushton—I certainly understand your concern, and I was here for the entire session with the Department of Education, Training and Youth Affairs because I am interested in those issues.

Ms HALL—Firstly, I would like to ask a question relating to housing. I would like to compliment you on all the extra dollars you are putting into housing, and on the flexibility and the healthy housing strategies that you are putting in place. During the day some

concerns have been raised over local government involvement, the quality of inspections and of ensuring that the houses that are built are constructed in an appropriate manner. Would you like to comment on that?

Mr Smith—In our submission we have identified some areas of work that we have been pushing particularly hard. The reason for that is that Minister Newman has been very concerned about the fact that there are not, at this particular time, national standards. In writing to the states and territories she indicated that she wanted them to adopt some of the features of the urban based standards—she wanted in place trade based activities, local regimes and cyclical assessment. She made it clear to the states and territories that that was the line we were going to take and that is exactly what we are doing.

The framework for design, construction and maintenance of houses will be a watershed policy framework for this area because it will actually commit the Commonwealth and states to principles of sustainable healthy housing: it will commit the states to a set of guidelines which are based on Healthabitat's work—the nine areas of safe and functional housing. Those guidelines will require the states to develop their own housing standards to reflect the variations in those states and territories, but also to reflect the principles of the guidelines. As part of the agreement, outcomes will actually be checked every two years through an independent assessment of stakeholders, how they think it is going, and an independent assessment of a large sample of housing stock—maybe 1,000 houses—across rural and remote areas to see how that is going so that we can come back to them.

Ms HALL—I would like to extend it a little further. Earlier today it was pointed out that in some parts of the northern part of Western Australia they do not have any requirement for approvals or inspections by local government. Is that going to be forced upon local government? Will they need to inspect and approve buildings rather than there be just a haphazard development with inadequate standards and the associated problems?

Mr Smith—That is certainly the intention of the sustainable healthy housing framework. The difficulty is that the jurisdiction of local governments does not necessarily cover all places. Sometimes you do need other processes in place. The Northern Territory really does not have a network of local governments. It has some community councils and community local governments, but when you get up into the Pit homelands local government as a concept starts falling apart a little. There are ways around that. South Australia has quite a good model to look at what can be done from a state point of view, but also what can be done by including local people in the assessment and maintenance of houses. ATSIC may have mentioned that one of the things that we are trying to get in place is the housing functionality measurement that has been developed by Healthabitat. This measurement looks at whether these houses work and what actually needs to be fixed and when you do those assessments you go in and fix the houses as you carry out the assessments. There was quite a lot of resistance to that from states and territories, but since it is endorsed very much by ATSIC and FACS, and we have made it clear to them that we expect this is going to be part of the framework, there has been a gradual adoption of it.

One of the things that FACS did was contract Healthabitat people to provide us with advice, and under that contract we made available to each state and territory five days of free advice on using Healthabitat processes in assessments and inspections.

Ms HALL—One of the programs administered by your department is the Commonwealth Rehabilitation Service. That has had special programs that have in the past been designed for Aboriginals and Torres Strait Islanders. My understanding is that that service is being corporatised and that there is a plan further down the track to privatise it. How will that impact on the services to Aboriginal people with disabilities in our communities? I know that in the past that service has worked very closely with state health facilities. In some cases—Darwin was one and there was one in the Hunter—there were jointly funded facilities and they are responsible for some direct service delivery to head and spinal injured clients. There has been quite an amount of input there to Aboriginal communities, particularly in the Northern Territory.

Ms Rushton—My understanding is that the arrangements for changing CRS are still under consideration. I certainly could not answer those questions at the moment, but we can get information back to you.

Ms HALL—Thank you. I appreciate that.

CHAIR—Have you finished?

Ms HALL—No, I have three more questions.

CHAIR—I would like to come back to you. I would like Graham to have a turn.

Mr EDWARDS—I have in my electorate a community called Cullacabardee. I was out there are a couple of weeks ago. They tell me that they cannot access any finances for housing, housing improvements or community support. When a community tells you they have a problem like this, whom should a member of parliament pursue? Is it your department? Who is it that we should go to?

Mr Smith—I am not familiar with that particular community in Western Australia. Is it a homelands community? Is it an out-station?

Mr EDWARDS—It is a well-established community north of Perth, on the fringes of the metropolitan area.

Mr Smith—The difficulty with Western Australia is that the Western Australian government, because of some particular arrangements with the Commonwealth, recognise 48 communities and believe that those communities are their responsibility and that all other communities which are growing up outside that particular number are the responsibility of the Commonwealth. That means it becomes the responsibility of ATSIC. The answer to your question depends on whether that community is recognised as one of the communities serviced by the Western Australian government. I could follow that up.

