COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

FRIDAY, 25 JUNE 1999

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Friday, 25 June 1999

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

Supplementary members: Mr Jenkins and Mr Nugent

Members in attendance: Mr Edwards, Ms Ellis, Mrs Elson, Ms Hall, Mr Jenkins, Dr Nelson, Mr Nugent, Mr Quick, Mr Schultz 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.

PARTICIPANTS

AGIUS, Mr Timothy, Director, Aboriginal Health, New South Wales Health,

BARCLAY, Mr Bill, Chief Executive, Tiwi Health Board

BROWN, Dr Ngaire, Indigenous Health Adviser, Australian Medical Association

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

DEEBLE, Professor John

DELANEY, Mr John, New South Wales Zone Commissioner and ATSIC Health Portfolio Commissioner, Aboriginal and Torres Strait Islander Commission

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

EVANS, Dr Lloyd, Medical Administrator, Royal Flying Doctor Service

GREEN, Ms Krystina, Program Manager—Indigenous Issues, Australian Local Government Association

HOUSTON, Mr Edward Shane, General Manager, Office of Aboriginal Health, Health Department of Western Australia

HUNTER, Mr Arnold 'Puggy', Chairperson, National Aboriginal Community Controlled Health Council

NANGALA, Mr Stanley, Director, Office of Aboriginal and Torres Strait Islander Health Unit, Queensland Health

O'KEEFE, Ms Elissa, Member, Royal College of Nursing Australia

PURUNTATAMERI, Mr Marius, Member, Tiwi Health Board

ROE, Ms Yvette, Acting Chief Executive Officer, National Aboriginal Community Controlled Health Council

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

STRASSER, Dr Sarah, Director, Rural Training, Portfolio of Aboriginal and Torres Strait Island Health Education and Training, Royal Australian College of General Practitioners

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

TORZILLO, Professor Paul

YEEND, Ms Julie, Acting Assistant Secretary, Reconciliation and Equity Branch, Office of Indigenous Policy, Department of the Prime Minister and Cabinet

Committee met at 9.16 a.m.

CHAIR—Welcome. I am Barry Wakelin, Chairman of the House of Representatives Standing Committee on Family and Community Affairs. Thank you very much for attending, particularly those who have travelled so far. Many of you have travelled a significant distance. It is part of the task of this committee, and I am sure that many of you who represent national organisations do a lot of travelling in your various responsibilities.

The issue of indigenous health has been a challenge for successive governments and communities for a very long time. I was looking through the ANAO report this morning, and it reminded me that the Commonwealth has had some linkage since about 1911. It has, indeed, a long history. The challenges are as acute as ever, but I think we can look forward optimistically, because I have no doubt that there is a determination and a will from right across the community to progress this issue. Everybody has been invited here today for their particular skills and the particular contributions they can make, and there are more people who will come in. I am looking forward to it. It will be a reasonably open, free-flowing affair, I hope, so that we can have discussion across the table. We have our keynote speakers and then we will open it up for discussion after that.

The members of parliament are here as part of the committee. We are here to listen. We are here to ask questions in the discussion period. We will not be participating in that sense because that is not our role today. Our role is to draw from you your skills, your professionalism, your knowledge of the sorts of things that we need to do as a parliament to move the issues forward.

A word to those from the states: I understand from the work of Professor John Deeble that about 80 per cent of the finances spent on Aboriginal health are within the state province. Obviously, the states are key players, and we really look to the partnership and within the framework agreements to progress that. I now call the first speaker, Professor Paul Torzillo, who I understand has some linkage with my part of the world, in Nganampa health. Paul, would you assist us by opening the proceedings on the issue of remote health services.

Prof. TORZILLO—Good morning. I work with Nganampa Health Council in the Pitjantjatjara homelands. It takes about an hour and 25 minutes to have an appropriate discussion about the housing for health work, so I cannot do that this morning. I will spend five minutes on it and give you a couple of bottom lines from that work, much of which is now in published and public literature, and then I will spend my second five minutes on health service delivery.

Overhead transparencies were then shown—

Prof. TORZILLO—In the early eighties, we were faced with the issue that most of the experienced people here will know a lot about, which is that everyone had always said that the living environment was one of the main reasons why Aboriginal people were sick. So we decided then to take a detailed look at this: if the living environment was causing illness, how was it doing that, what were the key drivers and what could be done about it?

Starting with the Pitjantjatjara homelands, we conducted a review—the UPK report, which means a strategy for wellbeing. So we defined then what were the things that people needed to do to keep themselves well if they were living in the bush, and they were the same things that anyone around the table would have to do. We prioritised those things in the fashion you see on the slide. We then proceeded to look at the living and housing environment in detail and tried to determine what was the health hardware, which is an expression that Fred Hollows used—what were the things you needed to be able to do those things. If you are a mother living in the Pitjantjatjara homelands or anywhere else, what do you need to have to be able to wash your kid once a day and wash their hands and face frequently? Why couldn't that happen, and what would you need to make it happen?

We did a detailed study of what was happening on the lands; we then went on to make some recommendations about design, implementation, construction and supervision. A couple of key issues that came out of that work were that maintenance was a major driving force in the poor living environment. It was not funded, it was not planned and it was not being done. It was clear to us that maintenance programs, properly funded, properly planned and properly conducted, could maintain health hardware, maintain the things you need to have a healthy lifestyle, and if it was not there, then the provision of housing actually generally provided a health hazard because housing broke down. Water did not get in; waste did not get out.

The second generic issue for people interested in policy is the idea about a critical mass phenomenon; that is, if you are in an environment where things are good enough that you can wash your kid twice a week, and you improved things so you could wash your kid three times a week, you would probably have no impact on the health status of children. What you need to do is to ensure that, in communities, 90 per cent of things are working 90 per cent of the time and can be used. That has been a major problem with the limited way in which housing and infrastructure money has been dished out in the last 30 years.

A few years later, at Pipalyatjara, we went back and looked at a community where we had put in some wet areas to houses with better construction and better design and looked at what that did to functioning. You can see here, if we compare what happened in 1986, when we did the first survey, only half the houses could get cold water, less than half could get hot water and waste could not be removed from more than half of them. When we went back with this better construction, better supervision, you can see that the performance of this health hardware was much improved.

The third generic issue is that, when we started this work, we thought that no government of any persuasion would ever be able to afford the maintenance costs. We were completely wrong about that. We did a 12-month study at Pipalyatjara detailing and costing every single piece of maintenance that was done in the community and on the houses. What we found to our surprise and everyone else's was that, if you looked at the maintenance

which was essential for health—electrical safety, water in, waste out, the ability to cook and prepare food—and if you looked at things which impacted on that health hardware, the costs were in fact very reasonable: around $6,500 for 12 houses for a whole year where there had been no maintenance before. The generic issue that came out of that work was that this sort of maintenance was affordable. It had never been tagged to housing programs in the past and in many places it still is not.

Another big issue that came out of that work was where the problems arose: why did houses break down, why did health hardware not work, why could people not wash, why could you not get rid of waste? Eighty per cent of all the costs of that were due to in-ground problems: initial shoddy construction, no supervision, poor contract work. The flip-side of that is that in a detailed 12-month study we found one episode of minor vandalism to a power box by a youth in one community.

We have now done work in Queensland, New South Wales, and a few exploratory visits to communities in the Territory and WA and the principle that vandalism is not a cause of houses breaking down in remote communities has been borne out. When houses are completely broken down because of poor construction and are vacated, kids may well vandalise them as they do anywhere in the country. It is not blackfellas who are damaging houses; it is initial poor construction. Although it still seems to be a bit difficult for certain people around the country to accept—and, as far as I know, we are the only group who has done a study on this, who has published the work and who has looked at it in a number of other places over the last decade—we can find no evidence that vandalism is a significant issue here.

We did find some health benefit in that study at Pipalyatjara. That is a complex issue, and I could go into it in discussion. You cannot read this slide, and I apologise for that, but this is for people who think that these issues are problems only in remote areas. The green column represents a remote community that is about a two-hour flight from a capital city—a state that Stanley has become a bit familiar with recently. The blue column represents a community that is a rural country town in an eastern coast state, and the red column represents an urban centre in a major city. They are three Aboriginal communities.

On this axis here, nought per cent to 100 per cent is the proportion of houses in those communities that can deliver safe electrical systems within the houses, the ability to shower and wash, to have a functioning toilet, to get rid of waste effectively from the house, and to prepare and cook food. The 50 per cent mark is about here. So you can see that, whether you take a remote area community, a rural town community or, in fact, an urban community in a major capital city, the performance of houses generally is extremely poor. The generic principles that we found in the bush, in fact, have been found when we have looked at other places as well.

As I have said, there are a lot of background work and data to provide which would support these things but I will just put up eight quick policy implications which I guess might be the concern of the members here. The first is that we think that at least a major focus of infrastructure expenditure should be on the provision of functioning health hardware. A lot of the work we have done has also shown that if health hardware works

people use it, and that is what the Pitjantjatjara project showed. The major problem is not an educational one; the problem is that things do not work.

The second policy is that there is now a monitoring, assessment and fix tool which has been developed to assess infrastructure and housing programs. That can be done as a way of assessing the effectiveness of housing expenditure and, in fact, the effectiveness of infrastructure expenditure. There is a link in the chain that starts at the community bore, goes to the windmill, to the pipe, to the tank provision system, to the piping to streets, connects those to houses, gets into the house and goes to the tap over the tub that needs to have a plug in it with hot water working if you are going to be able to wash your kid every day. If anything in that chain breaks down, then you will not get effective health hardware at the end point. You can measure things at the end point to see whether that hardware is working and that will give you an idea of how effective housing money is, or broader infrastructure money such as water and common effluent system projects are.

The huge problem in the bush is that people do not do what they do in the cities. You cannot rely on contractors. You cannot rely on subcontractors. You have to have an extremely careful tender process, contract supervision and inspection. They are all key issues. If they are not built into budgets, then you do not get effective health hardware.

I have already talked about the necessity to tie ongoing maintenance funding to capital expenditure. Maintenance has got to be funded and planned.

The next thing to say is that, although a lot of people look for employment opportunities in housing construction, one of the difficulties there is that it is hard to get Aboriginal people into those systems because the projects are usually done by contractors from outside—it is not impossible but difficult. Secondly, they are short-lived. If you focus on ongoing maintenance and health hardware work in communities on a long-term basis, then that provides the potential for long-term, meaningful employment in communities and is an area that should be looked at with more intensity.

There is a need for simple product technology development. What are the best washing machines to use in the bush? What are the best hot water systems to use in the bush? There is a big issue about energy. Power and water costs are killing Aboriginal communities at the moment and they are going to continue to do that unless we look at energy conservation issues. The last issue that I think is important to the parliamentarians here is the whole question of user-pays philosophies and remote communities. Whether you have an ideological belief that people should pay for public utilities, the facts are that these communities are poor and when demands are placed on them to pay for water and power, power and water are turned off and there is no health benefit from those public utility provisions. In fact, you start to get a health disadvantage.

I will just spend five minutes on health service delivery. I think that in rural and remote areas there are five key things that need to be worked on to improve health. The first is, obviously, to change socioeconomic indicators. Most of the older players here have spent most of their time in the bottom part of this graph, but all of us recognise that entrenched poverty and educational disadvantage are huge factors which will prevent Aboriginal health reaching the level of the rest of Australian health. Unless that can be fixed, we will always

be behind the play. I think that, particularly at the moment, the poverty issue is important and bears on those questions about power and water costs and user-pays philosophies that are emerging from many governments at the present time.

I will come back to No. 2 and finish on that. The second thing is that there is still a huge problem in the work force area. The work force issues which affect health workers, managers, nurses and doctors, are different but there are work force issues of major importance for all those groups of people. We do not have enough people and we are not well enough trained. There have been a lot of attempts to improve the rural and remote work force generally in the last decade but we have not got enough spin-off from that yet and there still needs to be a lot of work in that area.

The third issue is that there are some key programs which are of such importance that they require separate support, things such as substance abuse, nutrition programs and other major areas. They need to be supported. They are most effectively delivered when they come from comprehensive health care services that are running in communities.

The fourth area is sustainable improvement in the living environment, and I have mentioned that. The fifth area, which is the area that I have spent most of my time working in, is the provision of a comprehensive primary health care delivery system to all remote communities. In this country there is no reason we cannot provide a competent primary health care delivery system to all rural and remote communities. We should be able to do this. The knowledge base is there and the resources are there in a country like Australia. What does that mean? It does not mean anything too clever. The components of a comprehensive health care service are listed on those slides. They are things that appear in chapter 1 of most basic text books about primary health care: an accessible, acceptable, 24-hour clinical service; the use of standard treatment guidelines; programs for children; immunisation; organised ante-natal care; STD control; some screening activity; some health education; some special programs and other things that are listed on that slide. It is within the reach of this country to provide such a service to all rural and remote communities and we ought to be trying to do it now.

One reason we should do this is that it can make a difference and it can make a difference now without all those other major social changes that we all think are necessary. I will use health council examples because I work there and I know it, but there are people around the table who could give other examples of places where things have changed.

We tried to implement such a comprehensive health care system in the 1980s and, as part of that process, we prioritised some target activities that are listed here. These were things we started doing in the second half of the 1980s and we have had some major improvements. We have got a comprehensive age and sex population register that we can utilise for program implementation. We monitor growth in 95 per cent of all our kids under three on a monthly basis. We have got close to 100 per cent immunisation coverage in all communities. We have made some big improvements in ante-natal care and STD.

Just to look at STD outcomes, when Nganampa Health Council started in 1984, 20 per cent of people screened on any day of the week had active syphilis. Now it is 1.7 per cent. In the last three years with a targeted program, we have halved the rate of gonorrhoea and

reduced chlamydia by 30 per cent. These figures have both come down further in the last year.

We have reduced the number of kids, particularly, but also the number of the whole population needing to be referred to Alice Springs by about three-quarters over that period. Many more people are treated in communities, and the social and economic cost of evacuations does not occur.

When we started, about 20 per cent of people had reasonable ante-natal care. This is a good example of persistent hard work. In 1993 you can see that about 60 per cent of people were achieving the sorts of targets we thought they should reach. In 1996-97, we are getting about 85 per cent compliance with targets we had pre-determined.

There are two last things I might say. Firstly, there is a bit of a tendency when you talk about environmental health for people to run away and say, 'We should not be doing anything about primary health care; we should just be improving the living environment.' Environmental health will deliver some benefits, particularly in child health, but that is one area of improvement. Nobody in the world expects to have to choose between having a good environment and no primary health care services, or having primary health care services and no improvement in their living environment. It is not just unreasonable, it is stupid to expect that Aboriginal people should have to choose between those two things. It is in our power to deliver both and that is what we should be doing.

Secondly, a basic comprehensive health care system can deliver some selective health improvements now. We are not going to improve every index of Aboriginal health, but we can improve some now in a reasonable time frame and we should be doing that.

Thirdly, one of the ways that progress has been made in Aboriginal health, as Shane Houston said to me this morning, is 'dogged persistence over a long period of time'. A number of these issues have been on the agenda of organisations such as NACCHO and they are on some government agendas, such as OATSIHS. It is important that new committees not just bring some ideas, but also do not try to replace completely the agendas where people have been already starting to do some quiet, persistent good work. What we should be doing is strengthening and supporting the work that has gone on, rather than trying to bring in totally new agendas.

CHAIR—Thank you, Paul. That is much appreciated. We move directly to you, Puggy, I think, for a general overview of community controlled services. I do not think that we are going to be specific to urban areas either, as I think we have broadened that out a little bit, if I have got it right.

Mr HUNTER—No, it is going to be urban areas.

CHAIR—Okay.

Mr HUNTER—First of all, thank you very much for asking me to talk on this. I do not mind talking, but I would not have minded knowing about it first—my deputy chair was supposed to turn up but he has the flu so I am left to talk about where it all started in

Redfern and the medical services in general. The point I would like to start off with is the position that a lot of my members have put to me: we hope that something will come out of this House of Representatives report in some sort of meaningful way and there will be some sort of commitment from the government to actually make the changes that are going to be recommended, instead of leaving them somewhere in the cupboard.

The point about the medical services is that the build-up of self-determination, self-management and empowering of the community started way back in 1971 with the starting up of the Redfern medical service in Sydney. From that stage on to today, Redfern is probably one of the less resourced places you have seen. It is a bit embarrassing sometimes when you think that it started from there and when you go back it is still just about the same as when they started in 1971. They are still in the old church, the old building, and still getting the roof fixed—well, they have just got that fixed.

The progression of the medical services from that time, moving into a whole range of areas, came from an understanding that people were not satisfied with the mainstream services. The position that we have been put into is: you have got to go out and do it yourself because no-one else is going to do it for you. From those early stages of trying to build up the services around the country there are now over 100 services nationally. Within that 100, the reality is not denied that some of these services are just broken down old places that are not resourced properly and are battling to survive out there in this sort of climate. But the reality also is that they will not go away, and there is the element of working for the community. There have been a whole lot of things said about it, a whole lot of negative stuff and a lot of positive stuff. One of the sad parts about it is that we do not hear a lot of the positive stuff a lot of the time, more so because they are too busy trying to get on with the real business.

I can probably talk about the racism that goes on outside in the real world and the problem that we still have with the mainstream, with the hospital system that still does not operate properly for our mob and the services in most of the areas. I have travelled around with the House of Representatives committee and seen policies that somehow bump against one another and do not make sense, out where I live anyway.

The thing that springs to mind under this community control is exactly what it means, that it is community control. There is an element of us still learning about the issues of taking on the responsibility of running our own health services out there. With all the reports that have been done, we do not have to go over all the stats every time we talk about Aboriginal health. We do not have to talk about all the reports that constantly get written and the disappointment that the services have with the outcomes sometimes.

With all those things in mind, there has been an improvement in the sense that we have moved forward from sitting down in the position of having no say to the position of being able to even sit at this table and talk about this stuff now. Over those times, there have been different governments, different state governments and all those different state governments' policies impacting on a concept of trying to fix the whole problem up nationally, because we see ourselves as Aboriginals, as one. We are constantly getting pulled into pieces as full-bloods, half-breeds and real fair fellows. Those are the sorts of things that constantly bump up against us, with people not understanding that, as Aboriginals, we are one mob.

Travelling with the House of Representatives has given me an opportunity of seeing some of the other places that I have not seen and of not just talking to people over the phone but seeing some of the conditions that my mob are living in and the sad case of pure neglect. With all due respect to the good intentions, there are some questions out there already. On the community control side of things, there are some other cases that my mob have asked me to ask about at this meeting here today, things like: are we ever going to actually implement some of these programs and reports that have been written up before; are we ever going to dust some of those policies off that actually make sense and that we agreed on way back in the years before? There are things like the national health strategy that is still sitting out there, all the deaths in custody stuff, the stolen generation processes—all the reports that are constantly coming out. Then there are always reports coming from the Institute of Health and Welfare and the Bureau of Statistics telling us the sad story.

The point is that we keep hearing the sad story and we, as Aboriginal people, want to hear a different story. But to get to that position we need the partnership that we went out with the states and the territories and signed off on—the bilaterals. We are hoping that that will make a shift in responsibility or some sort of understanding that there is a responsibility, that the Commonwealth does fund the states and territories to provide services to Aboriginal people out there and that one day they might abide by the rules.

It has been a frustrating thing to just talk about the services in general without actually asking the question: what are you going to do about the rest of the reports that have gone through and that have been sitting in parliament for a long time? Like I said, it has not been just one government; there has been a range of different governments sitting on Aboriginal health. We are still out there. The services have survived and you really have to take your hat off to the Aboriginal people for convincing some of the governments and the Commonwealth that there is an opportunity of having a partnership to actually do things for ourselves, and that there is a recognition of people with a culture that is different.

We have seen lately that, as NACCHO, we have had positions where we have joined in with reports. The Keyes Young report speaks quite openly about barriers that face Aboriginal people gaining access not only to programs but also to mainstream. It talks about the barriers that impact not only on people out in the remote areas but also the people in the cities and towns. It does not paint a different picture of Aboriginal people living in the cities; it paints the same picture right through—and that makes you wonder. You would think that someone around here would have got it right somewhere around the country.

I just caught the last of Paul's report. I have seen the reports and I suppose we are talking again about what needs to be done and what is not going to happen. I do not know. There has been movement. We have seen some changes in the state governments being aware that if there is some sort of partnership there will be an opportunity of working together; and the Commonwealth has made it clear on the working together process that if you want to work together and there is a partnership there will be an opportunity of actually receiving funding. That has been made clear to the community. It is how we actually get the partnership to work with the states that seems to be the issue. Sometimes it takes a while for the states to understand that we need to have a partnership to take this further because Aboriginal people cannot solve the Aboriginal health problem by ourselves. We know that

for a fact. We can see from the results that the non-Aboriginal people cannot solve the problem by themselves either or we would not be in the position we are in

The other thing that my mob asked me to talk about was the issue that keeps being talked about of the millions of dollars in the black hole. Those sorts of comments constantly come back to us. It restricts any movement further because every time they talk about this so-called money in the black hole we do not want to throw more there. My mob want to make clear that most of this money is not spent by Aboriginal people. It is spent by non-Aboriginal people making decisions for us. One thing the non-Aboriginal person has to realise is that they have made these problems come about by not talking to us and not having a partnership. When we get that clear, we may be able to solve that in a partnership manner.

The word that is always being used is to tell us to get 'runs'. We are a bit confused about why you have to be trying to get runs all the time when the stats that the government produces themselves should empower the government to go and do something about it without having to understand that there has to be some sort of pay-off, in a sense. I take up exactly what Paul said. I was in another place where we had done another review and where people were asking our mob, 'Do you want a house or do you want a medical service?' or 'Do you want roads or a medical service.' We always have to have a choice between these things which are taken for granted in the process of looking after everybody else in equity in the so-called social world that we live in.

The issues that I bring up and the questions I have to ask are because I can talk about things that we do up in my own area, in the Kimberley. All around the country there are services that are doing things out there within Aboriginal health that are unique to the area. Always trying to achieve this on a budget that does not go very far is very frustrating. We read all the stats, too. We see that nothing seems to be shifting, with the Bureau of Statistics indicators showing that there has only been a slight movement. What is the problem? Why are we having these same issues come up? I am not saying anything new—I am clear on that. There have been people way before me that have been asking the same questions.

But there have been things that have happened with our movement over from ATSIC. That has been coming back through OATSIHS. There has been an increase in the funding of Aboriginal medical services from coming across from ATSIC. Now we actually have a minister for Aboriginal health in Australia where we never had one before. We understand that there is supposed to be some sort of review of all this changeover. We have struggled to understand sometimes the policies of the government and how things should be made and put into place. We understand that the whole idea of coming across into the Commonwealth was to gain access to mainstream services. We have seen bits of that happening. We have been trying to gain access to other parts of the health department. One of the things that we were critical of ATSIC for, and more so of the government than ATSIC, was that ATSIC was not given enough money to address the Aboriginal health problem. We have seen the changes with even the staffing of the department compared to the ATSIC budget system. When we used to deal with ATSIC we only had about four or five people in there. Now there is a recognition that there is an area that needs to be covered, so there is more staff we are dealing with.