Mr EDWARDS—I ask the question because, listening to you this afternoon, it seems to me that you are doing an incredible amount of work. Under the Commonwealth-State Housing Agreement, the allocation of $91 million in tied grants is not an insignificant amount of money. How then are there communities such as this who seem to be falling through the net? I think you have given me the answer.

Mr Smith—The answer is that, to a certain extent, nobody knows what the need is or where the need exists. There has been no rigorous way of actually measuring need. Need has tended to be measured on an anecdotal basis. One of the reasons we want to put this multimeasure in place is so that it becomes quite transparent to the Commonwealth and state where the need is. If you do get a community saying that that is the state of play in that particular area you are in a much better position.

Mr EDWARDS—Perhaps I could come back to you on that a later on. We have taken evidence that qualitative information shows that Aboriginal people suffer mental health problems such as depression at a very high rate compared with non-indigenous Australians. You say that one of your major areas of work is through the Supported Accommodation Assistance Program, and that, after housing issues, the most important services identified to help address the problems of indigenous homelessness are the availability of and access to mental health services and disability services. Specifically, what work are you doing in terms of outreach to provide people with access to mental health services and disability services? Who are the major providers of these services?

Ms Rushton—I cannot give you a full answer right now, but I can tell you that the current SAAP program has as one of its improvement strategies a case management approach. If you are carrying out a case management approach, you are more likely to help individual clients link up with the kinds of other services they need, apart from emergency accommodation. Barry may be able to tell you more specifically about indigenous people, and we can get some more information for you.

Mr Smith—I will need to come back to you on the mental health outreach activity. In the disability area, the department has been trialling more intensive community based disability program initiatives. It has been carrying those out in urban environments because it recognises that it is difficult for indigenous people oftentimes to access disability programs because of the processes of going through CMOs, and location is often a difficulty. The department is keen to look at extending that service out into rural and remote areas so that, instead of looking at clients coming into facilities or arrangements, you can look at teams going out to those people. But I will take those two things on notice and provide further information.

Mr EDWARDS—I would appreciate that. In relation to the special services—the MACS that Barry referred to—would it be possible to get a copy of the 37 locations? What sort of funding is available at those locations for such things as vacation care and other child-care services? The other thing is: on your policy unit, do you have any direct contact with police forces around Australia? Given that seven or eight times out of 10 the contact that a young Aboriginal is most likely to have is with a copper, do you work with police services around Australia? Do you have any policy input from them?

Mr Smith—The short answer is no. We see ATSIC as being the pre-eminent department that looks after the Aboriginal deaths in custody side of indigenous servicing, and it also has responsibility for legal services from a program perspective. We have some indirect involvement—more on the youth side. We are looking at the appropriateness of youth payments and youth programs, and that has been more the department reaching out to a number of the states and territories and talking to them about the appropriateness—

Mr EDWARDS—What I am trying to get to is: where these special services are being funded in Western Australia and, I suspect, in other parts of Australia, if police officers come across—perhaps in the early hours of the morning—a group of young Aboriginal kids sniffing glue, for instance, they will not take them into protective custody. They have not committed a crime, so they just leave them. It seems to me that, through these MACS, there is the potential for us to get in front of the problem. But to do that you have to have some knowledge of the rate of contact between Aboriginal kids and police and some record of that data. You talk about Aboriginal deaths in custody. It seems to me that, because there is such neglect at an early age, there are more Aboriginal deaths in custody. I just want to try to address the issue of getting in front of the problem.

Ms Rushton—May I make a comment which might be helpful, from my experience in other lives. I think that kind of contact is very useful at a different level from the Commonwealth indigenous policy. I do not doubt that it would all be interesting and useful, but at the local delivery level you often find that the community workers have a strong network with the police to work out operational issues of how they are going to deliver things and how people will be referred. We could make some attempt to find out to what extent that is going on with MACS, but that is where I think there would be more strong connections.

Mr EDWARDS—There is one other thing I wanted to explore. You seem to hold ATSIC up as the group that you should and do deal with most. Do you deal directly with organisations like the National Aboriginal Community Controlled Health Organisation? We took evidence from them this morning and felt a great degree of frustration on their part. They are out there as service providers, yet they seem to have a great deal of trouble accessing the various levels of bureaucracy to get to the funds they need to put in place operational programs. I am sure we all felt a very strong sense of frustration from those people, particularly given the immense problems they have in areas like Redfern. Do you do any direct work with organisations like that? And do you go into community areas like Redfern?

Mr Smith—We work with the organisations which are most relevant to the program and in the policy areas that the department covers. Therefore, we do not have direct contact with an organisation like NACCHO because the Office for Aboriginal and Torres Strait Islander Health Services is the organisation that, on behalf of the Commonwealth, liaises with them. We tend to have more contact with organisations like SNAICC, which is involved in child-care related services, housing organisations and organisations associated with health services.