There are more issues coming to the table from NACCHO that have to be understood and dealt with. These things are coming thick and fast because this whole new world of health is opening up, but the point is that we are suffering in a sense because we do not have the resources to be able to access a lot of these services. A lot of our services out there do not even have the infrastructure to access the projects that have been on offer from the Commonwealth. So the infrastructure in some of our places is appalling in the sense that we have these little rooms and buildings that are falling down in some places. We often have one person just struggling along—we cannot get doctors and staff out into our areas. We do not have the infrastructure to even attract the doctors and the staff out to some of these places. We recognise that, if you want to get good staff, you have to actually look after them and, if you want those staff to stay in those areas, the place itself has to be at least worth working in.

Our other problem with local governments is that they are not kept to looking after the services for the Aboriginal people that they are supposed to be getting funding for within their area. Those shires or whatever they call them out in the regions do get special sorts of weighting for Aboriginal people within their area. They do not seem to provide very much in services for us out in those areas.

State governments also receive money through grants. Our state bodies are always asking for some sort of accountability, and we are always asking the Commonwealth to have a look at the agreements that the states and the Commonwealth have binding on Aboriginal health. The point that we have always been told is that those things cannot change because they are historical agreements. From our point of view, because we cannot change these things the victims go on being the victims.

We asked about public by-laws and public health laws that do not actually apply to the state government that makes the laws. They are not holding to their own by-laws, so they get away with not doing things—which normal people would be forced to act upon—under these so-called by-laws that are there. So the public health laws that do not work also do not enforce the states to provide appropriate services to our people.

There needs to be a whole change of processes to address the Aboriginal health area. When we talk about the Aboriginal health problem, I think we sometimes get caught up in the sense that it is a big problem. There are over 300,000-odd Aboriginal people in Australia. If Australia is the lucky country but cannot fix that, in a sense if you look at it from a broad point, it is a small problem. With the resources this country has, with the ‘slapping on the back’ of the things that are going to happen and the way we are heading with the future, I think the Aboriginal people should be part of this future. We should be able to have a say in gaining processes to fix things up so that we can then actually have the same life expectancy as non-Aboriginal people. So what we are talking about is just the basic rights.

The point that I always bring to the table is that we are only talking about our rights as individuals—those sorts of things. We have not actually asked for the needs of the people. We are not even actually seeking our civil rights that are given to everybody in Australia. Under our proposals, we have talked about a situation of gaining the responsibility or the opportunity to change the structure of the funding to the states and to the community.

We have seen changes. There have been some changes that have had a major impact. I think there has been the building of new medical services—Wu Chopperon up in Queensland and the Perth AMS in Kalgoorlie. These services were built from the 1995 joint planning money, but the thing is that they have been the last since 1995. There have been a whole lot of the services from those submissions back in 1995. There were $88 million worth of submissions back then. Those submissions are still there and there are more today because of the population.

The thing the government needs to realise is that the reality is the more we check through and pick up the services—and the services are getting more in a position of reporting—the more you will find. What we are finding still has not increased our happiness in the sense that there have been a whole lot of things that have been swept under the carpet.

There is still a whole lot about reconciliation. We from the medical service are a bit confused about the word actually when all these other things have not been sorted out and the rights of the Aboriginal people have not been addressed. We are heading into the year 2000, which we keep talking about, with the Olympic Games and celebrating the nation, the birth of the country, and all these goods things that I think the Aboriginal people want to be part of. With all this baggage that we are taking into the next year there is nothing to be proud of. I am hoping that this report will have a major impact on decisions that are made with the changes of governments—and disregarding the next government or this same government—but I hope there are going to be some good outcomes. With all due respect to the members that I have been travelling with, that is all I hear they want to do. I hear that very clearly. I hope that that is what is going to come out of it.

For my mob, it has been another House of Representatives report. I am sure the House of Representatives members were made well aware what people felt about another report. Taking the positive side of this, I think that the House of Representatives has a responsibility to find out what is going to happen to all these other reports that were put on the table, washed against the rocks and smashed up. So they need to be brought back in and all these other reports need to be made some sense of because we are just dying at a rate out there that is not allowable in any other country that I know of that is not a Third World country. It is not a very good picture, but I have been asked to put these on the table.

CHAIR—Thanks for that, Puggy. It was comprehensive and at very short notice. All the best to Naomi getting over that cold. We will move straight to Bill Barclay, if we could please. Just before we do that, if anyone did have their two-page submission or discussion paper in dot points, could they have it out so Jim can pick it up and get a few copies made. Not everybody did, I know, but if you have got them there, it would be much appreciated. Jim will pick them up and get some copies for everybody after morning tea. Bill and Marius, thanks again for coming so far. And up the Waratahs. Just forgive me for saying that. Bill, over to you.

Mr BARCLAY—Thank you, Mr Chairman. First of all, I would like to introduce Marius, who is the President of the Tiwi Land Council and a member of our board. He is here today representing the chairperson of our board.

Mr Chairman, we were not planning to be here today because a conflict with our monthly board meeting, which was to take place yesterday. But, because of a crisis which arose as a result of an extraordinary announcement that was made to us last week by the Territory Commonwealth Department of Health and Aged Care representative in regard to our future funding, we felt it was imperative to get down here very quickly and speak to the minister and find out whether this apparent decision had political backing or whether it was something that had been cooked up within the Public Service. I am glad to say that it was the latter.

CHAIR—I was not aware of that. We are grateful for your attendance, but you obviously come here in some crisis mode, and it is our gain.

Mr BARCLAY—And it is for that reason that I have not prepared slides and other possible things. I will read, in due course, from my submission. I should say by way of background that what Marius and I are here today to describe is what we and the board consider to be an extraordinarily successful trial to date. This is something that was successful beyond the expectation of the people who dreamt it up in the first place some three or four years ago.

Perhaps a couple of statistics might bring this into the open. Our hospital admissions since 1 April last year to 30 March this year are 20 per cent down on the previous year. Our suicides in the first six months of this year were zero; in the first six months of last year there were seven. Those are just two. I could reel out a dozen other statistics. Almost every index has shown an improvement. These are facts which will be verified in due course by Professor John Deeble, but the second evaluation report on the trial has been extraordinarily positive in almost every aspect of the activities that have been undertaken by the board.

The trial effectively commenced only at the beginning of last year. We took over our first health clinic from Territory Health Services on 1 April. Two further clinics were taken over on 1 April this year. The board employs some 84 people, of whom 70 are Tiwi and some 30 are CDP—just to give that some perspective. They are people who are carrying out an extraordinarily important task for the board. We are covering every aspect of health within the Tiwi community, clinical, mental, aged care, and, most importantly, the Tiwi For Life community health initiative, which has been to date successful but, because of the delays which have taken place in getting it under way, it remains for the final evaluation of that activity to be completed.

For those who are unaware of how this trial was financed, we are financed through the Commonwealth by way of a cash-up of MBS-PBS to the overall Australian average.

Mr NUGENT—What are MBS and PBS?

Mr BARCLAY—Medical benefits and pharmaceutical benefits. This amounts to some $601 per person and represents the discretionary spending available to the board. This is really what is new. The success of the board is down to resources. Nothing more nor less. And, if anyone thinks that Aboriginal health in this country is going to be improved without resources, they have another think coming.

In addition to the cash-up is the transfer from Territory Health Services of an amount equivalent to the recent average cost of operating their health services, and in addition to that, there is a Commonwealth management grant of some $400,000 that is provided. We believe that this is the only real subsidy in our funding arrangements and that, indeed, we could do without it. The discretionary funding, plus the funding from THS, would be sufficient to do virtually everything that we plan to do without recourse to that management grant.

It is for that reason that the board has already indicated to the Commonwealth that it would be perfectly happy to negotiate future funding arrangements with a view to a staged reduction in that management grant over a period of time. What frightened the daylights out of us last week was when it was announced to us that the cash-up would cease from 31 December this year, that it would no longer be available and that we would have to negotiate our future arrangements on the basis of the historically discredited grant system that every other Aboriginal trial or every other Aboriginal health system in this country has been subjected to for so long.

Frankly, the Tiwi Health Board have indicated that they are not prepared to go back to that system. I fully expect that—although this has not been discussed yet—at the next meeting they will discuss that, if the Commonwealth intends to follow that course of action, it may decide to go out of existence. That is not a threat; that is a simple fact of life. The board sees itself as having this discretionary funding as the only important funding it has for those decisions outside the provision of normal health services available to it.

Mr PURUNTATAMERI—The other reason is that we as Tiwis see the success that we have had for this trial. It is unfortunate to hear this news from our perspective, because it takes away the simple things. It takes away the power that we have in controlling our own destiny, our lives and health of our people.

Mr BARCLAY—Thank you, Marius. Fortunately, since yesterday afternoon, Minister Wooldridge was able to assure us that this decision had certainly not been taken at the political level, that this was something within the bureaucracy and that, in fact, the cash-up funding is still on the table for negotiation. We really came to Canberra to say that, if cash-up is off the table, then we are not really in any negotiating mode at all beyond the end of the trial, which is of course the end of this year.

With regard to the level of funding, the board has available to it some $5 million. This has been sufficient to mount some really important initiatives without the need to go back to the Commonwealth and justify this and justify that. These initiatives have been able to get under way in their own right. The board has responded to having this responsibility in a remarkable way. That is the conclusion that virtually everyone who has seen the board in operation has come to.

The board provides most of its own services. It does purchase other services both from THS and from other private providers. Since commencing operation, it has found that it is able to purchase all the drugs it requires—both high cost and normal drugs—from sources other than THS at a saving of some 20 per cent. It is able to purchase pathology, radiology, dentistry and a number of other services of this nature at substantial savings, and I would

have to say a far better service is being provided under these competitive arrangements through the accountability that the board is able to insist on with regard to the provision of those services.

In regard to THS, it has come as a shocking fright to a great number of people within the THS to find that for the first time ever they have to account for their time. They have to submit an invoice outlining exactly when they went to the islands, what they did when they got there and who they saw when they were there. That invoice has to be signed off by a Tiwi clinic manager, something that the THS people find almost unbearable.

The board is billed for by the HIC, the Health Insurance Commission, for Medicare services provided to its 1,800 consenters, 2,300 people on the island. We are now up to, at the latest count, some 1,900 consenters. Processing delays within the bureaucracy, within the HIC, meant that we never knew until the end of last year how much we were to pay. In other words, we had been operating for nine months before HIC was able to get its act together and get its accounts submitted to us for services provided so that we would know what we were up for. Prudent management demanded that we not enter into commitments until we knew what those bills were going to be. We now know what they are. We know what our commitments are going to be for the remainder of this year and we have been able, since that time, to get our programs in place and under way. A number of them, of course, have fallen behind because of that delay in the decision making process, which was never anticipated at the outset. We were told that we would have our first HIC account in April. We got it in November.

All we can say is that it is remarkable that, regardless of this, we have achieved significant gains—I mentioned suicide rates, hospital admissions, beyond anybody's expectation, certainly within the THS's expectation. Our care plans are now widely implemented. It has taken a considerable length of time to get them onto the computer. The whole system, the whole implementation of the care trial, is based on accurate implementation of a coordinated care trial information system that was developed by Northern Territory Health Services. It is now really coming into its own. It is now, probably for the first time, starting to produce the information that can be regarded as useful. But certainly, we have had to put up with huge delays in getting that implemented. That program was a brand new program and, with all brand new programs, it takes a huge length of time to get the bugs out of the system. It is really only in the last two or three months that that system is starting to produce the information that we require, the evaluators in particular require and that John Deeble requires.

The funding base that was provided by this cash-out and by Territory Health Services enabled the board to tackle the problems in the way that they knew best. I would like to go back to the period prior to the trial commencing last year in November 1997 when there was a meeting at Seven Spirits Bay on the Coburg Peninsula, attended by all the members of the board and a number of very senior public servants from both the Territory and the Commonwealth. I also attended that meeting. I was being surveyed at the time to see whether I was an appropriate person to be appointed chief executive. I had come from New Zealand to do this. I was very interested in the funding arrangements that were being proposed for the trial. In fact, I had no intention of moving from New Zealand unless those funding arrangements were, in my view, satisfactory. But I did not need to say anything. The

board made it very clear to those public servants why they thought this trial was set up in the first place and the basis on which they agreed to operate it.

They were not quite the answers that those public servants were expecting because the board members made it very clear that they considered that, without improvements in their living standards, nothing else mattered. It was the basic conditions under which people lived in the Tiwi Islands that had led to the extraordinary statistics in relation to renal disease, rheumatic heart and diabetes—these three killers that had almost destroyed the Tiwi over the last 10 or 20 years.

They made it very clear to those public servants that, unless the funding was provided to enable those community health initiatives to get under way, they could forget about it. They were not interested. So that was the message that was taken away. I must say that I was immensely encouraged to hear this message.

This probably sounds a little disjointed, but I am taking pieces from my paper and speaking extemporaneously, if you like, from it. The health centres that we operate from are obviously critically important in terms of the delivery of health that we are able to provide. Because of the funding arrangements we have had, we have been able to upgrade, provide new equipment and renovate all our facilities and we have been able to install management systems in each of those clinics that involve the Tiwi health workers at the highest levels of responsibility—something that is, I think, probably quite unique. We have Tiwi health workers who manage all of our clinics. In effect, all our non-Tiwi employees come under their management in each of those clinics, that is, doctors, nurses and every other employee. The system has now been in place for three or four months and is working extremely well.

CHAIR—How are you going there? Do you want to summarise? I do not want to cut you off.

Mr BARCLAY—Yes, we have employed new people with attitudes compatible to change in the general nursing, mental health, training and support areas. None of this would have been possible without access to resources that I have described and the ability to employ and to apply sound management skills.

There has been significant cost, but no more than that to which every Australian is entitled. Improvements in Aboriginal health generally will not come cheap. It requires political will, willingness to relinquish control, adequately monitored management and the trust to empower people to make decisions about their own health and disposition of resources.

The cash-up of MBS-PBS is transparent. It is understood and perceived as equitable. Having experienced the system, Tiwi are convinced that they are now getting a fair deal, unlike the days of the traditional discredited bureaucratic grant system.

Probably all we would like to say, to wind up, Mr Chairman, is that the board supports the commencement of other similar trials, Aboriginal coordinated care trials, but only on the basis of fair and equitable funding arrangements as I previously described.

CHAIR—Thank you very much for that. It was very hard hitting and appreciated. Even though you did not intend to be here, we are very grateful. We will now come to John Deeble.

Overhead transparencies were then shown—

Prof. DEEBLE—These are the results of the material you have probably all seen that is in this report that was done last year, expending on health services for Aboriginal and Torres Strait Islander people.

I will not qualify them too much, but I have got to say that this is the first time it has been done and we believe the figures are within plus or minus five per cent of correct. As everybody knows, particularly in the hospital area, there is a lot of doubt about the accuracy of identification and we estimated about a 20 per cent national underidentification. That could be plus or minus quite a bit. We think, overall in testing the likely effects of error in those places when you know there is probable error, we are within a reasonable level of accuracy about the total.

I suppose the most important factor on that first statement is that, when you take all the spending into account, public and private, spending on Aboriginal and Torres Strait Islander people was only eight per cent higher than the average for or by other Australians.

The main reason for that, as everybody would of course realise, is that the amount of spending on the private services by Aboriginal and Torres Strait Islander people is only a fraction of the spending of other Australians. That is on the private hospitals, through private insurance, on private industry. Those kinds of services which are 30 per cent of the spending of the whole system are largely absent from the Aboriginal and Torres Strait Islander people.

If you look at government alone, per person the amount that governments, federal and state, are spending is about 1½ times the average that they are spending for other Australians. That is a lower ratio than has generally been assumed before. People were talking in the order of twos, but it is less than people had thought.

If you take the ultimate sources of funds, the Commonwealth and the states shared approximately equally in that, but then that is not surprising because, for public expenditure, they share approximately equally on almost everything because it goes through the state agreements and Medicare and so on.

As is obvious, if you think about it, of course, most of the Commonwealth contribution is not direct. It is indirect. It goes through its sharing of mainstream services. The only Commonwealth direct payment is the amounts that they pay in subsidies to the Aboriginal medical services—Puggy's mob—and that $90 million which was the health component of the AMS, because there is what, for convention, we have classified as a welfare component, too.

That is only 11 per cent of the total government figure, so it is not a large amount of the total amount of money which governments are spending on Aboriginal health. As the chairman pointed out, nearly 80 per cent of all the services were actually managed by the

states and the territories and the share of the indigenous people in the two major Commonwealth programs, which is Medicare and pharmaceutical benefits, was very small. If you looked at their access or their drawings on Medicare, that was only 27 per cent of the average for the non-indigenous people and the proportion for the prescribed drugs was only 20 per cent.

Again, that is not surprising, because those two big programs—Medicare and pharmaceutical benefits—are frankly designed best for middle-class Australians living in towns and cities, living in the cities because that is where most Australians live, where there are private services available and there is an economic base for the private services, and that is on both drugs and medical care. All of them are less effective, not only for indigenous people but they are less effective in the rural areas anyway. So it is to do with the place of residence and the features of the programs as much as anything else. At the same time, as everyone knows, there have been efforts to try to make them more user friendly to indigenous people. My own opinion is that they can never be made entirely user friendly and stay within the law as it is now written.

In case you cannot read the numbers at the top of this overhead, they just clarify some of the things that I have been saying. You can see that the amounts delivered through the states for indigenous people are 1,700 out of 2,200. So, really, the states and territories do nearly all of it—run it all. Through Medicare and the PBS it is very small, and through other great government programs, other Commonwealth programs which include the AMSs, it is a bit more. But it still does not amount to a large sum. The bottom just shows the same data, visually emphasising that, for the states and local governments, spending per person is quite a lot greater for indigenous people. But for Medicare and PBS it is the other way around—it is quite a lot greater for non-indigenous people.

The other thing is that only a small proportion of the expenditure was actually through services specifically designed for Aboriginal and Torres Strait Islander people. Most of the spending was through the mainstream services—that is, the use of hospitals and community health services run by the states and territories not specifically for indigenous people but basically for people in the same socioeconomic category as the majority of indigenous people, or the same areas. Most community health services in the states and territories now are really limited to disadvantaged people of one kind or another, and that disadvantage will mean that the indigenous people will use them fairly heavily. It does not mean that they were constructed that way. It is the result of the way the systems are made. Most non-indigenous people use the private systems and so access Medicare and pharmaceutical benefits. Many disadvantaged people use the community health services, and the indigenous group is a significant share of those.

Another interesting factor is that across the states and territories there were really very large differences in the amount of expenditure per person. Generally, it was highest where the highest proportion of the population was indigenous people and where the highest proportion of the population was living in rural and remote areas, particularly remote areas.

So, while we have shown a figure of some $800 million and a ratio of expenditure to population of, say, in total, an eight per cent margin in favour of indigenous people, it is at least arguable that the real use of services was no different at all, because some of what we

have attributed to being indigenous is actually being remote. It may well be that the use of services was no greater, because it cost more money to deliver the same services to remote areas. In fact, if you knew the margin of cost by the areas in which people were living, it might even be that their actual use of services was less, not more. But we are in the early days of trying to isolate those factors.

To give that some sort of visual dimension, this overhead shows the indigenous/non-indigenous split per person across the states and territories. Now remember that does not include the Medicare pharmaceutical benefits or the AMS. It covers the 80 per cent which is handled by the states and territories. You will notice that the bars which are filled in for the non-indigenous people are almost identical across the country. It is running at around $500 to $600 per head for non-indigenous people. But for indigenous people there are enormous differences. Western Australia and the Northern Territory, which have the highest proportions of indigenous people in their populations, and also the highest proportions of those people living in remote areas, had the highest expenditures. New South Wales, which has the highest Aboriginal population, was actually one of the lower-spending states. Obviously, the ACT was, but that should really be rolled in with New South Wales because it is indistinguishable.

Mr NUGENT—It is only a local government area.

Prof. DEEBLE—You have to do it because it is a sovereign territory, but it really should not be treated with that amount of seriousness. I am a resident of New South Wales.

Mrs ELSON—It is a good thing that Annette is out of the room at the moment.

Prof. DEEBLE—I hope that is acceptable to *Hansard*. If you roll those two in together, it would make almost no difference to the New South Wales total, but it would certainly suggest that the New South Wales figure for the state with the biggest population is on the low side. The Tasmanian one, I have to say, is almost entirely estimated, because Tasmania was unable almost to provide any information of any value about their spending, and we had to estimate that from indicators that were not as precise as they might have been. But that is a small population of indigenous people anyway. You can see the enormous amount of money that the Territory is spending per person, which I will come to in my conclusions.

I suppose the overall most important finding, apart from giving some values to the numbers for the first time, was that public expenditures on the health of Aboriginal and Torres Strait Islander people appear to have been—these are 1995-96 figures—almost exactly the same as on other Australians in the same income category. The support for it is illustrated on the overhead there. In case you cannot read the numbers, I will try to describe them. If you divide the population into five sections with 20 per cent of the people in each rank order so that the first income quintile is the lowest income people and the fifth is the highest, you go up in income. Then you see that, overall, health expenditure falls as income rises. That is not surprising because a lot of people who are old are also on low incomes. There is also an association between poverty and poor health, which is not understood well anywhere but it seems to hold everywhere. What the causality is we really do not know. Was it because they were sick that they were poor or that, because they were poor, they were sick? The government share is greater, and it works all the way through.

That is for the whole population. It is translated into the graph with the little boxes which show that there is a national average of $1,300 per person in 1994. We do not have any data since then, but we do have Aboriginal health data. You can see government expenditure falling. The big bar is Aboriginal spending in that year. You will see that it is about equal to the lowest 40 per cent of the population as a whole. The conclusion drawn from that is that plenty of other Australians were receiving the same amount of government expenditure on their health as were the indigenous people.

They get it because our system works partly on health but much more on your economic status. That is what entitles you to government services. You do not get government services just because you are sick, except through Medicare. But you get many other government services because you have a combination of sickness and lower incomes. That applies to both Aboriginal people and to the indigenous people. So one would say, 'Yes, they are being treated fairly in relation to their income.' The question is: are they being treated fairly in relation to their health? If their health is a great deal worse, the income part might be looked after by the system, but the health part may not be.

I am not qualified as an economist to make a judgment on that, and it is very hard to make a judgment as to whether there is a direct link between ill health and what should be spent on mainly curative services. There may not be a curative service that would effectively influence their health. There may be other services not in the health arena which would affect their health more. Certainly, it has been a useful finding and the most important.

This study is being done again, starting next year or at a two-year interval, by the Australian Institute of Health and Welfare. The techniques can be refined a bit. Hopefully it will be a bit more accurate.I think OATSIHS has plans to do it on this basis and gradually refine the figures and monitor whether it is changing much. Most health expenditure and health use series are so stable that they do not change over many years. The composition has not changed for 20 years. The total grows, but everything else remains the same. I do not imagine that it will change a lot, unless there were errors in the first one, which should not be too large.

I have not got a list of things because that is not what I am qualified to do. I just suggest things that I think ought to be taken into account in this kind of work which have contributed to other people's knowledge. I think when I talked to you before, I said I would provide the material, but I have not because it could be potentially misleading.

When you analyse the access to the Medicare and pharmaceutical benefits, you can see there is quite a difference between the behaviour and, therefore, the drawings of people who live in metropolitan, rural non-remote and rural remote areas. The rural non-remote drawings were much closer to the Australian average—a little over a half of the drawings—that is, those of indigenous people living in country towns but not in remote areas. The figure was lower in both the metropolitan areas, where I had attributed that to the presence of the Aboriginal medical services, and in the remote areas where there were no private services at all or very few.

There was quite a difference, which raises the question of whether you can say anything very much more about this until you really do start to break it up into groups, and not just

continue to treat the indigenous people as a whole. Maybe those people who live in the metropolitan areas do have different patterns and problems to those in the remote. It looks as though the rural people are much more like, but not identical with, the other Australians. There would have to be serious thought as to whether that was a useful thing to make or whether there were some other distinctions. I doubt whether we will go a lot further in understanding by just looking at the whole lot.

Secondly, and this is not a plug for the Northern Territory although I have been doing some work there, in the Territory, which is probably more dependent than many others on their Commonwealth grants, this relationship is reflected in the calculations that go into that. Obviously, with states providing or managing 80 per cent of the services, and providing out of their own money 50 per cent of the funds, the degree to which the needs of Aboriginal health are calculated in the distribution of Commonwealth tax money is crucial. It is not so crucial for a big state which has other sources of revenue, but it is crucial for the smaller ones. Population-wise, that would also include Western Australia. That distribution does take fair account of it. It is improved in the Commonwealth Grants Commission formula, but I would hope that this work has some influence on that.

CHAIR—Thank you, John. We very much appreciate it.

Proceedings suspended from 10.51 a.m. to 11.11 a.m.

CHAIR—There were statistics there which were quite revealing to most of the committee in terms of establishing the base of funding across the nation because they put to rest a lot of the misinformation and falsehoods that are out there. Of course, other speakers have raised issues as well. Bill Barclay and Helen Evans might like to comment on that as well. To quickly clear the decks of this morning's session, are there any questions?

Mr EDWARDS—I have a quick one. It is about something that John raised before. One of the things that Aboriginal communities have said to us in most places is that ABS figures are wrong and that they understate the Aboriginal population.

Prof. DEEBLE—They did have a 30 per cent growth in the last census. There was an enormous growth in the reported population. How much that rectified that situation I do not know. It must have done something towards it because it is quite impossible for the population to increase by 30 per cent by any means other than better identification.

Mr EDWARDS—I raised the question because it could—

Prof. DEEBLE—It would lower the averages.

Mr EDWARDS—Exactly.

Prof. DEEBLE—In a sense, it is completely impossible to check the amount of underidentification if it is to do with a combination of the community acceptance and the individual's identification.

Mr EDWARDS—But your figures would just be based on pure—

Prof. DEEBLE—They are, but they are ABS figures from the last census.

Mr NUGENT—I would like to pick up on Bill Barclay's presentation. I rang the minister and told him about your offer to hand back $400,000, and he is very grateful. But seriously, as you know, Mr Chairman, I am a simple soul, but there seemed to me to be an area where there was some conflict in what Bill and some of the others around the table were saying, particularly on this cashing-up arrangement and its likely termination. I noticed the head that was shaking in disagreement most violently was Helen Evans's. I wonder if we could ask Helen to clarify that for the committee and give a different perspective.

CHAIR—I understand Edward has been actively checking a couple of things, but Helen might like to make a couple of comments.

Ms EVANS—Yes, I would like to make some comments in clarification and a general comment on the coordinated care trials. I think most people are aware of these trials. There are four Aboriginal coordinated care trials and nine mainstream ones. The theory is that the Commonwealth is cashing out the equivalent of MBS and PBS that would be used by the people in the trial plus some other programs in some of the coordinated care trials. Some of the mental health money and HACC money, et cetera, has also been cashed out, and the states are cashing out theirs. Shane might like to comment.

The idea is that you pool the money and then the service provider can use that money any way they want, rather than having it channelled into the specific areas that it is entitled to. Therefore, they might end up deciding to buy services that are not currently funded by government, but they feel better meet the needs of people.

In the Aboriginal ones, we have had it cashing out for whole populations, unlike the mainstream coordinated care trials. Because there is not a very good picture of usage of MBS-PBS—indeed, in some cases no MBS-PBS usage by Aboriginal people—the amount that has been cashed out for Aboriginal trials is the national average use of MBS, whereas for the mainstream trials they have actually cashed out what that person's average usage is over the year. So there are some differences. That is just a bit of background.

They are trials and the Aboriginal ones are all due to finish at the end of this calendar year. They were to the end of the financial year and they have been extended to the end of the calendar year. I absolutely agree with Bill. The picture that is coming out now is that there are some very positive things happening with Tiwi and the Western Australia coordinated care trials—two in particular—that have some fairly concrete results that are looking very exciting.

The evaluations are not due in until the middle of next year. Because we felt—and cabinet agreed in the last budget—that it would be a great pity to stop the trials at the end of the calendar year when the money finishes, then wait until the evaluation is available in the middle of next year and then make a decision about whether they would continue, that interim money should be made available. That is going to be the case with the Aboriginal trials. The money is going to be made available on the same basis it is currently being made available until the middle of next year when the evaluations are out, and we can go back and see what they show.

So the short answer to a rather long build-up is that I am really unsure how this misunderstanding arose, Bill. Because after the last budget there was a very clear decision that the funding would continue until the middle of next year, instead of finishing at the end of the year when the evaluations became available. That has always been our understanding and that, indeed, is what is going to happen. I know the minister told you yesterday that he is in no position to make a commitment beyond the middle of next year, because he is bound to see what the evaluations show. Then he will have to go back to his cabinet colleagues for a decision.

CHAIR—Bill, would you like to respond?

Mr BARCLAY—Yes, I would certainly like to respond to that. We would not have spent $3,500 coming to attend this meeting had the information that you have just conveyed to us been conveyed in the same manner last week. We attended a meeting of the monitoring group last week and your Northern Territory manager announced to the assembled gathering the important information that cash-out funding would cease on 31 December this year. I am afraid that is all the information we had to go on. We were not told anything else—that was it.

There was nothing open for argument. There was nothing left on the table for negotiation in regard to cash-out funding. Everything else was negotiable, but no cash-out funding. I would suggest that it is a communication difficulty within your department, rather than any misinterpretation on our part in as much as there were seven very senior Territory public servants present at that meeting and our own representatives. We all agreed on the information that we had been provided with.

CHAIR—We will let it rest there for today.

Ms EVANS—I will just make one more comment, Mr Chair. That has obviously been a miscommunication and it is something that we are following up, because it has obviously caused the Tiwi Health Council considerable aggravation. We were not aware that it was an issue until the day before yesterday. It is not my understanding that that is how it happened, but I need to follow it up because it has obviously caused a lot of stress.

CHAIR—Thank you, Helen.

Mr SCHULTZ—Briefly, I endorse the comment that Bill made. That was the first thing that came into my mind. There is obviously a very severe problem with regard to communications and the messages are not being conveyed to the people that are affected by any decision that may or may not be forthcoming.

Ms HALL—Is the department going to reimburse them?

CHAIR—I will not enter into that. We had better move on. We have got some pretty interesting issues we really need to explore. We have got people prominent in their fields all around the table today, and, as I said, it is not for MPs to get too much involved other than ask quick questions. It is really for the people from the states, ATSIC, Commissioner

4Delaney and everybody else to get themselves involved here. Ngaire, we encourage you to be involved in the discussion and bring forward your honest opinions about where we are at.

The first topic, as you can see by your agenda, is indigenous control and ownership and everyone will have the others. Puggy touched on that very much this morning. It has been a key issue with NACCHO. I am not going to unduly lead the meeting. We have just mentioned $3,500. All of you are senior people in your fields. There is a lot of work that you no doubt could be doing somewhere else, but we really need you to participate today in the discussion.

As I said, we have appreciated the time you have given, so we need your opinions. Can someone start off on indigenous control ownership? Keep it short, if you would, because obviously we are limited in our time. Just keep it concise. I might start dobbing people in. Does anyone want to kick away with anything there on that one? Thank you, Elissa.

Ms O'KEEFE—I am representing the Royal College of Nursing. I am also the sexual health nurse for the Monaro region in New South Wales, which means that I have day-to-day contact with an Aboriginal and Torres Strait Islander population, because they constitute 1.6 per cent of our population in our area.

As we all know, societies of any description are political animals, and no more political than any is our Aboriginal population. There are a few factions within it and, as such, the people that are best able to decide what the right thing for their community is actually the community itself. This changes from place to place. Whether it be across the street or across the country, it changes. I think for appropriate services the people of the Aboriginal community in each area should be taking control of what the resources are spent on, where it goes and what priorities are uppermost for their community.

CHAIR—Thank you very much for that. Anything further?

Mr PURUNTATAMERI—I will just carry on from what I have said earlier in regards to our trial. We believe that a large part of our success can be simply attributed to Tiwis feeling better about ourselves now that we are in control of a significant part of our lives. The success of the board is rubbing off as others look to see how the lessons that are being learnt can be applied to themselves. It is very important that self-esteem and wellbeing not be underrated in effecting otherwise unexplained improvements in health outcomes.

CHAIR—Thank you. Dr Sarah Strasser, you travel this country far and wide, from Gippsland in Victoria, as we were talking earlier. You combine the practical hands-on. What are you noticing about indigenous control or ownership?

Dr STRASSER—I would like to introduce myself, where I have come from and my experience, and take it up from there.

CHAIR—Yes, thank you.

Dr STRASSER—I am director of rural training for the Royal Australian College of GPs, and in that I cover the portfolio of Aboriginal health education and training, and it is on a

national basis. My own experience is that I am a rural GP in Gippsland. I have worked for a couple of years in Canada and worked with North American Indians there. That is where my interest really started in indigenous health.

I have also chaired some world rural and remote sessions at the WONCA meeting. I cannot quite remember what WONCA stands for but it is basically the world organisation of primary care physicians. What we found is that really in developing countries the rural and remote issues are very much the same. I could see that there was some mirroring of the situation for Aboriginal health in what was going on overseas.

In preparation for coming here I was able to go through some of our previous meetings. I am afraid I have to point out that the dot points that I have put down are reflections from those meetings and comments; they are not endorsed by the Royal Australian College as they come from me. But I know that they are the general gist and they are the direction we are trying to take.

What was pleasing to find was that there is some rhetoric that has been put into action. I would love to say it has made huge gains; it has not. They are only incremental ones but they are being sustained. I really wanted to cover the direction we have been going in, which is working in partnership with NACCHO, being smart, as Puggy would say, mirroring what has worked well in other areas in education and training for doctors, reducing the barriers to taking up Aboriginal health as a career and creating some initiatives to do so. Also, our real job is ensuring that there is high quality education and training across Australia.

Going to the first, working in partnership with NACCHO has been an interesting experience but we have not always got it right. We have had to learn how to work in partnership. One of the first things we learnt was that we could not assume communication would flow in the direction we thought it did. We have found that we have had to approach all the layers of the organisation to make it work. In fact, our new CEO of the college, Mr Gerry Mac, really gave us some great leadership a few months ago in our first meeting with Puggy, committing the RACGP to discuss with NACCHO any issues related to Aboriginal health before speaking. I hope, Puggy, you got my message that I was coming here.

Our first venture with NACCHO was the curriculum development. Since then we have done some supporting modules. We have found that where this has been implemented best has been where it has been done in partnership with the state-based ACCHOs or local Aboriginal groups. In particular, I would like to comment on the Aboriginal and Torres Strait Islander reference group that has been set up in North Queensland at Townsville and the work with QAIHF. In New South Wales we are gaining ground where they have also seen this and copied it and are developing a reference group orientated specifically to health, education and training.

I should also comment on the dot points. Many of them would reflect well for other health professionals and not just medicos. The other thing that we have been doing in partnership is looking at the AMS positions for training. We have tried to change the approach to funding of registrars in AMSs to make them more attractive so that within the scope of our grant from the government we have been able to provide salary or subsidise salary. This has made it much more attractive to the extent that we have managed to increase

the number of Aboriginal medical service posts that we take up from 19 to 27 this year. That means that about 36 registrars will be going through six-month or 12-month posts.

One of the components of the curriculum has been introducing cross-cultural awareness across the program. At coffee I was glad to be able to catch up with the person who keeps a tally on the figures. She was able to tell me that to date we have 1,260 registrars, 78 staff, 48 GPs and 12 Aboriginal health workers who have gone through cross-cultural awareness programs. Some of those have gone on to facilitator courses.

One of the things that we discovered was that we could not just tell the registrars to go and do this. We actually had to do it ourselves and it was important that our training program staff, whether they were doctors or not, went through a cross-cultural awareness program and then they were better able to tell the registrars why it was relevant and what was important. We have found that, in fact, it works the other way as well. We have had to give an understanding of what the training program does and where the GP registrars are at to the Aboriginal people that we have been working with. That has been a learning experience and it has been very good.

Moving on to being smart, what we have tried to do is mirror what is working well in other areas. One of the things that we found with rural training, though I would like to emphasise that I cover the whole gamut of Aboriginal health training and not just rural and remote, was that the strategies that we have used to gain ground with rural general practice training are applicable to Aboriginal health in all contexts. One of them is really constant presence and promotion to raise the profile and the understanding. We are increasing the number of presentations and supporting people to go to mainstream conferences to present topics related to Aboriginal health at both national and international levels. We are also trying to increase the attendance of our own registrars at indigenous forums. For example, there was the ethics forum at the Caroline Chisholm in Melbourne and also at the NACCHO showcase. It was a fantastic way of demonstrating what is happening elsewhere and our registrars came away from that quite inspired.

One of the things that we are targeting is that we would really like to be able to employ an Aboriginal origin person at national, state and regional levels to act as a liaison and work as an educator within the training program. At the moment, we have one person called Ada Parry up in the Northern Territory, and I am sure that many of you will have met her. She does a fantastic job but, as she keeps reminding us, she is only one person. I feel this is critical, but it has been said a few times. It usually comes back to the issue of money, of course. But we will get there; I am quite confident.

The other thing is, within our own organisation, one of the successes with rural GP training has been having a national forum to have a show and tell similar to the NACCHO showcase, and we would like to do that specifically for Aboriginal health, education and training.

CHAIR—Terrific, thank you.

Dr STRASSER—I have not finished.

CHAIR—I am sorry. Okay.

Dr STRASSER—To reduce the barriers to take up Aboriginal health and creating initiatives, what we actually need to do is develop streamlined career pathways in Aboriginal health and facilitate entry back into mainstream medicine when it is appropriate. Part of that needs to be orientation packages before and debriefing afterwards that gets fed back into the cycle. Certainly, supporting both our registrars and the supervisors in terms of professional, personal, social and financial support is something that we are trying to achieve. We constantly have to monitor it and check that it is where it should be.

The other key thing is supporting new initiatives at a grassroots level. Last year I was given an Aboriginal health discretionary fund which let new initiatives be developed and then, when they were found to be positive, the state training program would pick them up and let them run. That was quite exciting.

I guess to ensure high quality education and training, it needs evaluation. That is something that we need to be doing in the future and we would like to do that with NACCHO. It is at the discussion level; we have not got any further to date. But some other ideas are that we would like to develop what we are calling some gold plate practices, where they demonstrate examples of excellence in Aboriginal education and training.

In relation to the terms of reference, with respect to the barriers to access, one of the things that we have found with rural training is that by having more registrars doing more posts, it just creates more bums on seats and gets more work done. We have to do that to relieve the teachers of some workloads so that they can actually teach. That is another important strategy—that we are trying to increase our number of registrars going out.

In summary, we find that it is only working with NACCHO in a partnership relationship that makes it work. It is smart to use the strategies that are successful elsewhere. We are trying to reduce the barriers and increase the number of registrars. It is slow, but it is good progress.

CHAIR—Thank you very much for that. John, would you like to speak now?

Mr DELANEY—Yes. First of all, I would like to apologise for not replying to you formally. I only found out about this on Tuesday of this week. We are in the process of completing a formal reply for the committee next week.

I will try to be specific on community control. Puggy Hunter mentioned those reports and reviews such as the NAHS, the Royal Commission into Aboriginal Deaths in Custody, the stolen generation, *Ways forward*, and certainly Professor Deeble's reports, as well as many others. All of these champion the cause of community control. But I do not believe that any Aboriginal organisation, whether it be in relation to medical services or whatever, has achieved or realised community control in the true sense of the word. We talk about self-determination and local community control. Let me say from the outset that bureaucracies—with change of government or even change of ministers—change the rules all the time. I am qualified to speak on this. I am a member of three Aboriginal medical services and I have

been on the boards of management of several organisations in the Sydney metropolitan area in which I live.

If we look at the stringencies imposed upon Aboriginal community controlled organisations, we will find that it is more solid than any other accountability process. I reflect on the special audit of ATSIC programs and organisations. I also reflect on the report by the registrar of Aboriginal Councils and Associations which ultimately delivered the concept that Aboriginal community controlled organisations were more accountable. In fact, all of ATSIC's programs have been found to be more accountable. ATSIC had in train remedial processes to take care of those things for which the special auditor was imposed upon us.

While we have these overarching principles that direct us, then self-determination and community control are non-existent, and will be so until such time as funds can be appropriated by the various organisations and given in an unfettered and untied fashion. We hear statements about the capabilities of Aboriginal organisations to do their own outsourcing. Helen mentioned that in respect of coordinated care trials. Certainly, Bill Barclay and Marius have given us a very solid idea of what can happen if we get the funds and resources given to community organisations to enhance the wellbeing, health status, housing, et cetera. It is hard to separate health and not include all of the other things in it. But we need an unfettered allocation of funds. It was surprising to hear about the $854 million, of which $90 million went to Aboriginal community controlled health services. But that is about par for the course.

Wherever we go, the more control we give to Aboriginal people, the more successful they will be. If you look at the bilateral agreements in housing, in New South Wales it is functioning admirably, given that it is only in its infancy. The legislation came down in July last year. So it is in its infancy and we are developing it. Aboriginal community control is the ultimate objective of all of us in New South Wales.

Federal, state and territory funding authorities must get it in their heads that we are about taking care of our people in our own particular fashion. Changing the goalposts for the reporting mechanisms, the statistical information and the data collection processes—I think Puggy and Yvette can talk about that from a medical service point of view—happens with all of our organisations. As soon as we can get untied, unfettered grants to organisations to do the job on the ground, we will get more success and certainly a better lifestyle for Aboriginal people.

CHAIR—Thanks very much, John. Can I see whether anyone from the states might like to come in at this point.

Mr AGIUS—I would like to follow on from Commissioner Delaney's comments. Certainly, the New South Wales government is committed to supporting community control through partnerships that it has with community controlled AMSs. In fact, our previous minister, Andrew Refshauge, was certainly committed to supporting community control and had a formal agreement with the peak body in New South Wales. While Commissioner Delaney travels around the country and boasts about how effective that partnership is—and certainly the concept of that partnership—we are not advocating for one minute that it is

perfect, because we recognise and acknowledge that we need to finetune it so that we can ensure that there is integration of both the system and community control, working together around this sort of forum or around this sort of table to address the problem.

I think for too long the community has attempted to address the problem, and has become frustrated in doing so, on its own. The system has failed miserably over many years to address the problem. I refer to the benefits of the partnership, despite its problems. In fact, we came from a partnership meeting yesterday; we do not always agree, but at least there is dialogue now about how we might jointly address the problem of Aboriginal health in New South Wales.

The concept has been around for a long time and the community has certainly been advocating for a long time that it needs to manage its own affairs with regard to addressing Aboriginal health. There is certainly no opportunity for the system and the institutions to abdicate their responsibility for addressing Aboriginal health. It is a good concept. I think it is great, not only as a bureaucrat, but as an individual and as a member of the community. I think it is wonderful. We are certainly working with the community in New South Wales to strengthen it. Only yesterday, we agreed, given that our partnership was signed two years ago, to now review it in view of that period to try to finetune it and make a commitment to continue to get it right, so that we are actually sitting down and talking across a table about addressing Aboriginal health.

CHAIR—Tim, can you describe the meeting yesterday? It was at senior officer level?

Mr AGIUS—Yes.

CHAIR—Commonwealth-state; and who else do we have?

Mr AGIUS—No. The partnership that we have with the community is between the community and the New South Wales health department. At senior officer level, we have either the Director-General or the Deputy Director-General and me, representing the department. We have a number of our officers from around the state who sit down with the AMSs and with elected executive members of the AHMAC. In fact, I took a count yesterday and there were about 65 people sitting around a huge room.

Despite how big that is, sometimes that can be very unmanageable in Aboriginal affairs. Given that John was there, we were able to get through an agreed agenda, agreed outcomes, agreed positions, which involve the community in the process. It is those agreed positions that get reported through to the minister to advise on what decisions have been made, what policies have been agreed to, what strategies have been agreed to, and also what policies and strategies have not been agreed to. Then there is the forum, which involves Commissioner Delaney and Commissioner Wright, OATSIHS, AHMAC and the department.

CHAIR—Thank you very much. Harry Quick?

Mr QUICK—Following on from that, Tim, with respect to the community partnership model, how do you build into it the needs for, for example, Redfern and Wilcannia within

that model, so that community needs are met within a bureaucratic model, because the needs and the services that are available to those communities are totally different in lots of ways.

Mr AGIUS—There are always those differences. What happens is that the AMSs actually raise whatever issues they have through their peak body, which is AHMAC, and we can address those issues out of session or, if they are significant enough, they are put on an agreed agenda on the day. But if they are specific issues related to the AMS, they can be addressed independently with the respective AMS. The forum itself addresses very broad strategy and policy issues.

Mr QUICK—How do you liaise with New South Wales Housing and Community Services to get this interagency approach, rather than you finding bags of money and developing community partnerships, and then New South Wales Housing and New South Wales Community Services also having to have similar structures?

Mr AGIUS—The New South Wales government has an Aboriginal environmental community development program. It is a $200 million, seven-year program. That forum consists of D-Gs and CEOs from each agency, and that is quite a huge forum. There is that linkage and interaction there. At officer level, it is probably not as good as we would like it to be. In fact, our minister last week indicated that he wanted, having come from housing, urban affairs and planning, to see over the next 12 months better linkages with those other agencies.

Mr QUICK—How does it all work when you have to sit down with the various departments and structures of the Commonwealth?

Mr AGIUS—We certainly have a good relationship with the state office in New South Wales. During this partnership week, which is actually this week for us, we meet on the Friday with the Commonwealth in a forum, where the community, both Commonwealth agencies and the health department sit down to thrash out or go through those issues.

CHAIR—Thank you. Let us go to Shane from Western Australia.

Mr HOUSTON—Thank you, Mr Chairman. I would like to touch on a few things and I will play devil's advocate, I suppose. I totally endorse the views that Tim has raised about partnerships not being an easy thing. Like any relationship, they can go from sublime bliss to an absolute hellhole, depending on the subject and the nature of the day. But that is the nature of life. I think the important thing about the partnership process is that the players remain committed to the task of sitting down and having those fights face to face, or having those agreements face to face and working through the issues.