When you are talking about working with the police or talking about liaising, one thing that we do have in our favour, from a FACS point of view, is that we fund Centrelink to have a network of Aboriginal liaison officers at the local level. They are very much our eyes and ears with regard to disseminating information and collecting information and also facilitating activities at the local level. We also fund a network of workers called Support Networks for Aboriginal Parents who, again, are out there to play a community development role in terms of facilitating the development of services and a linkage between services. There are about 140 Aboriginal liaison officers and 30 of the SNAP officers.

As part of our purchaser provider agreement with Centrelink, we have regular meetings with those people from those networks to look at issues both from a research and a service delivery perspective and a policy perspective. We also have an agreement with them to work very closely with a number of their area offices such as Area North Australia, Area North Queensland and Area Central Pacific. So we might not necessarily go out there and have that hands-on, but we do have people out there who are our network and who provide us with that contact and that feedback.

Mr EDWARDS—How can you, as the Director of the Indigenous Policy Unit within the department, be assured that the policies that you are putting in place and the money that is being expended as part of those policies is reaching the people who are most in need? How do you measure that? Do you accept the information that filters up to you through the various levels of bureaucracy?

Mr Smith—I do not think I have a total picture and that is why, again, in our submission we reflect the fact that we are putting a range of other strategies in place to either measure things independently of the states and territories or put other consultative processes in place so that we can go more directly to the people that we are providing the services to. In the strategy that we use for seeing whether our services are out there in place and working, we use a certain amount of third party information. That is provided by the states and territories or by Centrelink or by the other organisations and services that we fund.

We use some data which is collected independently, which is primarily the data provided by ABS. We use that as a validation exercise—cross-checking. We get quite a lot of work done for us by the Australian Institute of Health and Welfare as an independent third party. We fund the Centre for Aboriginal Economic Policy Research from ANU to carry out a range of research and investigations on our behalf.

The next line back is the liaison officers, the Centrelink funded services. The last activity that we are involved in is our own fieldwork from a research perspective. The unit over the last 18 months—it has only been running for 18 months—has investigated areas such as the CDEP projects in conjunction with ATSIC and also Centrelink. We have carried out investigations in terms of payments to indigenous families and their children. Investigations are under way in terms of payments to older indigenous people and why they do not actually make it to older age.

The last line is our own personal contact. One of the things that I have encouraged our staff to do over the last 18 months is to get out of the office and be involved in field visits, and in workshops with indigenous people on specific projects. I think that is a little different for our organisation to do that. So, when you look at what we do to try to measure and try to know whether things are working, it is a fairly comprehensive range. It is not one instrument. I prefer to use that range because I think we are getting information from a range of sources rather than from one. If you only use one method and it goes wrong, you have had it, so to speak.

Mr EDWARDS—Have you ever visited Redfern?

Mr Smith—Yes, I have.

Mr EDWARDS—Have you had direct contact with the NACCHO people?

Mr Smith—Again, like Trish in previous lives and previous activities, I have had quite a lot of contact with the health services. I did quite a lot of work in North Australia where I was involved with the North Australia Development Unit, which was a service delivery research unit and program development unit.

CHAIR—I think we can say that that is a full, comprehensive and broad ranging answer to Mr Edwards's question on a very pertinent point. Ms Hall has a couple of quick questions.

Ms HALL—I was asking about the Commonwealth Rehabilitation Service. You touched on the second part of what I wanted to ask about when you were talking about Centrelink. Does the Commonwealth Rehabilitation Service still have their Aboriginal liaison offices in place?

Ms Rushton—I am sorry, I do not know that, but I will find out for you.

Ms HALL—The other two questions I have relate to access to child care, youth programs and OOSHS. What is the department doing to increase access, given that only one per cent of Aboriginal children access child-care centres, and similarly with OOSHS, and the lack of youth services that are available. What is the department doing to increase that?

Ms Rushton—I will have to get the answers to that for you.

Ms HALL—That is fine; get the answers. I have a GST question. Given that the funds raised from the GST will be handed directly to the states, what implication will that have for tied funding to various projects and for the delivery of lots of services of your department?

Ms Rushton—I think we had better get a full answer on that one for you.

Ms HALL—Thank you.

Ms Rushton—I could give you an answer, but I think it would be much better to get the answer.

Ms HALL—I know it is of great concern to local governments. I felt that it would probably be of some concern to your department and the types of programs that you are running.

Ms Rushton—I am sorry; we are not prepared for that.

CHAIR—I need to thank the Department of Family and Community Services for their evidence; it is much appreciated. It is proposed to incorporate the supplementary submission from the said department in the transcript of evidence of today's proceedings. There being no objection, it is so ordered.

The submission read as follows—

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

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

Committee adjourned at 4.09 p.m.