One of the critical things in respect of community control is that I would agree very much with the views that Marius has put forward that, as people gain greater control over the circumstances of their life, they actually feel better, and that is one of the critical elements of measures of health, I would suggest. But the question we need to also ask, from a more critical perspective, is: does community control equal an independent Aboriginal medical service? I think the answer should be: no.

There are some circumstances around the countryside where the nature of the community—its size, its position, a number of other factors—would simply mean it would never get a fully blown Aboriginal medical service of the likes that we have seen develop, and rightfully develop, in places like Wu Chopperon, Redfern, Perth, the Kimberley, Alice Springs and other places.

We need to ask some of the hard question about whether there are other forms of community control which are legitimate and which can contribute in a very effective way to the improvement of Aboriginal health in any particular location. I think the answer is that there are. We find, for instance, that in the south-west of Western Australia—and I dare say in other parts of the country—small Aboriginal communities, with local GPs with whom they have a reasonable relationship, are maybe amenable to striking different forms of partnership which bring together the interests of Aboriginal communities and the role of GPs in a way that has not yet been trialled in many other locations.

One of the examples that I should speak of is the development of family practices in the south west where divisions of general practice form a relationship with local Aboriginal health services around the delivery of services to an Aboriginal community. There are going to be other forms of partnership or community control which challenge some of the historic models of community control. One Aboriginal medical service in Western Australia, for instance, has now collocated on a hospital campus, which is a significant challenge to some of the community models of community control.

CHAIR—Which one is that?

Mr HOUSTON—It is Bunbury. The questions that need to be teased out at a local level are: do these changes in models diminish in any way the principles of self-determination, the principle of Aboriginal people having the maximum extent possible control over their own lives and the decisions that relate to their own health. It would be useful for the committee to consider, not just the AMS model as a static, stand-alone organisation, but other forms of partnership, other forms of relationships, which nevertheless could embrace a measure of Aboriginal control over the decisions regarding the delivery, development and evaluation of health services.

CHAIR—Thank you very much for that.

Mr NANGALA—I am the director of the Office of Aboriginal and Torres Strait Islander Health in Queensland Health. I concur with and support very strongly what both Tim Agius and Shane Houston have talked about concerning the spirit and collaborative approach of partnerships between the state jurisdiction and the Aboriginal community—in my state, I have to say, the Aboriginal islander community control health services. We, too, have a number of forums that are in line that comprise Commonwealth representatives—ATSIC, the Commonwealth Department of Health and Aged Care, OATSIHS, of course, and QAIHF, which is the Queensland Aboriginal Islander Health Forum, and ourselves, Queensland Health.

In the time that I have been in Queensland what has been rewarding is that we have looked at capacity building and ensuring that there is transparency in maintaining the

deliverables when we are addressing health. Most importantly, we have looked at a collaborative mechanism that involves good planning and, not only good planning, but also the effective evaluation and monitoring of health outcomes, be that by an Aboriginal medical service delivery model or a Queensland state health model.

Very recently we have also included the GP divisions—and Dr Strasser highlighted that importance. In Queensland we are actually working very closely with the GP divisions including the AMAQ, which is AMA Queensland, to target indigenous health. Together with our minister and Director-General of Queensland Health, we are actually looking at some positive outcomes that target service delivery and we are also looking at the design and deliberation of health service models within the state of Queensland.

In the spirit of true partnership, we are also tying up now, with the local GP divisions and the Aboriginal and Islander community controlled health services in the state, a number of memorandums of understanding that have set measures and targets for us to meet and address within the state of Queensland. We are doing that. I cannot overemphasise the ethics that I also have in the role that Aboriginal community controlled health services play in this country. It is really important and it also produces good leadership. You need leadership in indigenous health.

I am also embarking on another structure within the state of Queensland to look at leadership across the indigenous communities, which looks at holistic issues such as community and social development. That is a given issue. We have our leaders, and our most senior indigenous leader in this room is Commissioner John Delaney.

What is really important, apart from the ATSIC level, is that we need leadership structures within all the indigenous Australian communities that can look at taking on that custodial and maintaining role in addressing health and wellbeing right across the whole community sector.

What we are telling a number of indigenous communities in Queensland is that, to fix health, Queensland Health cannot do it alone. The Aboriginal and Islander community controlled health services cannot do it alone. In fact, we have to work together on a community health basis. The participation and involvement of indigenous people, even from the community controlled health sectors, is integral in good planning, in order to better the health and wellbeing of indigenous people.

CHAIR—Thank you very much, Stanley. Can I ask the ALGA whether you want to make a comment about this issue or whether you have a view on indigenous ownership and control? Would you like to make a general statement?

Ms GREEN—We are encouraging many councils to increase the level of community control within the decision making processes in local government. To that end, we have strongly supported that they establish consultative councils or advisory mechanisms, the chairpersons of those either being the mayor of the local government council or reporting directly to the council as part of the act of the local government. That is sometimes not possible, as most local councils in different states are covered under different acts of government. But usually, the mayor sits on those consultative councils and then has some

kind of feedback. The processes are working very well in some areas but are not necessarily working well in other areas.

Whilst we have many local governments that are moving towards community controlled processes as far as decision making is concerned, there are a lot of local councils out there that have a long way to go. It is by no means perfect.

CHAIR—Thank you for that. That was quite valuable. That is our experience as well, having moved around the country.

Ms HALL—I have a question for Krys. With respect to local government—and in my area there is a very good community consultation committee working in Lake Macquarie—what concerns me is the disability grants that go to different councils. It is all very well having a consultative committee, but what about really involving the community, and the fact that part of the formula for funding is that money is actually spent on Aboriginal people and in the local government area? What is the association doing to ensure that that part of the disability formula is put into play?

Ms GREEN—The disability factor for financial assistance grants is very minimal. There is a perception out there that there is a high disability factor incorporated into local government for the number of Aboriginal and Torres Strait Islander people living in the community.

Ms HALL—I know it is only one component.

Ms GREEN—It actually works out to about $1 or $2 per year for each person. There is not much that a local council can do with $1 or $2 per year per Aboriginal person. The whole disability grant factor works out for every Australian citizen at $45 per year per person, and one-third of that is earmarked for roads, so it can only be spent on roads. The disability factors that people talk about are very minimal in a local government council. Most of it is on the revenue base from rates, and there are certainly issues, particularly in New South Wales, regarding rates, and in the Northern Territory and Western Australia, where there are no rate revenue mechanisms in Aboriginal communities. So they are issues that need to be addressed outside.

CHAIR—Thank you very much, Krys. Barry Smith?

Mr SMITH—I am from the Department of Family and Community Services. I want to make a couple of observations about some of the things that people have been raising—some connections, I suppose. One theme that has come through regarding community control is the theme of capacity and leadership. We need to be looking at two sides of the coin when community control is actually being enhanced. We also need to make sure that the necessary resources are there to encourage and build capacity and to build the skills. So I just wanted to put that link on the record.

Picking up from what Professor Deeble was saying earlier, in rural and remote areas, one of the aspects of community control is community control through necessity, not through choice sometimes, because the community is the only available provider. Therefore, in terms

of rural and remote areas, we might need to think about not only that skills transfer—the management—but if they are the only provider out there and if there is this higher cost issue, we need to see that as a double issue that we need to address, not just as a single issue.

The other thing that seems to come through in terms of what Bill was raising earlier is that I was intrigued by the concept that he was happier to accept cashed out payments and had a difficulty with accepting grant payments. The term that he used was that cashed out payments allowed for more discretion and the grant payments did not. I think there is a bit of a challenge there for us about why that should be so. A lot of the discussion here on community control has been about partnerships, flexibility of responses and things like that.

CHAIR—That is much appreciated.

Mr QUICK—We were in Coober Pedy with Barry's and Helen's departments. It was 52 degrees in the shade, if you could find any. The elderly people in the Coober Pedy community wanted access to a bus provided by your department for youth, but under the terms of the grant, that was all that it was able to be used for, so the elderly people had to wander through the bush to access all the various health services they needed. I can understand Bill's point of view where the community should have some choice. The grants system is hopelessly flawed in many regards. The bus was sitting there all day and 20 or 30 elderly people in Coober Pedy were being forced to walk through the bush. That is just one prime example.

Mr TAYLOR—Partly in response to that, to a certain extent that is an issue that comes back to this House and the extent to which the accountability requirements of parliament itself—through Senate estimates processes and whatever—set up the parameters for agencies such as OATSIHS, ATSIC and Health and Aged Care to report in some detail in many cases on exactly where money is going, and often at quite small levels. Often it is not just an issue for bureaucrats and community controlled organisations. It is also an issue for the way in which parliamentary scrutiny sets out the terms of debate. It is an issue for quite a lot of us round the table.

Mr QUICK—I am not apportioning blame.

Mr SMITH—I think that is the issue I was raising. In terms of accountability, flexibility is often associated with high risk, but often can be highly successful. I do not think we have necessarily had a full discussion about the balance between accountability and flexibility amongst all of us at this point in time.

Mr QUICK—It is accentuated when you are not too sure whether the Adelaide branch of the Commonwealth department has the flexibility to say to the community, 'You can do it', or it has to then be referred back to someone in Canberra, then back to Adelaide, and then back to the community. Those processes are also uncertain and convoluted.

CHAIR—Helen, do you want to address that one specifically?

Ms EVANS—I just want to make a brief comment about the flexibility and accountability. There is a trend overall in government funding to look at what outcomes we want and lift some of the stringent requirements about line by line financial accountability and replace them with outcomes and outputs. But then there needs to be an agreement on what it is you are trying to achieve and how you know what it is when you have achieved it. It has been the multiple numbers of appropriations in Commonwealth government funding and the requirement that you can only spend the money for that thing that has been the problem. There is now a move to try and roll up appropriations and have much more flexibility and take less of a focus on that rigid financial line by line accountability and what you are trying to achieve. I think that is a really important way to go. That is what coordinated care trials are about. They are about rolling it all up.

CHAIR—Thank you, Helen.

Ms ELLIS—I just want to trot out one more example of the frustration. I am not sure—and my colleagues will correct me—whether it was Commonwealth or state, but it was about the provision of a beautifully equipped dental chair and dental surgery and no money for a dentist. I agree completely with the comments made by both Peter Taylor and Helen Evans on accountability and the parliamentary process. Surely, between all of us, we are clever enough to work out that that should not happen. We were shown through an AMS with this wonderful dental clinic which most AMSs would kill for. We thought how fantastic this was. We were very thrilled to see it until we were told there was no dentist because they did not have the money. That is my recollection.

Mr HOUSTON—Helen touched on a point I was going to raise, but I would like to reinforce part of the problem. We looked at the way in which Aboriginal health services were financed in the west about 3½ years ago. We found one Aboriginal organisation that had 27 different revenue streams for the one organisation. They had to produce 27 quarterly activity and financial reports and 27 annual reports and 27 annual audited statements. When we asked the management what they did, they said they wrote reports. They never eventually got to manage the service. One of the critical things that has been a success in the west—give it five out of 10—has been the move towards trying to change the way in which services are purchased from organisations away from the historic input based funding which has been typically the Commonwealth and state approach to these sorts of things. I move to the point that Helen has made to the notion of agreed outcomes and single-line prices for a particular outcome.

To be blunt, when we first proposed this there were a number of detractors who suggested that the propriety of Aboriginal organisations was not solid enough to ensure the protection of public funds. In fact, what we have found in taking the approach has been exactly the opposite. Not only has there been no diminution in the accountability of Aboriginal organisations but the move to contract Aboriginal organisations in this fashion has shown that the state system has been about 50 per cent as efficient as the community control sector. So there are significant benefits, in terms of outcomes and structure and functioning of Aboriginal organisations, as well as being able to serve the interests of the parliament in respect of the accountability of public funds by moving towards a stronger outcomes based appropriation, and leaving people who know best how to do the job to get on with the job.

CHAIR—Shane, that is excellent.

Ms HALL—Who contracts the services out? Is it the Aboriginal community or the health department? What degree of control does the community have on that contracting out or brokerage?

Mr HOUSTON—Most of the contracts to date—and we run about 80 a year—have been between the office of Aboriginal health and various community controlled Aboriginal organisations. Somewhere between 80 per cent and 90 per cent of the total expenditure of the office is directed towards the community sector, as opposed to the mainstream. The contracts that we have range from everything from the provision of education services to the purchasing of secondary care services—laser retinoscopy, the lot.

Once we have struck a deal on the outcome services and outputs required, and there is a single price item, the organisation then gets on with delivering those services. The coordinated care trial has been in a different direction, in that it has given organisations an opportunity, by reorganising the way in which health services are financed and doing away with the need for people filling in click clacks every time the doctor goes, to decrease the number of Aboriginal people going to hospital as a result of running the trial. They have a greater degree of autonomy and flexibility than do the current contracts that we have with provider organisations in the west.

Ms HALL—Puggy, what do you think of them?

Mr HUNTER—Are you talking about the coordinated care trials?

Ms HALL—No, the brokerage, the contracting out and how it fits into the community control model.

Mr HUNTER—That is probably what I was going to talk about—what people have to remember. I can understand that people are coming up with different forms of community control and have different ideas of those sort of processes. I just want to remind people of the only reason why NACCHO is alive and why their medical services are alive and kicking today. Exactly as John said, we have better things to do in some of these places, and we are the only services in some of these regions. I agree that the reasons why some of these came to life is because the states and territories were not doing their job. It is that very simple.

You look at me and you think, what is this big bloke doing talking about health; he should be the last person to be talking about health? The issue is that this is the sort of thing that happens out there. If no-one else is going to do it, it is only us, the Aboriginal people, who have to get up and do it. The point is that it does not matter who you are.

The reason the NACCHOs are alive and kicking out there is because the states and territories have failed in their responsibility and the money that has been given over, and the Commonwealth—do not forget them fellas—on providing services to the community. It is very clear. Whatever model the states want to come up with, that is fine. The NACCHOs of the world have negotiated a very clear framework agreement across the country with the

states and territories and with the governments of the day. They signed off on an all of government approach. I have heard John Howard, the Prime Minister, say the same thing.

These are the things that ministers and governments sign off on almost every day for non-Aboriginal people. As Aboriginal people, we do not sign these things every day. We do not go around signing documents to say that we will do something because, when we do say something like that, we actually mean it. When we say that we want to go into partnerships and we say that we want to actually sit around the table and make decisions for ourselves, that is exactly what it means.

If someone wants to bastardise the framework of what it is out there, that is fine. They can go and do that somewhere else with those other mobs they want to do it with. The agreements are made—very clearly from our point of view—with the ministers and governments of the day to work in partnership with the community controlled Aboriginal medical services. We agree that there are going to be times when a town is not going to have the opportunity of actually running a full-blown medical service out there. We would be stupid if we did not think that. The point is that, at the end of the day, that is really up to the community to decide. If that is what the community decides with all of the information about it—on going towards community control, going towards a model that suits the community, going towards staying with the government if they want to—that is the decision that the community should be able to make quite openly.

To think that the government has it right again is fooling yourself. That is where we are today because the so-called governments of the day have got it wrong. They have got it wrong in the sense that it is always the case that we are misinformed. We live out there with that misinformation. We live out there daily where little kingdoms are built in the real world and where people come up and talk to communities like the Tiwi health mob and tell them that their funds are going to be chopped. At the end of all that discussion, we find out that there was a miscommunication. These things should not happen, and people should be held responsible for them.

The point is that you can actually come up with some new ideas about creating some sort of new structure for us. The point is that the ministers and the government of the day have signed off on this agreement. They do not care what anyone else personally thinks about what has to happen. If the department has problems with these things, they should take these problems back to the government and the minister, not come and bring their policies down to the community because they have a problem with the minister up top or belt the boys and girls around the head out in the community. That is constantly happening. We are constantly dealing with misinformation; we are constantly dealing with the state or territory interpretation of what policy says on the ground. The House of Reps has seen these things where policy does not seem to make sense when you ask the question out there. The so-called shires that I talk about do get their extra bit of money, but I must remind the shires again that we get money out there for us as individuals as well.

I still cannot believe some of the issues. You really have to wonder why it is that sometimes the states are in a sense putting up barriers for the community controlled organisations. If the community people can get off their bums and go around to the back door of the Commonwealth money bin and bring some more money into that service, you

would honestly think that the states would drive them around the back there and get the money. But that does not happen where I live; that does not happen around the country.

CHAIR—We will further explore this after lunch.

Mr HUNTER—Those really are the things.

Mr EDWARDS—One of the most important aspects of this whole inquiry for me is to try to understand why it is that the partnerships between Aboriginal people and the states are not working and to ascertain what it is that the Commonwealth should do about it. Moving around the country, it is obvious to me that those partnerships are not working—so many Aboriginal people and communities feel totally disenfranchised.

I want to come to the example of Port Hedland, which I think is one of the worst examples I have seen anywhere. The people who are working there on the ground, delivering health services are, in my view, bloody heroes. They seem to have the view that there is a major breakdown in the partnership from their point of view, with the state funding bodies. It does not seem to me that the state feels the same way. What is the truth of it? Can someone tell me? Are the partnerships working? Should they be thrown out? In a bigger sense, should Commonwealth moneys go direct to AMS's? Should the states be dealt out?

Mr HOUSTON—Given that Andrew has raised the question of Port Hedland, what I would suggest is that the difficulties associated with partnerships between the states and territories tend to be more of a political nature than a pragmatic program based nature. There are 80 examples where the states and individual Aboriginal communities and community controlled health services are getting on with the job. In the location that the member has raised, the Office of Aboriginal Health has an annual contract with the Wirraka Maya health service there for just over $1 million a year. That project was not in place seven years ago, or six years ago, so there are significant gains being made. That is not to say that there are not continuing legacies that arise out of the historic relationship between the community sector and state agencies.

I think what we do need to understand is that, while there will be a political difference—and that is the nature of politics—between the community sector and state governments and, for that matter, the Commonwealth government on some matters, and differences of opinion are healthy, there are, nevertheless, many examples, and in our case up to 80 examples, of where individual community organisations and communities have an arrangement, a partnership, with the state and they are getting on with the job. They are not all perfect, but that is in fact something we should be applauding rather than suggesting is a failure.

Mr EDWARDS—Shane, in a nutshell, you would say that the partnerships are working?

Mr HOUSTON—I would say that nothing is perfect. I would say that, compared to where we were a few years ago, I think we are miles ahead. This can be seen in fact that we have now started to see—for instance, in the west—Aboriginal community controlled health organisations receive the bulk of additional resources being provided by the state—and this is something that we should be applauding. Port Hedland, as I said, is about a million bucks a year. We are in fact the majority funder of about six of the Aboriginal medical services in

the west. The partnerships are working. We will have continuing political differences, and that is life. As I said, in 80 instances in terms of the contracts, they are working. People are getting on with the job and that is fine. The questions about purchasing health services, the contracting of health services, are not inconsistent with the bilateral agreement. In fact, the bilateral agreement positively points us in that direction and asks us to embrace these issues.

One very good example in respect of the west was at Wiluna. When the state department failed abysmally in its services, they withdrew and contracted the local community organisation to provide the services. They are doing a better job than we would have done. I think that is something that we should be applauding. The same thing is in Warburton, for instance, and in other locations across the state. In Jiggalong, for example, the state said, 'We can't do this; we'll get out. We'll contract the community control sector to provide these services'—and they are doing a good job.

Mr DELANEY—I want to speak about one issue and Helen raised it. She asked about AMS's and what they want to achieve. We do not get enough money to fund and to achieve what AMS's in New South Wales have achieved. When you walk around the streets of Sydney, particularly in Western Sydney where I live, older people like myself still enjoy the quality of life that was not possible before AMS's came into the arena. Walking around the same streets, you can see healthy expectant mothers and you can also see healthier newborn babies.

Although the community controlled services are getting funded out of a sort of historical funding process, they still have to do the work. If you asked Naomi or anyone else what they wanted to achieve, they would say, 'You give us enough money'. That $854 million and the $90 million for AMS, that is around 10 per cent of the overall allocation. In Sydney, at least 70 per cent of Aboriginal and Torres Strait Islander people are serviced by Aboriginal Medical Services.

As to asking people what they want to achieve, I could do a very creative financial record of what I want to achieve in the four AMSs in the greater metropolitan area of Sydney. As Dr Torzillo said, we can do it but we need the resources, and certainly Bill Barclay said that. You have got to give us the resources to do it. ATSIC have been saying, since health went over in 1994, I think it was, that to have a healthy community there, we need to have a look at the funds to do that, and we need to look at those rural and remote issues for the costs of that.

The deputy chair mentioned the flash dental service, for instance. The dental service in New South Wales is the responsibility of the state government. I can tell you about the one in Walgett where, to attract dentists, they want $300,000 for a salary package. So we have got the South Coast of New South Wales, Wollongong, Walgett and Wagga Wagga with all these flash dental services. The community can tell you what they want to achieve and, if you give us the dollars to achieve that, we will not come near you for a while.

But the whole process is about financial accountability. When someone jumps up and says someone is ripping off something, it is always the black organisations that get investigated by special auditors or the registrar for Aboriginal corporations. And at the end of the day, we are found to be squeaky clean

So I go back to my original statement: give us a block funding for the delivery of service to our community, based on statistical information. Naomi at the AMS in Redfern has got more people on her books than are supposed to live in the place. Professor Deeble mentioned the Bureau of Statistics. Shane and I sit on that board. They are now admitting that there are serious deficiencies by not including community controlled organisations in the census. One fellow from the bureau said that he had been working in Western Australia since 1984 and he could not find a way to train Aboriginal people to undertake a count of their own communities.

Until we get some hands on management responsibility, until we get some of the real issues concerned with the old 'self determination' that people use all the time, we will not be able to achieve anything. If you want us to do the job, we can tell you what we want to do, but give us the cash out of the $854 million to do it and we will be able to. We will provide the healthiest indigenous lifestyle you have ever seen.

Mr EDWARDS—Block funding to whom, John?

Mr DELANEY—To community controlled organisations.

Mr EDWARDS—Like NACCHO?

Mr DELANEY—NACCHO is a—

Mr EDWARDS—Through NACCHO, through ATSIC—who?

Mr DELANEY—Well, to me. I was the chairman of the Sydney regional council when it happened in 1994, and I said that ATSIC had the capability, through regional offices and regional councils, to be able to appropriate the health system—but give us the same money.

In ATSIC, in the section here, we had one and a half units of staff to take care of Aboriginal health and now we have got $10 million with OATSIHS. For goodness sake—it has escalated—that $10 million is something out of that $854 million that we could have used in appropriating the needs of people and in getting Dr Torzillo's community fixed up with all those little bitty things that, at the end of the day, cost a lot of money.

But we are not given those principles of self-determination, as seen in the Royal Commission into Aboriginal Deaths in Custody, the NAHS strategy, the Stolen Generation report, the *Ways forward* report and the Deeble report. When are we going to get the results of these, to give us a bit of this self-determination thing that people, particularly white people and Prime Ministers and ministers, talk about? Some people say, 'Throwing money at the bloody thing will not fix it up', but you are throwing it in the wrong direction.

In fact, I will give you a little analogy. I sit on the partnership and yesterday we had the corrections health guy, Dr Michael Levy, come in and tell us that, finally, they are going down the track of enlisting community controlled organisations—medical services particularly—to help with the problem of the serious detrimental health conditions in places where people are incarcerated. Despite the royal commission recommendations, they are increasing. The money they have spent on RCADC has gone the wrong way. It has gone to

the bureaucracies, corrective services and the police. They get bigger and better gaols. They have got more coppers and juvenile justice detention centres. They are bursting at the seams.

We never had any of that money that the Prime Minister and the ministers say they have thrown at us. But give it to us; what we want to do is give you a formula. Dr John Daniels and I went to Brewarrina to do a review for OATSIH. We gave them a solution per capita, as required by all Australian citizens in health service delivery. But we have not even got a reply from them yet, and that was three months ago.

CHAIR—I am going to have to cut you off there, because we are going to run out of time.

Mr DELANEY—It is a very passionate issue that we are talking about. As an Aboriginal person here, representing a group of people, I would like to say what I think about these things because I am talking truisms on this issue. Thanks for your time.

CHAIR—I appreciate that, John, and we will continue that through the day.

Ms GREEN—We keep talking about primary health care and the funding of AMSs but AMSs are now in most cases directly funded by the Commonwealth. There are real problems in infrastructure funding and that is one of the responsibilities that was identified in a report that ALGA did for the Local Government Ministers' Conference, *Local Government Services to Aboriginal and Torres Strait Islander Communities: Its capacity to achieve the national commitment to improve outcomes for Aboriginal and Torres Strait Islander peoples*. This report was tabled at LGMC last week and it has already been buried. ALGA's recommendations were considerably watered down without our consent. What we had hoped was to work with ATSIC to progress this report because it is only a statistical report. There are three volumes of it. The report highlights what everyone does not want anyone to know. It says:

. The Aboriginal and Torres Strait Islander Commission is a primary source of funding for Local Government services to Indigenous communities throughout Australia, and should be recognised as such.

. The administrative costs of dealing with the historical backlog of services needs to be acknowledged. ATSIC's role in providing additional resources for this administration, both in discrete and encapsulated communities likewise needs to be acknowledged.

Those services are water, sewerage, roads, housing. They are all those things that people in urban based communities, whether Aboriginal or non-Aboriginal, take for granted and that are not being provided, except through CDEP out in remote communities.

I do not want to diminish your role, Puggy. I think it is a wonderful role with AMSs and NACCHO has done some very good work, but we also need to concentrate on infrastructure, as Paul has said, because without healthy infrastructure, you are just throwing dollars after dollars, dishing out pills and medical services.

CHAIR—Thank you, Krys.

Mr JENKINS—Puggy quite rightly highlighted that the framework agreement requires that the community health sector be involved in the development of the regional plans. This is a bit unfair to Shane, but one of the examples that the committee has had where there appeared to be glaring problems was in the Kimberleys, right across the region. I do not know whether that was because there was a lack of an overall plan or, as Shane has described, because of small 'p' politics or because of a concern about competing for funds. Questions are asked on the ground, for instance: why isn't the diabetic worker under the community controlled outfit? Why is it under the state? Why is it that you can get on the ground problems between community controlled medical services and the way they perceive the hospital up the road?

To get something out of today we will be trying to find out whether there is something structurally wrong that we could change to prevent those things or whether we have to have 'persistent doggedness'—as, I think, Paul said—to continue to try to improve things. At the end of the day, John Deeble's figures, which show such a high percentage of the funds in the hands of the states and territories, mean that we have to place pressure on senior bureaucrats here from the states who—whether it be in Sydney, Brisbane or Perth—know what they are trying to do. Is there is a structural problem by the time we get out into the coalface?

Mr HOUSTON—Nobody would doubt that mainstream health services continue to miss the mark in a great many cases in Aboriginal communities. I think that anyone who suggests otherwise is a bit of a fool. Nevertheless, as I was trying to point out, some significant gains have been made. The regional planning process that is enshrined in the bilateral agreements is a critical process towards striking the right framework through which, and towards which, the various players can commit their resources and energies appropriately.

From my perspective, one of the things that we have often found is that people who manage health services are dominated by the question of hospital based services. The bulk of the $855 million is, let's face it, Aboriginal consumption of hospital based services. The real difficulty that we have is to, in fact, change the historic structure of health systems so that we can increasingly move more and more of the resources, which are currently being consumed by secondary and tertiary level services, into primary health care services. That is no mean feat by any stretch.

We have to accept the fact that all governments—Commonwealth and state—live under a reasonably tight fiscal regime. There is never going to be an endless bucket of money for health. So we have to work out, with the resources that we have, how we get more out of it and how we use it better. I think one of the critical things that we have to embrace is this notion of getting more of the money out of hospital based curative treatment services into primary and secondary prevention services, social health services and those sorts of things that Paul listed on his sheet.

I do not want to focus just on the Kimberley, because I think that is unfair, but we could take some examples from the Kimberley as it represents an interesting snapshot. In the Kimberley, Aboriginal people constitute about 25 per cent of the total population, but they constitute about 80 per cent of the business of the health system. The bulk of the money that goes into the Kimberley is directed towards hospital based services, and that will be so until

such time that we can actually shift the demand for services. So rather than demanding secondary based services we can, in fact, satisfy people's needs through the primary level service.

One of the things that we also have to bear in mind from our perspective—and this is one of the points where Puggy and I always have a discussion—is that the Kimberley is relatively better resourced from the Commonwealth than are other parts of the west. One of the things that I must do, and the state must be concerned about, with the level of resources that we have is to try to distribute it so that everybody gets their fair share of the cake. If one region receives a larger Commonwealth allocation than does another region, it seems appropriate that we should try to level up the cake, so that the needs of the communities get served.

I will make one very important point here: we have to be very careful about the rhetoric, 'People in remote locations are the only people who have health needs.' Health needs across Aboriginal communities across this country and within any one particular jurisdiction remain generally about the same. The patterns of ill health change substantially from region to region. We have to pick that up and we have to do something about it. For example, diseases associated with poor environment are more prevalent in the north of the state than they are in the south of the state. Deaths from lifestyle diseases, like heart disease, are significantly greater in the south of the state than they are in the north of the state. Heart disease is no less important than environmental health, and environmental health is no less important than heart disease. So we have to find a mechanism to try to balance that out.

It is one of the things that I would like John to talk about. We have actually got to stop thinking about how much we should be spending on projects and we should be thinking about how much we should be spending on Aboriginal health so that we then might engage in the reformationist approach to Aboriginal health, like purchasing health services for outcomes, leaving providers the task of getting on with the job to do the service they know best. They are the sort of critical reforms that I think this committee could embrace and make some real inroads in.

CHAIR—I am sorry. I am going to have to cut all my colleagues off and bear your ire later. I need to go to John Deeble. I will try to get back to my colleagues later on.

Prof. DEEBLE—I am sorry that I have to go. I will have to do this again tomorrow.

CHAIR—What I would like to try to focus on in our available time is Commonwealth state coordination and funding which is in your area. But you want to make a technical point as well?

Prof. DEEBLE—There are a few technical points. I am an economist but I am also a statistician and a mathematician so there is some arithmetic that I think people ought to understand. I fully support the community controlled primary health care organisations but I am also a realist. The death rate from cervical cancer age standardised is 11 times that for the non-indigenous population. For respiratory diseases, it is between eight and 12 times, aged standardised. They are real things. That is not going to be handled by a primary health care service. That is being handled in the hospitals. It is being handled by a specialist

system. There is evidence from other countries and this, Puggy, is not in any sense to suggest that the community controlled model is not the ideal model for a primary health care service. In the Canadian and American experience, for those things that were amenable to a very highly specialised approach, a single service or a specific service was actually better in terms of outcomes. I am torn between the notion of saying, yes, it is very important that primary care be under community control and saying that if you want to impact on those things which are killing Aboriginal people, then a more directed service may be unavoidable—not a paternalistic, organised one but nevertheless a more directed and coordinated one and that is going to be in the tertiary area for the moment at least. You cannot ignore the burden of disease that exists at the present in the hope that somehow or other you will avoid that some time in the future.

CHAIR—Some disagreement? Fine, we will come back to that later.

Prof. DEEBLE—I would like to stress a technical point. We all quote age standardised death rates. I have even done it myself. In this report the first paragraph says that, on average, Australian and Torres Strait Islander people die at three times the rate of other Australians. I wrote that with some epidemiologists and people like that. Can we keep this in mind: this is not the rate at which people actually die. That is a dramatic overstatement of the real difference. When you age standardise, you in effect say that, if the life span of the two populations was exactly the same, the Aboriginal death rate on that standardised life span would be three times greater. The mathematics is complicated but it is a very simple thing. Let us imagine that 1½ per cent of the non-Aboriginal population die every year, which is about right. That equates to a life expectancy in the middle 70s. If you were to multiply that rate by three, the Aboriginal population would be dead before it was 30 because you would have four to five per cent dying every year. The epidemiologists and the scientists have actually coined something which is useful for themselves but which is not the real world. In the real world it is about a 50 per cent higher death rate.

If you manufacture a standardised population for the purposes of demonstration, you show it is three. If 1½ per cent of the overall population dies every year and you say, 'We'll raise that to two per cent' you knock about 10 years off life expectancy and there is a 17-year life expectancy difference for Aboriginal people and the rest. It looks like a tremendous difference and almost unassailable—an impossible difference of three times the death rates. That is not the truth. The truth is that it is only less than 1½ times the actual rate. I really think that is important for people to understand. This statistical artefact that the epidemiologists construct is useful for their purposes. The actual rate of death is not that much greater, therefore it can be reduced.

CHAIR—Did you say artefact?

Prof. DEEBLE—It is a statistical thing which is useful for them for their purposes. It is only after seeing it in this and being asked to look at some work that other people have done estimating resource needs from these rates that it became clear to me that, of course, this is a quite misleading thing to be talking about. That is not the relative rates of resource use. The relative rates of resource use are what people are actually dying at—not three times, 1½ times.

It is a thing that I think people ought to be reminded about because sometimes when we quote in here 17 times the rate for something a little bit of commonsense would suggest to you that if the rate was 17 times one per cent, that would mean that the rate is 18 or 25 per cent death rates a year. That is impossible. It is not the true situation, but it is the convention of the epidemiologist that gives you that position. I really thought I ought to say that so that people do not get carried away with some of the statistics that are thrown at them.

CHAIR—The Commonwealth-state coordination issue is a real issue. Obviously the members of this committee are highly concerned in terms of the relationship between Commonwealth and state and between community and state and the issue of delivery. Is there a comment that you would like to make about that in a general sense?

Prof. DEEBLE—There is the whole question of who else would run the hospitals if the states do not? I do not think it is a realistic possibility that the Commonwealth could get itself into running hospitals nor whether it should. For a large part of the area, 55 per cent of all the Aboriginal health expenditure is in hospitals. Though they use private specialist services less, they use our hospital outpatients a lot, but that is only the in-patient side—this 55. I cannot see that that is going to be very much altered.

What I do believe though is that the Commonwealth's role might be more effective if it was in the short run directed towards specific disease programs. If cancer of the cervix is 12 times higher, then I think, for effectiveness in terms of health outcomes, there ought to be coordinated programs directed to that, which go across all the Aboriginal medical services, the AMSs, which will not be dealing with those things once they pass the primary care level, but which will be handled by the states in their specialist and hospital systems. I do not think you can leave them out on the ground that this is not primary care, so we are not interested in it. Through the OATSIHS and others, they may operate with the states on specific disease programs which are of significance for Aboriginal people and of special significance in the case of STDs but operate those as Commonwealth promoted programs. I believe that is just pure health outcome, not the good feeling, but the pure health outcome. It might be more effective.

CHAIR—Do you have a framework agreement?

Prof. DEEBLE—I do not have. I am not familiar with it.

CHAIR—That is all right. Thank you.

Dr NELSON—Is it possible, John, to pilot, in the same way that we have in primary health care in the Tiwi and other areas, the cashing out of the secondary and tertiary services and giving that budget to the primary health care service to purchase those services on behalf of the indigenous population for whom they care? That would give them, obviously, significant power in relation to the secondary and tertiary providers. It would also give them significant incentives to further improve their primary health care to reduce, if you like, the subsequent demand. Is that a possibility?

Prof. DEEBLE—Strictly, the cashing out in the Tiwi and Katherine formula does include all of the specialist services other than those that are associated with public hospital in-patient treatment.

Dr NELSON—Yes, but that is what I mean.

Prof. DEEBLE—They have got it.

Ms EVANS—Can I clarify that? The current coordinated care trials, the state cashing out, includes the hospital component, so it is actually the full gamut. It is not just primary cashing out.

Dr NELSON—I see.

Prof. DEEBLE—They have really got the lot. They have got all of the funds that the non-indigenous community use on private specialists, which are substantial, which will not necessarily be directed towards private specialists but could be. I would still have some overarching, at least in the short run, concern with those health problems which are actually killing people.

Dr NELSON—Dr Strasser, you have an alternative view, I think.

Dr STRASSER—The one example which Professor Deeble picked up related to cervical cancer, and I would have to say that the best way of getting rid of cervical cancer is to put the money into primary health care and prevention, absolutely. It is not a secondary or tertiary issue. I would like to add some other points. Our problem with the state running the hospitals in Victoria is that they are closing all the time.

CHAIR—It is a bit fundamental, isn't it.

Dr STRASSER—I did include an article from the *International Herald Tribune* which I think you may well find very interesting. It is entitled 'Let's respect both sides of the development coin' and it is written by the Nobel Prize winner in economic science, plus the President of the World Bank. My understanding is that this is the first time that any two such eminent people have written about the economics and development of—they term it very well in their article—freedom. It relates to the whole conversation that we have had this morning.

CHAIR—Thank you very much. We are right out of time and we only got through about half the agenda, but we will have to bring that back into the discussion after lunch. Can I suggest that we assemble at 1.30 p.m.

Proceedings suspended from 12.53 p.m. to 1.33 p.m.

CHAIR—In session 2 we dealt with indigenous control and ownership, Commonwealth-state coordination and funding. We are up to infrastructure. We have touched on education and training—Dr Strasser touched on it earlier—and health services. I want to make a few general comments for future reference.

In terms of Commonwealth-state coordination and funding, the Commonwealth Grants Commission general grants and specific purpose grants do not seem to place sufficient onus on state and local government to measure and report progress in addressing the needs of the indigenous community. Current funding also appears to be insufficient to meet the backlog of needs which limits the capacity to restore future needs. In the area of Commonwealth Grants Commission and specific purpose payments, last week in the parliament the Commonwealth Grants Commission was asked to talk more about the needs of Aboriginal people in terms of the allocation of funding.

Someone might like to pick that up. If Helen returns, I will come back to the framework agreements. Another one that our secretariat has been really pushing us on is that the coverage and timeliness of data about all aspects of the health system is very poor. This goes to Commonwealth-state coordination. The last one that I will touch on at the moment is the fact that states and territories have not developed effective mechanisms for dealing with cross-border patients. In some areas they have, and some of the members are aware of that. Annette Ellis and Alby Schultz can certainly very quickly remind us of what is happening in the ACT and New South Wales. In other states—Shane, you might have a comment about that as well—the protocols have been developed on that. I refer, for example, to the obvious issues of geography in the north of WA.

Those are some of the issues that are perhaps outstanding in terms of a discussion about Commonwealth-state coordination. Does anybody want to talk about infrastructure or pick up any points I have made? Shane, do you want to comment on cross-border issues? Is there an issue there and can you enlighten us a little bit?

Mr HOUSTON—To be blunt, I think we would have to say there is. We often find that while the issue of payment for services between states and territories is well organised within the health industry itself and there are reconciliations that occur between jurisdictions periodically, that is not so much the problem. The real problem often tends to be in the services to the people. It is not uncommon, for instance, for clients who are sent from the north-eastern portion of Ngantjatjara communities to Alice Springs for services to end up in Adelaide. That often creates a difficulty for people who have been sent to Adelaide.

The same could be said for part of the problems in respect of the movement of people out of the Kimberley across to Darwin, particularly for tertiary level services. Part of the problem rests with the current issues around the PAT scheme and the ability for us to better organise that particular end of it. There have been some changes to the existing arrangements with a view to, rather than shipping people out, using PATS budgets to buy services in.

To be honest, there continue to be occasions when people receive less than what you would consider to be acceptable services. It is not just a cross-border issue; it is also an issue for people from the country who are sent to Perth. It is not unheard of for a person to be left

at Perth Airport with a taxi voucher with a note that tells them to go to the Autumn Centre. That person has not seen the Autumn Centre and does not know what it is.

One old man came down from the Pilbara and they took him to the Royal Perth, a multi-storey building. They went to take him into a lift and he refused to get in it. This is an anecdote. They tried everything to get him into the lift, and at the end of the day they brought in an Aboriginal woman who was a social worker and she sat down and talked to him. He said, 'The reason I'm not going into that lift is that I've been watching all those men going in there, those doors close and they come out women.' It underlines some of the difficulties associated with getting people from remote communities into tertiary services.

There are some proposed changes in respect of the metropolitan, but there are not yet any clear programs in place, from our perspective, about sorting out those cross-border issues between the Territory and South Australia. Although it has now been on the table for about 2½ years for something to be done, it is one of those things that has not been dealt with.

CHAIR—With respect to the issue of being at Halls Creek and the distance to Perth being significantly longer than to Darwin, the costs and those sorts of issues seem to stare out at us.

Ms ELLIS—I just wanted to take this particular discussion a bit further. Shane, we are not picking on you because you are from Western Australia, but we just cannot let the examples we have go by. Barry just touched on one very briefly then—the Halls Creek situation. In the Kimberley, we had many examples given to us of where it was attempted to take people to Darwin, only to be refused by Darwin. It was said to us on one occasion that, when the person in charge in Darwin was away for the weekend, they got them in under cloak of darkness almost. It just seems insane, when we are all discussing cost level and the need to retain costs and Darwin is so much closer, that the two states cannot come to some agreement about how we handle that. I am not necessarily blaming WA or the Northern Territory, I am just saying here is a terrific example.

Another example is not interstate but intrastate. Correct me if I am wrong, but I understand that for the Kununurra area, the next up the line local medical area is Derby, but there is no air link between there and Derby. That seems to me to be a bit insane. So the only way that people from that area can get treatment is to go to Exmouth or Port Hedland and get a bus or something like that because there is no air link between the area I am talking about. Tell me, Pug, if I am getting any of these names wrong.

Mr HUNTER—You are out of bounds already.

Ms ELLIS—But this is what we were told when we were up there.

Mr HUNTER—The only way you can get to Derby from Halls Creek or Fitzroy Crossing is by the flying doctor.

Ms ELLIS—Okay, it is not Kununurra. I got the placename wrong, but the story is the same.

Mr HUNTER—Even from Kununurra you have to go down to Broome and then jump across. It is the same thing again.

Ms ELLIS—That is the link. Yet we were told that Derby was the place that they had to go to.

Mr HUNTER—Yes, that is right.

Ms ELLIS—There are just two examples. I think the Halls Creek-Darwin one is the most extreme example other than Dareton out of Mildura, which is on the New South Wales side of the Victoria-New South Wales border. The Dareton community has a choice between Adelaide, Melbourne and Sydney and a constant battle over where they end up medivac-ing people to. Dareton is basically geographically a suburb of Mildura for nearly every purpose, except it happens to be across the river and therefore falls into New South Wales and falls into this terrible cross-border situation. That comment is not aimed at Shane; it is just a general comment.

CHAIR—No, no.

Ms ELLIS—But they are two very good examples of how we really need to come to grips with this and get over the border problems.

CHAIR—Thanks, Annette. Annette reminds me, please do not be intimidated by Hansard. This is confidential, it is exclusively for our benefit and it is not something for the public record.

Ms ELLIS—Absolutely.

CHAIR—It is for our benefit to be able to peruse it and just remind ourselves of the proceedings today, so please feel free to speak openly. It is a confidential record available internally to the committee.

Mr SCHULTZ—Just on the question of cross-border sharing of resources: I was involved as a member of the state parliament of New South Wales, with a very constructive exercise that was undertaken by the then Premier of New South Wales and the Chief Minister of the ACT. They got together with their bureaucrats and heads of departments. Over about a three- or four-month period, we quickly sorted out the problems associated with sharing of resources between states. For the life of me, I cannot understand why that is not occurring elsewhere. Is it so complicated or are people so intransigent that they cannot get together to offer some sort of practical relief to the people who have the difficulties that my parliamentary colleague, Ms Ellis, has just described?

Ms GREEN—The New South Wales/ACT cross-border hospital program is working really well. However, it is a shame that other programs are not. We still have major problems here cross-border in that, if a patient is discharged from the Canberra Hospital and lives in Queanbeyan, they cannot receive services from the ACT such as home and community care or any of those programs because it is a cross-border issue. The hospital issue has been organised and managed but other programs still require a lot of work.

CHAIR—So it makes a very good point.

Dr TORZILLO—I want just to emphasise what Chris says. I think there is a big cross-border issue for the north-eastern Ngantjatjara communities and the Pitjantjatjara communities in South Australia and the Territory. Whilst there has been an agreement about the costs of hospitalisation in Alice Springs where those people go, what has happened in the last five to six years is that other services which have historically been provided in Alice Springs for those communities in the two states and the Territory have gradually been withdrawn and are now only available to people in the Territory.

There is a range of issues that have to do with antenatal accommodation, child health and other services. As Chris was saying, there has been no progress on resolving those issues, and certainly not for South Australia. There has been an unwillingness on the part of the South Australian government to take that up and ensure that the people from the north of South Australia are not disadvantaged by being locked out of those services. To some extent that still applies to parts of the Ngantjatjara communities. One of the things that I have observed is that, in the negotiations about those issues, quite junior level people have been sent to the meetings rather than senior bureaucrats. Maybe that is a reason that these efforts have not progressed whereas issues about hospital claims have progressed.

Ms GREEN—Or they have happened at too high a level and the information does not get put down the track so that people delivering the programs on the ground know that there are requirements.

CHAIR—It works both ways. Thank you very much. Lloyd Evans, I just come to you because I think that some of these cross-border issues might happen to be of interest to the RFDS. I am sure you have other comments to make as well.

Dr EVANS—The RFDS is willing go across borders. We do it all the time and there is no fight between our four sections except that Broken Hill in New South Wales are at times difficult. Any of our young doctors at Broken Hill have to register in three states because they have to work in South Australia, New South Wales and Queensland. Just to give you an example, when someone is sick at Birdsville, Charleville in Queensland look after Birdsville, but the people want to come down to Port Augusta for hospitalisation, so we have to cooperate quite willingly in those sorts of episodes.

About 40 per cent of our work is Aboriginal. We had 181,000 contacts in the last 12 months in the financial report. With evacuations and retrievals, we are very happily helped by the specialists in different areas, especially anaesthetists to help out outback doctors who have to be multi-skilled and able to, hopefully, intubate and come on board with an intubated patient. Unfortunately, we cannot always get staff that are adequately confident of doing what they were trained to do.

Then we have those being brought down for investigation. We try to repatriate. We had one person in the top of Western Australia taken into Darwin. He could not be helped, was brought to Adelaide, and then we had to rehabilitate him back to the north of Western Australia. The total cost of flying was nearly $35,000. We cannot have highly powered, specialist staff in every major hospital.

With primary health care, we have been asked to go into every area that no-one else wants to go. We try to achieve that. Pika Wiya at Port Augusta have not got enough medical staff, so they have just handed Nepabunna and Copley in South Australia over to us for that. This is happening in quite a few areas. In Queensland, Jeff King has arranged to employ two GPs to go out and live in Aboriginal communities because the state government cannot get enough people to go out into those communities. That is working well. We feel that we may be able to do that.

We have two indigenous liaison officers working for us now. The one in South Australia is financed from Western Mining. We have had to go privately to look for these extra staff. We are able to get a few but it is very hard going. Queensland have taken on a psychologist and that person has been very good for debriefing and helping. Queensland has more bases than any other but Western Australia has just about as many.

We are trying to put more staff on the ground, and this is where infrastructure comes in. Just to give you the example of Coober Pedy, we can take six health professionals from Port Augusta on our Chieftain to Coober Pedy for the day, but if we could upgrade the aircraft to a Pilatus PC12, we would have them on the ground for two hours extra per day. That means six professionals on the ground every day in the north of South Australia for two extra hours. That means by using better infrastructure we can get more use from our resources. We are hoping the South Australian government will help us with that in the next budget. It is an election year in South Australia next year so there could be something coming our way.

Concerning collaboration, we are working with other groups. We have all done cultural awareness. We are very thankful to Colin Weetra of Whyalla who is doing it for all our staff, and with all our new staff.

Concerning proactive management, we have tried to do that at Yalata in South Australia, out past Ceduna. We can say that in the last two years there our peri-natal mortality has gone from five per cent to nil because of proactive treatment. Any baby that loses 10 per cent of its body weight is brought back to Port Augusta, rehydrated and then returned to Yalata. We have had very good results. I am open to any questions.

CHAIR—Thanks very much, Lloyd, you made me feel quite at home. On indigenous control, just going back through the wreckage of this morning, if you like, and just quoting from our brief here, it says:

> The Commonwealth/State framework agreements require the involvement of the community controlled health sector in the development of regional health plans, but do not really define how this should occur, or what role that sector should play in implementing those plans.

Do you have a comment on the framework agreements? The ANAO has reported on the framework agreements. It is fair to say that they are emerging and that they are seen as a generally productive and constructive way to go about it. Would you care to respond to that concept of definition of regional health plans?

Ms EVANS—When there were comments made earlier about the framework agreements I was going to say that for the first time, each of the states and the Commonwealth and NACCHO are reporting to the health ministers in August on the framework agreements. That

is the first formal report on how the framework agreements are functioning. Obviously, we would need the permission of health ministers but I would like to suggest that we might give those reports to the committee because that will be the first comprehensive report on the framework agreements.

CHAIR—Yes.

Ms EVANS—As has been implied around the table, they are working to varying degrees in different states. In some states they are working extremely well as a collaborative mechanism and in other states it is still working its way out. Several people have made the point that any partnership agreement does not just happen, you do not sign an agreement and then it happens, it actually requires ongoing work on it.

Under the framework agreements, at the state level there is an agreement to set up a planning forum and to develop regional plans. Each state forum has done that differently, but the requirement is that it involves all four parties. For instance, the Central Australian plan, which is the first one to get signed off, and the South Australian plan, were signed off by all four members. Everybody makes an input and everybody has to sign it off. Does that answer your question?

CHAIR—Yes, I think so. Thank you. It is an emerging thing. The issue of data is one that will come up later. I will just signal that that is something that someone might want to talk about later.

Graham Edwards, is it appropriate to come in here with the issue of access to mainstream health services?

Mr EDWARDS—We have had a fair bit of anecdotal evidence put before us as we have moved around to various, mainly regional centres, to say that Aboriginal people have incredible problems trying to access mainstream health services. There is a view that there is some entrenched racism which makes it very difficult for Aboriginal people to access these services.

We had a very good example given to us in New South Wales where a young Aboriginal boy had broken his hand. He went to the casualty section of the hospital and was told, 'There's a bit of a problem, you've got to get to a specialist in Sydney.' That was it, they just sent him off. There were no x-rays, no referral paraphernalia at all. He then went down to the AMS and they arranged all that and arranged to get him to Sydney.

There was another high profile example just last week in Western Australia, once again in Port Hedland, where an Aboriginal bloke was told by a GP, 'Piss off you rock ape.' Excuse the language, Mr Chairman.

Is this anecdotal evidence that we have received widespread? Is it happening in these regional cities to the degree that we have been told it is? I understand that much of the state funding has to go into hospitals and regional services that are mainstream. It seems to me that much of the pressure that is coming onto AMSs is coming on because Aboriginal people

cannot access, or do not access, these mainstream services. Is it a problem? I would appreciate some comment as to how you might overcome that?

CHAIR—It is an excellent issue.

Ms ELLIS—I want to add something to that. The other more subtle way is for GPs in a town to not bulk bill. We heard of that in many places. You could interpret that as saying that the way to handle this issue is to not bulk bill. Therefore, the AMS, if there is one there, not only picks up all of the indigenous community but also inadvertently people from the lower socioeconomic level of the non-indigenous community. I wanted to add that to Graham's question.

Mr EDWARDS—That is a good point.

CHAIR—Thorny.

Ms ELLIS—Very thorny.

Mr HOUSTON—The first issue that is raised by Mr Edward's point is that the question about the provision of culturally appropriate services to Aboriginal communities has been around since Adam was a boy. We have continued to grasp a single theme in order to try to deal with that. That has been about trying to make people understand Aboriginal culture. I have rapidly come to the view that that is a facile view and it is not going to work. I base my reason for saying that on a couple of points.

A few years ago the west embarked on a state-wide Aboriginal cross-cultural education program. Ten per cent of the health work force went through, in one twelve-month period, a cross-cultural program at a cost of about $270,000. Twelve months after that program had been completed, 30 per cent of the people that had done the course were not longer working in the health system. We cannot sustain expenditure of that magnitude and get it to the point where we reach a critical mass of coverage appropriately. It seems to me that we have to find a new way of tackling this issue.

One of the things that has been developed more recently has been this notion that we should be going to the point at which health professionals—be they doctors, nurses or allied health professionals—are actually trained, and make them understand the way in which culture impacts on the clinical delivery of their particular professional skill.

We do it at the point of their education. I think it is still the case that the content of Aboriginal education in most of the mainstream medical courses is six hours, or slightly more. It seems to me that we have to do something about saying to those people, 'Not everything you do impacts on culture. Similarly, not everything in culture impacts on what you do.'

The example that I always use is that, if I get hit by a truck, there is not too much cultural about how you keep me alive if the injuries are that bad. But if I am a palliative care patient, or if I am a woman having a baby in many parts of this country, there is a whole lot cultural about the services that need to be provided. So we should be doing

something about understanding those cultural differences and building that into the education of practitioners before they get to the ground as a first stage. That in itself will not achieve the end, though.

We also then have to argue that we have to change the workplace practices of our clinical facilities—and in the first place we are talking about hospitals—to ensure that the logic which underpins clinical practice is also altered to reflect these cultural understandings. At the same time, we also have to understand that that will cost, so we have to think about paying them differently for these additional services.

It is interesting that the theme is starting to catch on. Just two and a half weeks ago we had a workshop with the Western Australia division of GPs, the state office, and they have in fact agreed that they are prepared to look at the clinical practice of general practice to incorporate cultural values. I think that is the first step. We then have to get on to this change at the workplace level and the way in which we pay things.

The other side of the coin is that we have to get serious with mainstream providers and stress that these issues are not negotiable. If I can draw an analogy, with the National Health Service in the UK most people took the introduction of the purchaser-provider model with a great degree of humour at the beginning, until one of their CEOs was sacked for not coming in on budget. Then they started to take it seriously. When we sack our first general manager for not properly servicing Aboriginal health needs in the manner that I have just described, then we will start to see some significant change.

So we have to make it all bind together and make sure that mainstream service providers understand their obligations. Their obligations are not obligations which are discretionary. They are, in fact, rooted in law. There is Commonwealth and state legislation which makes it illegal to do anything which impinges upon a person's economic, social or cultural rights. We have to find a device which pounds the providers into submission and says to them, 'Get it into your heads that you must do it this way.' Until we do that, we are still going to see the sorts of problems that are all too common.

I would like to think that not all of the providers are racist. We have excellent people working in very difficult circumstances. Some of the remote area nurses work under very difficult circumstances with a high level of dedication, as do Aboriginal health workers and other people. But there are still too many examples of where it is too common, and not just in hospitals, but the point that Mr Edwards made about the GP in the Pilbara.

I remember walking into one of our hospitals also in the Pilbara with a man who had just been hit in the head with a block of wood. The don went off at him for being drunk, and he did that in front of the general manager for Aboriginal health, the general manager of rural health, and at that stage one of the minister's policy staff. That don did not last long.

It seems to me that we have to have a combination of more properly building in cultural understandings at the front end, and making sure that the workplace is adapted to make sure that they pay attention to that as a non-discretionary function. We will pay them differently for that circumstance and the same will apply for GPs, and that we also then make it binding from the funder and owner perspective—the states and the Commonwealth point of view—

that those services that we fund must be provided in a manner consistent with the legitimate rights, views, values and expectations of Aboriginal people.

CHAIR—Thank you, Shane. An excellent response.

Mrs ELSON—I just wanted to ask a question, which I was going to ask before lunch. Again, when you have given your report over, Puggy, I have noticed it does not agree with a lot you say. We are having this meeting today to find out the differences between what you are saying you do and what is actually happening out in those communities. I wondered if Puggy could give his side of the story of what he can see not happening.

Mr HUNTER—I am not so much disagreeing with what he is saying. These things are happening in pockets and the whole thing is that we live in a state. The point is that the Commonwealth funds the Kimberleys more money, and I was going to bring that up with the Commonwealth. If that is okay that they would do it in the Kimberleys, they need to write down somewhere that they will look after the Kimberleys very clearly, so we know where we stand with the states. Because there seems to be that sort of thing that we see from the Kimberley point of view, and Shane made that statement here that he thinks we are okay, so they do not put funding into our area.

But I live in Western Australia and that state actually gets money for the Kimberley people as well. I do not want to get into that argument, but the point is that that should not be the case. You should just look at who is willing enough to get up off their bum and chase the money because no-one else is doing the service.

So the point is that, if the Commonwealth and the states are agreeing on that somehow, then we need to be told as the community that that is what they have agreed on, because that is what seems to be the case here. I just listened to what was said and that was okay. They said, 'We will look after them mob, and you look after the rest of Western Australia.' But, if that is not the case, then we are entitled to the same amount of money that comes into Western Australia as any other Aboriginal person within the region.

There is the issue about some of these projects around the places. I understand that there is a process that has to be gone through. We in Western Australia are very clear that the partnership is not working. We know that for a fact. That is one of the things that was reported back to AHMAC. I raised at our last workshop with the state planning that I hoped there is some sort of format, so that the states and the communities are going to be with ATSIC, and the Commonwealth in a sense, answering to AHMAC in a format that is clear. We are not miles away. We all know where we live and we all know what has been the problem.

I have read the responses of other states and territories to deaths in custody, and I do not know why they answer those things in a sense if they are not doing it. The deaths in custody talks about culturally appropriate services, cultural training and cross-cultural training. You read in our response that all that in progress. These things have not been implemented. Who implements them, from our understanding, is exactly what it says; it should be in partnership.

This is not only in Western Australia. Let's get that clear. This is not happening right around the country. These framework agreements are very clear. They talk about planning in the first instance. It is very clearly planning and sit down and talk. It does not say about controlling the money. We are clear on that. The states and the Commonwealth made that clear to us, so we do understand that. We do not have a say at the end of the day about where they want to spend their money. We know that, but commonsense should tell them. We do not argue the toss.

But communities are still missing out because the states and territories are still going off and planning things outside the framework. We have only got the framework to hang our coat on. The states and the territories are constantly in a sense doing things that are outside of the framework agreement or the agreement that they agreed to do.

I told the minister for health that it is no good asking me what colour car we need. Don't come and see us after you have bought the car. We want to know what sort of car we are going to buy, so we can get to where we are going all together at the one time. We all understand the big picture, so that we have ownership of the idea. So don't just come around and ask us black fellas, 'What colour car you want, brother?' because that does not work for us any more. Maybe it used to work years ago.

So the whole partnership thing means exactly what it means to us. It means sitting down and planning. Don't come to us later on when you have made your decision, because that is how we get lots of reports. We are still constantly receiving that decision making process that is outside of the framework. The Commonwealth is well aware of this. Let's not kid ourselves. They cannot do anything about it, because of the same sort of thing. They can only be the Commonwealth, because the agreements that are signed do not hold anybody to anything. We are aware of that, but we think that that has not worked, so let's do something that might work.

CHAIR—Thank you, Puggy. Helen, would you like to come straight in there on some of that general area?

Ms EVANS—Thank you. I would like to make a couple of comments around the business of planning and Puggy's comment about the Kimberley. Going back a step, it is quite clear that responsibility for Aboriginal health is a shared responsibility. I think it is a false dichotomy if we talk about either the community or the mainstream; it is a shared responsibility right across. Taking Shane's point, a point that has been made by a number of people here, we talked about community ownership but I think that it is also important that mainstreams have ownership of Aboriginal health as well because there is a danger that they flick pass it to the community and say, 'Oh, well, you have got community controlled services for that, so they can do it.' In the past the Commonwealth health department has been guilty of that as well: when ATSIC had health, we tended to say, 'Oh, well, that is ATSIC's responsibility.' Until everybody has ownership and, taking Shane's point, until it is made explicit in area health managers agreements et cetera that they have to be accountable for Aboriginal health, it is going to be a problem. It is collaborative.

Also, because of the historical development of services, there is an extraordinary variety across regions as to who is doing what, where. It will also depend on what the region is—

whether it is remote, whether it is rural, whether it is urban. That is why the concept of regional planning came up, because there is not one national template. It is going to depend on what is on the ground at that time and who is paying for what. When Shane used that example this morning of perhaps the Commonwealth putting more money into the Kimberley and then the state might put more money somewhere else, that is a legitimate position, but it needs to be jointly agreed. That is why you have a regional plan—

CHAIR—That is Puggy's point.

Ms EVANS—where the parties sit around the table and say, 'This is what we need. Who is going to do that? Who is going to take responsibility for it?' 'Well, the Commonwealth is already doing that—or the state is already doing that—so we will leave that there and the state might put more resources in elsewhere.' But the whole emphasis has got to be on collaboration. It has also got to be on having rewards so that people are not rewarded for conflict. There has been a lot of reward in the past for conflict. Mr Chair, you have raised this with me. The rewards have to be where everybody sits down around the table and everybody agrees. I think it has to be everybody—I agree, Puggy. That is one of the reasons the latest money that was brought down in the Commonwealth budget is going to those areas where there have been signed-off regional plans. What that is trying to say is that, when you can all sit around the table and agree, that is where the resources will be channelled.

CHAIR—Thank you, Helen. Can we go to Stanley now.

Mr NANGALA—Thank you. One key point of clarity: I was born and raised in the Kimberley, not the Kimberleys. The Kimberleys is in South Africa.

The issue I would like to raise is on the cross-cultural Aboriginal training awareness program. Following on from what Shane Houston has said, in Queensland our director-general has actually championed and is the key sponsor for the cross-cultural Aboriginal standards set against minimum standards to apply to 77,000-odd staff employed within Queensland Health. As a consequence, with the minimum standards, we are also looking right across the board at the rural health training units who are the delivers of the cross-cultural training programs, including Binang Goonj, the NACCHO and QAIHF accredited cross-cultural deliverers of the program to the Aboriginal medical services. So there is a link that is evidence of collaboration with the role that Aboriginal and Torres Strait Islander controlled health services play in this state.

On the partnership issue, frameworks can only be dependent on when the first person pulls out. We are tied against national targets in addressing indigenous health from a state point of view. We are also tied with the statutory obligation to provide information through AHMAC. As a result, what we are practising in the state of Queensland is to ensure that the information that we provide to these peak forums is also assessed and provided to QAIHF, the Queensland Aboriginal and Islander Health Forum. That is occurring now. So some inroads are being made—I would say in the last four to five months. Prior to that there has been a history of a north and south syndrome that has affected Queensland with the AMS movement.

CHAIR—Thank you very much.

Mr AGIUS—I, after many years, asked the question: is it time we changed the focus from the individual to the institution? Is the individual the racist or is the institution the racist? We have thrashed cultural awareness and cultural education to death, and I think what we are hearing are the results of that: it still has not changed the attitude of the individual that operates within the institution or the system. So we need to think of other ways of addressing racism within the institution. In fact, institutional racism is still well alive. We need to change our thinking about how we address that. As Jane has said, there are those incidents that arise, but at the same time there are many staff who are very supportive in dealing with those issues—this is non-Aboriginal staff—and who do as much as they can to address that stuff.

In relation to GPs, Annette gave some examples of some country towns that do not have GPs that bulk bill. That is true. There are many. However, there are some divisions of GPs who are now prepared to work with local AMSs and with communities where there is an AMS to put together some sort of service, either in a surgery, in a hospital or in some sort of clinic, in order to provide services specifically to the Aboriginal community. So there are those situations where local doctors will not bulk bill, and there are other towns where the division of GPs is working together with communities. There are also communities where AMSs exist who find it extremely difficult to retain a GP because, as soon as they recruit a GP, local politics does not allow the GP to be retained in the AMS, therefore the AMS cannot hang on to a GP and so they continue to suffer.

Finally, to follow on from Shane's comments on the pleading issue, there are informal arrangements locally with Commonwealth officers at a state level where we are looking, in the interim, at identifying where the gaps are. We did this recently in New South Wales and we realised that there were a couple of towns or regions that did not attract any Commonwealth funding. So there was agreement with the Commonwealth for the state to actually pick up that responsibility to make sure that there were services there until the long-term planning arrangements that are in place had been completed to address the overall gaps across the state. To support what Shane was saying, there are times when we need to look at where those gaps are and actually do something about them until the long-term planning has been completed.

CHAIR—Thanks very much for that.

Ms ELLIS—Would this be an appropriate point to ask a question regarding the allocation of Medicare provider numbers? It is very relevant.

CHAIR—Yes, I think you are right.

Ms ELLIS—There has been some discussion around the committee, in the ether, about the allocation of Medicare provider numbers vis-a-vis the question that we are talking about here in relation to the supply of medical services, particularly in those country towns. I have a town in mind—one we went to—where there were four GPs, none of them bulk billing, and an AMS collapsing. What would be your reaction, Tim—or anyone else's, for that matter—to the provision of the Medicare provider number to the service, to an AMS—that is, to the position, rather than to the doctor—to start to try and overcome that?

Mr AGIUS—We are currently having some discussions with a couple of communities that do not have an AMS and with the local area health service to come to some other arrangement, which is considering having a provider number provided to the community, the AMS. They are only recent discussions so we have not quite explored what the possibilities are. But if it is an option and it allows us to get a GP to the area, then we would have to consider it, absolutely.

CHAIR—While we are on GPs, there is a comment I would like to make, arising from a few visits, on the issue of stability of staff—and I will go wider than GPs. We were at a community where we rolled in as the committee, it was about half past nine in the morning and we said, 'Where are the doctors?' 'The doctors?' they said. 'Oh, they're over at the hospital. They do it every Friday—they go there and they have an hour with the local hospital.' The Aboriginal health doctors were over at the hospital. They came back about an hour or two later. Of course, the obvious question was, 'How long have you been in this particular town?' Fourteen or 15 years it was. So I just make the point about stability, which is perhaps part of this overall issue.

Dr NELSON—Can I clarify exactly what we talking about: a provider number given to an Aboriginal medical service that does not have a medical practitioner?

Ms ELLIS—I am not advocating this.

Dr NELSON—I do not understand what the proposal is.

CHAIR—I think we canvassed it in—

Dr NELSON—Whether we canvassed it or not, what are we talking about?

CHAIR—My understanding is you apply the Medicare provider number to the facility rather than to the doctor.

Dr NELSON—So whether there is a doctor there or not—

CHAIR—No, it would only be based on when the doctor offers the service, I would presume.

Dr NELSON—Are we then talking about a provider number going to the Aboriginal medical service, but there would be no further provider numbers available in that community, so if a doctor wanted to work there they could only work at the AMS? Is that what we are talking about?

CHAIR—I think we can negotiate that. The presumption might be that because you put a provider number there, there is no doctor available to that community. That would be the criterion, I would presume. We may need to take advice on that.

Ms ELLIS—Absolutely.

Dr NELSON—I do not mind talking about it, I just do not know what we are talking about.

CHAIR—I think we have got it in our notes. We will go to Elissa, who has been waiting patiently.

Ms O'KEEFE—It is an asset of being a nurse, I suppose. My first point is the one that was brought up about racism and cultural awareness training. Whilst cultural awareness training is admirable and in a similar vein to raising the awareness of anything different, whether it be different colour, culture or whatever, as much as we try to raise awareness we are not necessarily changing attitudes. I just want to make the observation that raising awareness is not necessarily changing attitudes. Changing attitudes is something that takes generations to happen. Somebody said that if we keep working away at it diligently, educating our children and keeping the word out there, that will eventually happen.

The other thing I wanted to mention is something I know has been on the Health Ministers Advisory Committee agenda for a while. It is about health staff, and particularly about attracting them, retaining them and remunerating them. That should be high on the agenda for this committee. Yes, we can talk about funding, we can talk about needs. But if we cannot actually get the feet on the ground where they are needed—whether it is in Redfern, right in the heart of the city, or wherever it may be—we need to be looking at how we are going to attract people out there, what we are going to provide for them, how we are going to keep them there. We want to keep there for a long time so they learn about the community and can give all they have got, and we want to pay them accordingly. I think that is something that needs discussion. I did not know which topic it came under—I thought it encompassed a few.

CHAIR—We talk about holistic and I am putting it under the holistic approach. Thank you for that. You have touched me deeply because my wife, my sister and my daughter are nurses. Mr Quick, can we just touch on the Docker River example. I would like to just quickly mention that. You know the example I am talking about.

Mr QUICK—I have been glancing at Sarah's thing about key initiatives and training of doctors relating to vocational training and all that sort of thing. When we went out to Docker River there was one nurse who had been out there for God knows how long. She was about at the end of her tether. She had a group of Aboriginal health workers working with her. If there was enough money to provide another nurse, she would be able to get regular sleep. Her burnout rate would dissipate. There would be professional liaison between her and her partner in the operation. Part of her time off could be spent upgrading the skills and qualifications of the Aboriginal health workers.

The fact was that the landing strip was not up to standard. Therefore, the Flying Doctor Service could only come in at infrequent times. The road was absolutely appalling. All these things compounded the problem. If there were a few more bums on seats visiting there it would make it easier to convince the Northern Territory Health Services people or the Commonwealth government to do something. But no-one ever went out there. How do we convince someone to say, 'We need that like the Coober Pedy thing.' These barriers are there.

She has tried to convince as many people as possible to do something. The paediatrician that we saw there, who came from Darwin, could see the whole system just falling apart. If that nurse does not get that additional support, if she does pull the plug, all her corporate memory and the cultural awareness that she has got and the skills she has transferred to all the other people will be lost.

Are the states going to get off their bums and say, 'We will do it'? Bill said it took HIC nine months to get a decision making process together. One of our terms of reference says:

barriers to access mainstream health services, to explore avenues to improve the capacity and quality of mainstream health service delivery

When we as a committee come up with recommendations, I would like to think we are going to shake the foundations of a whole lot of people. Someone mentioned the Reformation. From my understanding of history, that shook the living hell out of the whole system and the system took a whole new direction.

I am a little disappointed that we have virtually gone down to the lowest common denominator by talking about racism for half an hour. I think we need to get back on track and get back to the terms of reference. We had so many things mentioned initially about what is happening in the homelands. I think the model is there. Let us get back to that and focus on that because I think that is the right way to go. I do not know whether I have made sense or not.

CHAIR—That's excellent, Harry.

Mr QUICK—Ngaire has been quiet. There are lots of links across there about—

CHAIR—Ngaire was next on my list, and I was going to ask Peter Buckskin—

Mr QUICK—How do we get those things up and running?

CHAIR—I was going to ask Julie to explain her presence today. You are very welcome. I know I have Chris and Jill. Ngaire, it's over to you. You pick up any point you like but I thought cross-cultural education and training was one area that you thought you might like to talk about. It is your baby.

Dr BROWN—They are obviously my two favourites. I just wanted to make a couple of general comments, if I may. One is that it is nice to see people from such diverse personal and professional backgrounds here. I do not think it is important that one person or one group believes they have all the answers. I think it is more important that people recognise their niche and where their expertise lies, and they are then given the resources to capitalise on those skills. Groups like these should be networking and collaborating.

I also do not feel that we need to re-invent the wheel because there are great ideas out there. There are reports that remain on shelves, in particular, the National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths in Custody which made some great recommendations—some over 10 years ago—but where have we seen the change from

them on a national level? We have not. Certainly there are pockets here and there—there are ad hoc initiatives—but we need to be looking at it at a national level.

Just to reflect upon a number of points that have been made in terms of education and training, it is certainly about attitudinal change—importantly, not only doctors but also nurses, health workers, dentists and physios—within the medical profession. Two particularly relevant recommendations from previous reports have been that indigenous culture, history and health need to be made core parts of curriculum when we are teaching our health professionals, and also that we should be training more indigenous medical and allied health professionals. I think they will have a big impact, whether we are talking about racism or whether we are talking about work force issues, to get people out into the bush, into rural and remote communities and into indigenous communities.

If we latch on to the undergraduates when they are still young and impressionable, we can help shape their attitudes by presenting them with, I suppose, what is the truth and what is the experience of Aboriginal communities. It may spark their interest in rural and remote and indigenous health. It will help to legitimise those areas of the health profession as legitimate career pathways. At the moment, it is fine for you to want to be an orthopaedic surgeon, a physician, a paediatrician and work in a big flash hospital, but it is not so flash if you want to work in the bush. You are often behind the eight ball in professional terms, and I do not think that you are awarded the kudos or the recognition that you deserve. You need a broad range of skills to work in rural and remote communities and indigenous communities, particularly because you are socially and professionally isolated. You are often the only person there. You do not have time for up-skilling, for in-services or locum relief.

If people know about these choices early on in their career pathway, they are aware of the cultural nuances. If it is taught along the way—and not just to undergraduates—and the colleges are responsible for the ongoing training of their professionals as well, I think it would make a huge difference. Obviously, it is not going to be within the next few years but, hopefully, it will have ongoing impact.

CHAIR—Ngaire, can I say that in my observation of the last little while in the training of medicos—I am not sure which community it was—apparently it was with some irony that US medical students were jumping the queue and getting out here ahead of our own Australian medical students. I understand that has been undergoing some change. You might know about that; I am not sure.

Dr BROWN—Yes. It has been the case in the past where, for electives, a lot of our Australian medical students want to go overseas for their experience, particularly to Third World countries. It is the unfortunate truth that many of our Aboriginal people are experiencing those Third World conditions here in Australia, in a developed nation. We are the lucky country and that should not be the case. But, because our undergraduates and our graduates are becoming more aware of the issues in Aboriginal communities, they are becoming more interested and are therefore given priority.

It is the sad truth that there are some fascinating clinical experiences to be had in Aboriginal communities—TB, leprosy, rheumatic heart failure—at rates that you will not see in an entire career in a metropolitan or an urban practice. So, as our students are becoming

more aware of that, they are certainly becoming more interested. We need to spur that on because not only is it great for them in terms of learning, relationships and their ability to supply good medical service to their patients but also it supplies some cheap labour to communities as well.

CHAIR—Thank you.

Ms HALL—Dr Brown, what do you think about the idea of giving some sort of special accreditation, or recognition, to doctors who work in remote communities and rural communities? Do you see that as something that could increase the status of working in those communities and, in itself, act as a bit of—

Dr BROWN—Yes, I do. It is all part of what I was talking about—legitimising it as a career path for people. I suppose in urban and metropolitan areas where there is a lot of diversification in talents and specialties and those services are accessible, it is very easy for people to become blinkered in their experiences. When you are perhaps the only person out and about in a remote community, you have to have a very broad range of skills—everything from treating a cold, treating trauma and giving vaccinations to delivering babies or whatever. I think it needs to be recognised that the people who choose to work in those areas are very special.

Ms HALL—Thanks.

CHAIR—Can I go to Peter Buckskin from the Department of Education, Training and Youth Affairs. Thank you for being with us and thank you for being so patient, but it is time we brought you into play, I think, on training and education. So over to you. You had some comments earlier that you would have got in if there had been half a chance—but you will play it the way you see it.

Mr BUCKSKIN—Firstly, can I be so bold as to congratulate you, Mr Chairman, and your committee for having this seminar as part of the process of the inquiry into indigenous education. As a Commonwealth bureaucrat, I tend to come to a lot of inquiries and Senate inquiries into the area of indigenous affairs, and this is the first time I have actually seen a process of a working group together on one day to focus on this very important issue of indigenous affairs.

Also, personally for me, it is good for my own mental health and social wellbeing, because I see around the room a lot of indigenous colleagues, which I do not get to see too often. Being a lonely indigenous bureaucrat here in Canberra, it is really good to see something like that. I have got you smiling already.

CHAIR—Well said.

Mr BUCKSKIN—I have some things which I think have come out of today which are also very significant for the portfolio I work in. If you look at some demographics, which I will just quickly talk about, and then the role that we play from a Commonwealth perspective in the area of delivering services to indigenous people in the area of education and training, and our contribution which we can make to the pre-surface and post-surface

postgraduate type work of people working in the health profession and the types of issues that Dr Strasser talked about in terms of that, I thought it was interesting to hear the gold-plated examples in terms of best practice and again to go into the area of training and development, which I think are issues our portfolio can talk about.

I have a paper—just over two pages—which tries to address the terms of reference that specifically impact upon my portfolio—that is, the need for improved education of medical practitioners and specialist nurses, and the extent to which health service status is affected by educational and employment opportunities. I will not go into delivering that paper and talking to it specifically; I just want, firstly, to talk a bit about the demographics.

In our communities, because we are such a young community in terms of indigenous Australia—we are 14 years younger than the mean for the rest of Australian society in that our mean age is about 20 years old—the work we do in our portfolio from the school sector to the VET area, to the higher education area and to the youth area is very substantial in terms of our interest in that particular area.

With the services that we provide, we impact upon about 150,000 indigenous people. We are also trying to impact upon that institutionalised change and the changes in the attitudes of people in our contribution to the reconciliation agenda within the school sector. We are developing a whole range of projects, endorsing learning and talking circles to ensure that we are sharing with lots of other people because, let's face it, 80 per cent of indigenous people in the schooling sector—that is very much like the statistics that you would use in health—are participating in, and going to, services which are delivered by government or non-indigenous community controlled organisations.

Clearly, the number of people who are accessing community controlled education—either at the school sector, the preschool sector or the VET area—is less than 20 per cent. Yet, we talked about accountability, but the levels of accountability that we place on those institutions that are community controlled are far more vigorous than those we place on our bilateral arrangements with state and territory governments. I am pleased to see that that is changing.

I will leave demographics there, except to say that we also need to concentrate on, and acknowledge, that we have made major progress. I will leave you with one single statistic which will help you focus on the fact that there has been some movement in this area. For example, the retention rate was about nine per cent, and now it is about 33 per cent. That shows amazing growth over the last 10 or 12 years in Australia. My generation has probably had better access to education—I would not say appropriate cultural education—than, say, my parents. I remember my mother telling me many years ago that she had no access to education.

You can see that in terms of the retention rate we have come a long way, considering all the obstacles which indigenous Australians have had to overcome to participate. There are some correlations in the area of indigenous health and access to services. We talked about databases and about not having an appropriate database. It has been only recently—probably over the last five or six years—that we have started to collect appropriate data in the area of education to identify what the problem really is rather than just being anecdotal to drive

policy initiatives. I think, from what I have heard this morning, the same issue is there for health.

Clearly, we hope that work done by the Department of the Prime Minister and Cabinet in the area makes sure that the ABS examines data collection more closely and that statistics analysis is progressed more swiftly so that, in the future, we can have better information before us. It also needs to be taken into account that a lot of our communities are sick of being researched and statistics being counted. Our communities need to understand—and I say it to the communities that I work in—that we really need that database to actually drive policy and to identify the many issues.

We are a purchaser of services, like most other Commonwealth departments. Therefore, there is a high level of risk associated with the purchasing of services. You really need to have in place a pretty tight risk management regime to identify how you will ensure that people actually achieve what their targets are in terms of their bilateral agreements.

I hear, from this morning's evidence, that you have a whole range of acronyms in health, just like we have in education—such as AHMAC, the Australian Health Ministers Advisory Council—where there are these bilateral agreements. Clearly, in that, we need to ensure that there is a process where you can measure performance growth in this particular area and then have strategies in place that do not use punitive measures to attack systems that do not progress as fast as they could, because there is a whole range of other things that impede upon the achievement of targets in the area of education, as I am sure there must be in the area of health. If they are not actually achieving what they are saying they do, then let us look at the strategies which they are adopting and then try to address those so that they are much more relevant.

These agreements also clearly need to be done in an agreement context of a tripartite arrangement rather than a bilateral arrangement. The third party clearly needs to be indigenous Australians. In most instances, we are not an equal partner because we are not perceived as important. Usually people are more interested in two ministers getting together and signing off rather than chairmen of Aboriginal organisations or chairpersons of ATSIC regional councils, et cetera. So we need to ensure that that partnership and that relationship is on an equal basis. I know that we are working in the area of education to achieve that.

We talked a bit about community control this morning and, as I said, we have a whole range of bilateral agreements with states and territories. Because 80 per cent of our people are in a system or getting a service from non-indigenous communities, the indicator there is more about proportion of people in terms of what that service is providing who sit on government education boards, or councils that advise ministers, or councils that develop curriculum of accreditation type organisations. In proportion of the population of the state we need to be involved on the mainstream bodies that are delivering services in the area of education.

From we have learnt we have seen that now, because of these bilateral agreements, there are more Aboriginal people involved in accreditation bodies around states and territories and curriculum corporation type activities in terms of the development of curriculum. They are

there as a representative of their communities. They have different processes to select people to be on those types of mainstream boards.

At the same time, we have a whole range of independent community controlled preschools, schools and VET sector providers. Some of the famous ones in the VET area are things like the Institute for Aboriginal Development in the Northern Territory and the Tranby Aboriginal Cooperative College in New South Wales. They are totally community controlled. We support that 100 per cent. Our funding arrangements ensure that they get a higher per capita rate than we provide to the government sector.

In terms of the government sector, we say to them, 'You have 80 per cent of our business, therefore you need to ensure that your decision making processes reflect the population of the people that you are serving.' Most people are actually fulfilling that type of target around states and territories. An indication is that three of the people who are sitting here are executive directors of indigenous health in their state or territory government. No-one would have thought of that 10 years ago. That is progress in itself. We have Ngaire Brown here, a doctor associated with the AMA. These are examples of achievement, despite what we have heard about this morning, that again we have to build upon.

In terms of the gold-plated stuff and best practice, we really need to ensure that we do promote this, because some of the things that we started hearing about today, we are all concentrating on what is not happening rather than what has progressed and what has happened. I think we really need to ensure that that continues.

We are promoting a lot of best practice in our work. For example, one of the best practice methods is the work with the Menzies School of Health Research in Darwin. We are looking at appropriate models to address otitismedia amongst young people, to start addressing it as an educational issue, and learning issue, as well as just a health issue, and give teachers the skills to identify what otitismedia is, and then develop teaching strategies to overcome that, considering it might take a longer period of time for the child to be physically better as a result of the treatment they are getting from their local medical service or health service in their communities. That is just an example in the school area.

The last thing I want to talk about is training and professional development. Clearly, we need to do more in the undergraduate work and the same goes for Australian teachers. You just cannot have one six-hour subject or one four-hour subject in terms of your undergraduate teaching qualification, or, indeed, in your nursing or doctor studies. If you do that people think that you are competent enough and have an understanding of the needs for indigenous communities. Those courses need to be absolutely essential and a compulsory part of undergraduate work. Until that is, that will be the elective that people will not elect to do. Because there is already an overcrowded curriculum in Australian universities and in Australian schools, it is easier for a lot of non-indigenous people not to pick that one up because they do not have an interest in it. That is a really important issue in terms of undergraduate work.

The government funds through my department 15 universities across Australia that provide a significant contribution to teaching and learning outcomes that are related to health worker training, nurse education and young doctors. Also, I understand from University of

Western Australia that they are into dentistry. So we are progressing that through our higher education programs and through other indigenous specific programs, and we are going to build upon that.

In regard to postgraduate work, the first Howard government announced six key centres in higher educational institutions, and one of those was for James Cook University to look at health and a partnership between Queensland University and another university. I am just looking for my list of what the subject area is. We are looking at the development of best practice in terms of ensuring that non-indigenous people, as well as indigenous people, are getting the benefits of more appropriate training in this particular area.

Dr Strasser talked about professional development, and there is a real tension here between the programs that I have responsibility for and the programs now that the Department of Employment, Workplace Relations and Small Business provide for under their Aboriginal training schemes. My department is involved in a couple of projects which are in place and are associated with workplace issues and the professional development of health workers to which we are contributing. It seems to me that a lot of those things go to professional development and the continued maintenance of training and updating of training, which is not really the role of my department, because we are actually into providing undergraduate or postgraduate services.

Indeed, if part of your employment is the Department of Health, New South Wales or the Department of Health, Northern Territory, and if you are enrolled in a postgraduate course, one would argue why should Abstudy pay for it or why should the Commonwealth pay for it, when you are an employee of that particular organisation? We would argue that in the career path planning of an indigenous person in your workplace, shouldn't you ensure that you have the wherewithal under the ongoing professional development of your staff to ensure that you can pick that person up? We would like to see our monies being used more towards ensuring that undergraduate work, so that doctors are coming out much more inclusive of the issues that impact upon indigenous people.

We are working with the DEWRSB people. We have a memo of understanding with them, and we have had initial meetings with the office of indigenous health in the Department of Health and Aged Care. They are the people who assisted us in getting involved in that training of people who are already in the work force.

Lastly, can I say in terms of workplace issues, again we have attention there in terms of that ongoing professional development of staff. It would be very difficult for us to be funding such activities, unless we would want to be creative—dare I say—and say that we would pilot such activity to see whether it demonstrates best practice. We would be negotiating to ensure that it can be sustained, replicated or duplicated within the organisation to which we would be piloting or outsourcing that pilot to.

Mr Chairman, I will be quiet there and say that is our contribution. You can read through our paper. Everyone has got it today, and there are further examples of the work that we are doing in the area of indigenous health. It is not that much, and clearly talking today and hearing people's responses to the questions that you put to them today, it has given me the incentive and inspiration to be a bit more pro-active from my department's point of view,

and to be more collaborative with my state and territory colleagues and with the other Commonwealth departments.

CHAIR—Thank you for your comprehensive presentation.

Dr STRASSER—I think one of the difficulties that I have here is that there is so much to tell you in just a short period of time. It is great to hear all of the different bits of information. I am making notes of names of people to contact next. I would like to clear up a few things. One is about the gold plate practices—that is what we are striving to achieve. I cannot say that we have got somewhere labelled quite yet but we are aiming for it. The other thing I thought that I should have said was that the curriculum that was developed in partnership with NACCHO was only introduced into GP training in 1997. We did not want to leave anything to chance. It is a compulsory component of GP training. That is why we have got good figures of people going through it. The issue really is that it does reflect the best practice and we would like that experience to be used with any patient regardless of where they come from. Unfortunately, it is a case for some people of only raising awareness and not changing attitude, but the more they hear it the more likely it is that eventually they will change their attitude as well. When it becomes a common practice then people will pick them up and we just have to persist with that. So you will still get GPs out there who do not have an understanding, but it would be crazy to drop it at this stage. It is just one of those other avenues of attack that we have to keep going.

I think in the undergraduate system there is an increasing amount of orientation or re-orientation of the curriculum to address Aboriginal health issues. In particular I am involved in the Monash course which is changing from a six-year to a five-year undergraduate course. We are radically changing the curriculum there. They have innovations coming up all over the place. For example, there is a Matthew Campbell prize. The delight of one young medical student—she was actually an Indian student herself—talking about an experience when she went to an Aboriginal health community. For her to come back and tell this large audience that she was called ‘chocolate bean’, because she was darker than the people that she was actually dealing with, just opened up people’s eyes and a different world for them. It led to a lot of interest and more electives and so on.

The hospital situation is dire. The hospital is notorious for teaching learned helplessness and is not conducive to learning general practice and so it is even less conducive to learning about Aboriginal health. I have made reference to that in my paper.

CHAIR—Thank you.

Ms ELLIS—Going back to Peter Buckskin, you refer to the Ministerial Council on Education, Employment, Training and Youth Affairs meeting in April in your paper. You give us the terms of reference which include:

Strengthening links between education/training and community development and identifying the implications for employment, health and housing . . .

I want to go back to Professor Torzillo’s presentation earlier this morning about housing and basic infrastructure leading to better health of community. What thought, if any, has your

department given or would you give to the consideration of basic training within remote communities of community members to enhance the maintenance of the infrastructure that is provided to them? Bearing in mind that I am not necessarily implying that we need fully qualified, as we understand in non-remote communities, apprenticeship graduation because the facilities are not there to provide that. But is there a way of coming up with some creative scheme to encourage and offer training at that level within those communities?

Mr BUCKSKIN—The MCEETYA decision established an indigenous task force to report on some parts of it at the end of this year and at the first meeting of MCEETYA next year. One of the subgroups of that task force is chaired by the Northern Territory Deputy Secretary of Schools Education, Katherine Henderson, who is going to be looking at ensuring that we can achieve some better linkages in a concrete strategic way.

In terms of what the Commonwealth does now to achieve that type of infrastructure and training, already through our MOU with DEWRSB—the department is new—we have got programs in place through the DEWRSB indigenous programs area which has a serious responsibility in terms of training. I understand that they have been working closely with ATSIC about assuring that there is appropriate training infrastructure on top of ensuring the CDEP people, for example, get training. That is where they are going.

In terms of my department and VET, we get into ensuring that young people are involved in things like school to work issues and VET in schools. We have already got some projects in the Northern Territory. One is at Port Keats where we have funded school to work activities where there is the basic training you are talking about, getting young men and women associated with some infrastructure work and general maintenance training. These people start around about the 15- to 18-year-old age group. Again, we do that in partnership with what the state and territory systems are doing in some of these remote communities. They want to offer curriculum for people that are post compulsory. We could bring in the school to work and the VET in schools for our people, which is clearly a better methodology for a lot of people. I can say that a lot of our people that are involved in VET in schools that are indigenous tend to stay on longer because of the methodology and the way they are treated. We could bring that down to a more junior age of about 13 so that the whole compulsory use of secondary education could be, in terms of approach, a VET in schools type methodology that you would teach these young people. These are the two areas that we were pursuing to provide training in community development. I mentioned also young women. There are other things that people also want to do such as being involved in other community activities—you look at the community store, the health centre, the school itself and a whole range of other things. We are trying to be diverse but we can only be as diverse as the community's readiness to want to develop programs in those other areas. Again, it is necessary to that infrastructure to have someone in the store, health centre and school to be able to assist the education department as well as the Commonwealth to ensure that the money is used for that appropriate training.

CHAIR—Thank you. I am going to hold Harry and Jill for a bit. I have to go to Brendan straight away. I am going to run out of time and Brendan's experience we respect immensely on the infrastructure issue.

Dr NELSON—Part of what I was going to ask, Annette asked, but I wanted to come back to Paul Torzillo's stuff this morning and perhaps firstly Peter or John Delaney might give us a thumbnail sketch of how Aboriginal housing is currently funded and provided in remote communities. Could you for the benefit of the committee tell us that and I have got a couple of things I would like to ask.

Mr TAYLOR—That is not a simple question. Broadly speaking in remote Australia, indigenous housing is community controlled and owned. A lot of it obviously is constructed on indigenous community owned land and hence in a formal sense the ownership and the title to the property vests in the community organisation. In many cases, for housing, the direct responsibility in a legal sense for recurrent management and maintenance of that stock vests with the formal incorporated community organisation, either a local council, an indigenous community, the government council or an incorporated body that owns that land title. Likewise they quite often own the associated infrastructure of water, power and sewerage systems. I have to say there is a fairly complex network of relationships between the local community organisations, ourselves and state and territory agencies in relation to the roles and responsibilities for recurrent management and maintenance of housing and particularly the associated infrastructure. It varies significantly from state to state. It would be impossible to give you a thumbnail sketch of each of the jurisdictions because it does vary significantly across each of the states and territories depending on historical relationships between state and territory and local governments and Aboriginal communities and the nature of those communities themselves and the form of their particular title.

I certainly can provide more detailed briefings than we have provided already, if you want—quite a detailed understanding of the roles and responsibilities at the community level, which is where we think a lot of the key strategies need to be focused. But they do need to bear in mind the complex web of relationships between local community organisations and the range of Commonwealth-state funders and providers. If you like, we can talk about a couple of specific examples which might flesh it out a bit. That response might sound a little nebulous, but it is quite a complex set of relationships.

Dr NELSON—Is that set of relationships militating against improving what Paul and Fred Hollows have described as the health hardware in the housing sector?

Mr TAYLOR—To an extent, and I think that over the last four or five years some considerable progress has been made to try to reduce the number of players, particularly at the local level, and to streamline funding flows. On the housing side, we have struck bilateral agreements in most states and territories to try to integrate the planning and funding processes to communities. On the infrastructure side, likewise, in a few states we have managed to achieve much better funding and planning arrangements through integrating programs, particularly at the regional level. It remains an issue and there is a fair way to go to resolve that kind of problem.

The one thing I would say in this area is that we need to be fairly careful about what we are talking about in terms of repairs and maintenance and recurrent responsibilities. Paul, in his discussion this morning, mentioned a fairly long chain of connected elements in the provision of effective housing and infrastructure, from the fairly large-scale systems—bores

and generators—down to the questions of reticulation, through to how those services are actually delivered within a household or a living environment.

A lot of Paul's comments and a lot of the research that is done straddle those things, but as I said, there is a complex set of relationships at each part of the chain. In some states you will have different parties responsible for the larger scale systems doing regular repairs and maintenance to water systems and power systems and regular maintenance to sewerage systems. At the other end of the scale, you have got a question of who is responsible for recurrent maintenance of the housing stock at the individual household level.

Dr NELSON—Can you advise us on recommendations that we could make that would actually progress some improvement to those complex arrangements? You might have to take that on notice, and perhaps other people here with an interest in that should also do so, because that is the kind of thing that I think our committee needs to be thinking of advising the government to be looking at.

Mr TAYLOR—I think it is touched on in earlier briefings that we have provided, and certainly from Family and Community Services as well—that there is a range of quite well considered reform agendas that have been worked up between ATSIC, the Commonwealth and state and territory governments on the housing front, which will take some years to really bite and to be delivered effectively. On separate fronts, we are negotiating another set of reform strategies on essential services. There are still considerable outstanding issues in terms of Commonwealth-state funding roles. For example, in water and power, there are a number of states that simply do not think it is their role to provide subsidised power and water to rural and remote Aboriginal communities. That is a political fact that we have to work around. So yes, I think we can point you to reasonably well developed strategies that are either in train or about to be committed to by ministers.

Dr NELSON—And ideally, what you think should happen. What is politically or practically possible is perhaps another matter, but please tell us what you think should happen. The second matter is: John Deeble has done this comparative study in terms of health expenditure; is there any sort of comparable study in the housing sector?

Mr TAYLOR—There is some useful data about expenditure in the housing area. ATSIC recently has undertaken a survey of recurrent expenditure on water, power and sewerage in remote communities. That is about to be published. I think we have already provided a draft copy to the committee in an earlier form. That is certainly available. It gives you a detailed picture of who funds what in terms of water, power and sewerage systems across the country.

Dr NELSON—In terms of public housing, which is essentially what we are talking about, in remote communities—

Mr TAYLOR—Community housing rather than public housing?

Dr NELSON—Yes. For example, my friend Harry Quick has a couple of large public housing estates in his electorate. Is there any study that compares the amount of money

provided to indigenous people who require housing compared to non-indigenous people in similar circumstances who require housing, as John Deeble has done in health?

Mr TAYLOR—The funding systems are quite different. Yes, there is data that shows the level of indigenous access to public housing, their extended reliance on community housing, private ownership and reliance on private rental accommodation. ATSIC has done analyses of census data, the 1995—

Dr NELSON—The point I am trying to make is that when you go to Maningrida and there are 54 people in a three bedroom house, you do not see that in Gagebrook, which Harry looks after, even though people are poor. Is there a study that compares dollars spent in terms of need for housing for indigenous people versus non-indigenous people?

Mr TAYLOR—There is a reasonable amount of data on that front. What ATSIC has said about that for a number of years is that there is a need for Commonwealth and state governments to more strongly target public and community housing provided through state and territory governments to indigenous needs. Recent agreements between ministers have started to achieve that through Commonwealth-state negotiation processes.

Mr DELANEY—The lessons learnt over the years are like every other aspect of Aboriginal affairs—we have been taken for a ride to the extent of design and construction of houses, wherever it is, whether it be in Ramingining or Redfern. If you look at the public housing equivalent, you will find that, in the western suburbs of Sydney, where public housing is a fairly substantial part of the community, those houses are suffering the same consequences of being built by bad, unscrupulous construction bodies.

ATSIC, over the years, with DAA and ADC, have learnt the lesson that the principle here is the development of bilateral housing agreements signed off by the states and territories, so that we have got Aboriginal boards that run the things and which will be a lot closer to the action than any government authority has been in the past, to ensure that adequate and suitable housing is provided.

If we go back to the situation in New South Wales, I can mention Cummeragunga mission, when I worked for DEET under the housing and apprenticeship training programs. Those houses were designed by the community, for the community. We did not have those standard three bedroom houses like I had to live in, in public housing. Some of the houses there have six bedrooms and they are fairly liberal bedrooms but they have been taken care of.

What we intend to do in the future with the bilateral agreements is to ensure that appropriate structures are put in place by credible building and construction firms who might be able to dip into programs that Peter was talking about, and also the ones that Paul was talking about this morning, to ensure that there are ongoing maintenance processes. We might be a little bit behind the times, but the fact is that ATSIC regional councils have only been in existence for almost nine years. We are working on the system. We have seen the problems in the past. Again, we have seen a lot of non-Aboriginal entrepreneurs walk away with pockets full of money, leaving fragments of what is supposed to be a livable house. We are working on those things and we can assure you that we will provide this committee—

Dr NELSON—I am not criticising ATSIC.

Mr DELANEY—I am not defending ATSIC to that extent. I am just saying that the process in the past has been a learning curve for everybody, not just ATSIC. It is a housing, construction and development process, and we have learnt those lessons and will take it from there.

Dr NELSON—The point I am trying to make is that if there are 40 homeless families in Yuendumu, nobody really cares too much about it. If Harry has one homeless family in his public housing estates, it is on the front page of the local paper. You can mount an argument on the basis of John Deeble's work that we should be spending more money on Aboriginal health; how we spend it can be argued. We do not seem to have the information that enables us to mount a similar argument in relation to Aboriginal housing.

Mr SMITH—A big body of work has been done by the Commonwealth-state working group on indigenous housing. A lot of that work is coming to fruition now. Included in that work are documents in regard to a 10-year future vision for indigenous housing; work on how to measure housing need—there has been a lot of work done in regard to that; a large body of work has been done in conjunction with Health Habitat in the development of a framework for sustainable healthy housing, as a guide for all states and territories.

Basically, what Peter is saying is that there is, from an ATSIC, a FACS and a state point of view, a lot of material that can be provided to this committee. There has been some information that has already been provided, and part of that is a measurement of housing need. It was done once by ATSIC in conjunction with Roger Jones and it has been done more recently by the Commonwealth-state working group—again, in conjunction with Roger Jones. That was a measure of homelessness, overcrowding, measures of lack of services and lack of maintenance and affordability of housing. That work is available.

Mr TAYLOR—Just to respond to Dr Nelson's broader question about why there is not a political urgency about this matter, which I think is what he was asking, we certainly see it as a matter of political urgency, but there seem to be certain political barriers beyond which we cannot push.

Dr NELSON—That is exactly the point I am trying to make. We need to make recommendations as a committee that will move those barriers back, and be prepared to do it. What you are doing, with the greatest respect, is that you are talking to me within a bureaucratic framework. What we are trying to do as a committee is break out of that. I know exactly what you are talking about, Barry, and I know what you are talking about, Peter, but we want to make recommendations to the Commonwealth of Australia which push those political barriers back.

The last thing I wanted to say is that we have got Aboriginal health workers who are obviously not doctors or nurses. They play a critical role. Is there a place for some kind of Aboriginal housing maintenance worker and a career path for such an individual, with the communities being able to cash out their VET funding so that they can purchase those kinds of services when dwellings are being built in remote communities?

Mr QUICK—Following on from that, I have got a question for Peter.

CHAIR—Before you do, Harry, there are two in front of you. Brendan needs a response to that last question, don't you?

Dr NELSON—Yes, or take it on notice—one of the two. It just seems that there is a model in health that I think can also be applied to the housing sector.

Ms GREEN—I do not want to respond to the cashing out of VET, but there is a national environmental health strategy going to AHMAC on the 29th of this month, and in it there is a range of issues being discussed. One of those is indigenous environmental health workers and the role that they would play in housing. One of the main things that it is going to be looking at is developing nationally consistent housing and infrastructure standards for remote communities. At present, there are no standards, so it is no good getting people trained in what to look for if there are no standards to measure them by.

The other matter is consistent competencies for environmental health workers. The list goes on, and it is all in the paper that I have provided today. But if we take on board the national environmental health strategy, and indigenous environmental health is one of the top six priorities of that strategy, and really follow through with it, then we will answer some of the questions that you were asking.

CHAIR—You have a great disadvantage—you are a member of parliament. That is the trouble!

Ms ELLIS—I just want to follow up on Brendan's aggression. As a committee we know that under the Commonwealth-state Medicare agreements we get a figure understanding indigenous versus non-indigenous access to MBS and PBS. There are also Commonwealth-state housing agreements. What I am asking and what Brendan is asking is: is there a figure that tells us the indigenous and non-indigenous access to housing money? It is as simple as that. That is the question that we are asking.

Mr HOUSTON—The issue that Dr Nelson raises is an important one. We do not need to reinvent the wheel. This is an opportunity for Western Australia. Western Australia has 65 Aboriginal environmental health workers, who are competency based trained, working in the employment of Aboriginal community controlled organisations delivering the sorts of services that you have asked for. They have a career structure in place. So it seems to me that there already is an example of what we could and should be doing. There are also agreed standards in respect of housing and infrastructure that were put out by the Northern Territory and that are currently being finalised in the west. So there are standards. There is work being done. It is a question of how far we make it stretch.

CHAIR—Thanks, Shane. Puggy?

Mr HUNTER—I have been involved in housing for years. The idea of trying to have an Aboriginal housing authority with the same sort of thinking as the Aboriginal medical service has always been based on the same principle, that housing and health in a sense are together. The point is that my experience in Western Australia—I must say Western

Australia again—is that that is exactly what the community wanted to set up in the first place: a housing authority run by the Aboriginal community so that they can have a say in the process that surrounds the money that comes across from the Commonwealth through grants. What has happened is that they have had to settle for a Clayton's sort of agreement in the sense that the state still holds the power over where things go. We just finally put the framework agreement with ATSIC in this whole partnership.

The whole thing about it is that there is not enough money, first of all. I agree with Brendan that the same principles could be applied on cashing out, the same thing that we are talking about overall. It just so happens we have just done our health plan for the Kimberley. We have done all the housing side of things. To give you a snapshot on the Kimberley housing problem, there is about a four-year wait, a four-to six-year waiting list in Broome. Good luck if you want to hang around that long. We looked at the number of people getting born in the Kimberley. Just looking at the Aboriginal population alone, they need to build 70 houses a year to keep up with the population growth in the Kimberley. The state housing authority builds around 35, so they are not even keeping up with the actual rate of growth of the population, let alone trying to catch up. The catch-up rate we did for Kimberley planning, under the health bucket, is 700 houses, counting all the people round there and the amount of houses.

We went around and did the housing survey when they were asking our mob, 'Do you want a house or a medical service?' That is the sort of thing that people had to decide between. I agree that when someone is without a house somewhere there seems to be a great jumping up and down, whereas people live in these conditions here of 700 people and 40 houses. That is common knowledge. They said there is $1.4 billion to catch up on housing nationally.

The real issue belongs to the government. If it wants to actually address some of these problems we keep talking about, at the end of the day it means dollars. Disregarding what colour we are, we need money. From where in the community are we going to get that? We are the ones who come up with the numbers. Talking about the medical services and any other service out there, it is all right training up health workers to be aware of all these problems, but, if there are 20 people living in a house, what can you tell someone every day—that the house is overcrowded, that the toilet is going to block up in a week or so, or not even that? It is just impossible. Where the balance is, I do not know.

CHAIR—Thanks, Puggy; that is great. I have to mop up three things and then we have to break.

Ms HALL—I am going to ask all my questions in one go. To Peter: what is the unemployment level of Aboriginal people?

Mr BUCKSKIN—I have moved from the department of employment—

Ms HALL—I know.

Mr BUCKSKIN—so I do not know. That question needs to be directed somewhere else, not to the Department of Education, Training and Youth Affairs.

Mr TAYLOR—It is about 32 per cent.

Ms HALL—You say that the retention rate is 33 per cent. The retention rate for all students is around 37 per cent. What is your retention rate for—to what year? It is not even 33 per cent.

Mr BUCKSKIN—Year 12. The retention rate to year 12 is 74 per cent for all Australians. What I was trying to suggest is that within 10 years we have closed the gap at around 20-something percentile. We know that to get to the average we need another 40 per cent growth, so we are just showing how far it is behind. Again, the retention rate for non-indigenous children is also dropping because, before, it was even higher than 74 per cent. What I am suggesting is that we can actually change the level of retention. You do not have to wait another 10 years for that to happen. I think that that can happen in a shorter period of time. I gave an example showing that there has been an amazing growth, considering the low baseline to which we have come within less than 10 years.

Ms HALL—I just found it strange that you were quoting a retention rate that was higher than the school my children went to. But my real question, Barry, that I have been waiting hours to ask is: how does the unemployment level—and I would be interested in the opinions of everybody here—and the inability of Aboriginal people to find jobs contribute to their overall health and wellbeing?

Ms GREEN—Can I answer that quickly from my perspective? I am the mother of five children, and one of those is 13 years of age and has not been to school in two years. I can take you out of this building now and show you 20 kids under the age of 13 who are sitting around the parks. They are not going to go to school and have not been to school for a long time. If you take that into account, there are 20 kids who, in five years time, are not going to be employable and who are going to always live in poverty. In the meantime, they are all involved with drugs and they are all breaking into houses, because it is a cycle they get involved in. They get involved with the wrong type of people while they are out there and then they get caught up in that system.

I can tell you now from actual fact that it is our Aboriginal kids who are being influenced by the bad white element, particularly in this town. They get the Aboriginal kids to do the crimes for them because they cannot go to gaol for the things that white adults can. Unless we worry now about employment and all those sorts of things that keep our kids in school and make school accessible and interesting for them, we will be sitting here talking about unemployment rates until we are blue in the face and on crutches.

CHAIR—Good comment.

Mr HUNTER—Taking up the point of the CDEP business, it is the same thing again: CDEP in a sense is a decision on health and the government's idea of trying to solve the issue of some sort of employment. The reality is there are no jobs out there. There is an idea that we have the medical service around the country as an employer of lots of Aboriginal people and also lots of non-Aboriginal people. In some of the communities it suits the policies of CDEP, it is really how that community can utilise CDEP. That is really up to that organisation and that community.

What I have heard from talking to a lot of young people in a lot of the towns and places out there is that they want something better than CDEP. They want some sort of future through that process. I have gone around to communities and spoken to some young fellows that have been looking after full sewerage systems for communities for three to four years on CDEP, with a bit of top-up. Their trouble is that they cannot go anywhere else but have to stay on that community because that is the only place that is recognising their skills in that area. They are stuck there forever and they are stuck in that situation. The responsibility of doing some of these things impact on these young people out there. First of all, why are you getting onto CDEP? But, before that, there is always the education system.

I know the education system. Again, I am talking about Western Australia and the snapshot they did of the education level up in my area. It shows that we are pretty behind the eight ball. The sad part about education and employment opportunities is that they are still producing kids that are worse than me or the same as me when I came out—and I am not some sort of Rhodes scholar. How come, with all the amount of money that is going into the system, they are still producing kids that cannot read or write properly? How the hell can they expect that the schools are not being held responsible for the amounts of money that they get through our ASPA programs, through all the so-called assistance, and that these things are not reflected in a lot of our areas?

We looked at all the young people coming through high school in Western Australia in a certain year. Only one or two students were able to go straight into university. We had this tendency for all Aboriginal people, once they wanted to go and do a course, to have to go and do bridging courses. We might as well have a year 13 for us mob because we all seem to go off and do a bridging course because the system has not fixed us up through primary school or high school. CDEP is something that needs to be looked at properly, but in some of the towns these young people want something better.

CHAIR—Thank you, Puggy.

Mr HOUSTON—A study in Queensland in the last two years drew absolute links between the issues of employment and health status. In the international literature, there are scores of reports which go to that. The other thing I want to say is that I would caution people that they need to be concerned about magic bullets. Education or employment by themselves are not the answer. It is a question about developing a well-coordinated matrix of services which would tackle the problem holistically.

Ms HALL—That is what I was hoping to hear.

Mr BARCLAY—I have a very short comment about comments that were made this morning relating to accountability. I am horrified that anyone should consider that there is less accountability or less possibility for accountability—and this is leaving aside any legislative requirements—in regard to the cashed-out programs as opposed to grant programs. I believe that this is just not true and cannot be supported. We can put in place any number of accountability requirements. It does not take much wit to work out what is required. In our particular case, we are a private company. We have a 19-man board of directors, and every one of those directors has had to be informed very closely as to what their

responsibilities as a board director really are. This in itself is a form of accountability through the SEC.

I think we have got to get beyond this old public service way of thinking into something just a little new. We can put these things in place and they can be done easily, with proper training. There also has to be a level of trust that is given. Monitoring of management can easily be put in place as well alongside this degree of accountability. I just want to make that point: there is no lesser accountability with cash out than there is with grant schemes.

CHAIR—Thank you. I would like to make a quick pronouncement on what we are going to do when we come back from our short break. We have to start coming up with what our solutions, our approaches, our recommendations are going to be centred around. If you look at the six terms of reference, health is mentioned in every one of them. We know that it is holistic, we know that there is a fundamental issue, we have talked about infrastructure, about the health professions and training. We can go through the whole lot. To me, the tension is between how much you focus on those very specific health issues or on the broader range of issues. That is the tension that the committee is going to have to deal with. I am going to look to you people to help me resolve how we focus on that which is the most urgent and to give us some guidance on the direction that we should take over the next six months.

Proceedings suspended from 3.36 p.m. to 3.50 p.m.

CHAIR—We have got about six months work to do. We have got another field trip that the deputy chair and I were keen to make.

Ms ELLIS—With others.

CHAIR—With others, of course. The information from today's gathering will be put together and we will peruse that and put it into discussion paper form. We will be going out into the community over the next three or four months and then sitting down and writing a report. That just gives you an idea. There is still this process to go through with the community which we are very keen to do. I must say that I have been delighted with the response of people turning up and giving so willingly. The other thing that really shows up is that many people have appreciated the opportunity of having a sharing of ideas as well.

I suggest that we might go around the table now and volunteer statements of just a couple of minutes each on how you see it. Before I do that, there are some practical things like time lines. I think Graham needs to go and I know that he has a specific question. I will structure it so that those who want specific things dealt with—questions and the like—can raise them now, we will then go around the table with everybody's comments in their two- or three-minute summary of the day and then perhaps we will sum it up with questions to each other. I will start with you, Graham, on that issue that you wanted to raise.

Mr EDWARDS—I want to come back to the question of Commonwealth-state and community agreements, and I want to specifically ask Helen this. Helen, you mentioned earlier the importance you put on regional planning. In part, I assume that is to involve the communities and to break things down to a manageable level in terms of service delivery.

But the thing people have said to us all over Australia is that it is fine to have an agreement but the moment the agreements are made, the indigenous people are left with the problem, as people who are parties to the agreement get up from the table, walk away and forget about the agreements. It seems to me that, if we cannot enforce and ensure that there is some accountability to implement the agreements and ensure that Aboriginal people feel that they are having some control, what is the point of the agreement in the first place?

I would like your comment on that and I would like some advice from you as to what the Commonwealth can do, in your view, to ensure that the states and the other stakeholders stick by the agreements that they make and do something about providing more than just lip-service to the partnership and ensure that Aboriginal people are actually—I do not want to use the word empowered—given some control over what is happening.

Mr BARCLAY—What is the matter with the word empower?

Mr EDWARDS—I will just read you something. I have been involved in a disability thing and I will just give you a view of what the word 'empowerment' might mean. It is:

Empowerment is a term that forms part of the rhetoric of politically correct professional language and thinking. Freedom of choice in the sense of being in control of life decisions are often cited as key factors in its achievement. Only people can empower themselves. Empowerment is the result of self-awareness, self-growth and resources—not the result of any particular program or service that might be provided.

This view involves a paradigm shift for many service providers and agencies who think they know best or that clients don't know what is good for them.

This report demonstrates people with longstanding disabilities have experienced a range of life experiences that hinder the achievement of empowerment.

That was in relation to people with disabilities and I suspect there is much the same view in relation to indigenous people. I am not trying to put you on the spot, Helen, but I would really appreciate your best view about this question.

Ms EVANS—I guess you are asking me to provide a brief answer to the Commonwealth-state relations issue which has, I think, challenged everybody since Federation. I would have to say I do not have a clear answer to it.

Regional planning, yes, I would put a strong emphasis on it because of the enormous variation across the regions. So I think it has to be done, and that is also partly to do with ownership. Things work on the ground and they feed on themselves, so if you have got successful collaboration on the ground and models that work, then the people on the ground are likely to be committed to making them work. I think that is really important as well.

We want an approach that focuses, as I said, on collaboration, competition and outcomes, not on who is controlling what; it is on the outcomes we are all aiming for. You are much more likely to get an agreement on a regional basis. So, yes, we do put a strong emphasis on it, and also on, I guess, highlighting and moving forward on areas where it is working. I think we need to look at where there is a capacity to make use and then have outcomes and then put quite a lot of focus on that, because there is a very strong feeling of negativity and

a very strong feeling in the general community that nothing is going to change and nothing can work. So I think it is really important to actually build on those areas and services that are working.

In terms of the framework, agreements are only pieces of paper and it is what they produce that is the value, but it has got to be collaboration. The Commonwealth has no power to require the states to do anything. The states will do their own thing, so it is only as good as the parties and how they can make it work. It is an issue that Puggy raises regularly and raised with the minister only the other day and, as the minister said, 'We have a federal system. I can't instruct the states to do anything much.'

That is not giving a very satisfactory answer. As I said, it is a matter of all working on it and keeping working on it. There is not one answer that lays it in concrete and then away you go.

You made a comment earlier this morning too that maybe we should look to the Commonwealth taking back its money and funding directly to communities. I would have to say that I do not see that as a solution, and I think a lot of people have provided comments that feed into that. A significant amount of the money that is now Aboriginal health money goes into hospitals.

Mr EDWARDS—I understand that, yes.

Ms EVANS—Hospitals are run by the states. About 73 per cent of Commonwealth money that is earmarked as Aboriginal health money is going either through the states to hospitals, et cetera, or through the MBS-PBS—which is only a small amount—and only 23 per cent of the Commonwealth's money is directly administered by OATSIHS. So I actually do not see that as a solution. It is actually not a way to go.

Mr EDWARDS—But you would see the reason for making that comment when, as I said, we picked up so much anecdotal evidence saying that Aboriginal people are not accessing the areas that the money is going to.

Ms EVANS—That is right, and I think there has been a lot of discussion about getting the mainstream services to work better. But I think there are a whole lot of different combinations, and that is on the ground, too. It is getting divisions of GPs where there are large Aboriginal populations; it is getting area health services; it is getting community control services; it is actually getting everybody to work together. I do not have any magic solutions.

Mr EDWARDS—No. I have just one more quickly, Mr Chairman.

CHAIR—You have got a bloke alongside you who is raring to go.

Mr EDWARDS—I will finish up here. For me it is the crux of the report in many respects. While the federal government might not have too many powers, it has one power that it has consistently wielded over the states, and that is the power of funding. I think that that is the power we have in terms of the recommendations that we can make about funding.

There is no way you can set up a dual system where you have hospitals for Aboriginal people and hospitals for non-Aboriginal people. No-one in their right mind would suggest that. The reason the AMSs are under so much pressure is that their people are not accessing the mainstream hospitals. It seems to me that it comes back somewhere down the track to the partnership agreements that are entered into in the first place.

CHAIR—That is good Graham. I think that it comes back to what Brendan Nelson was talking about earlier. We have the structure of federation but, as big an inhibiting factor as we might perceive it, it should not prevent us, at the very least, from challenging those impediments right to the border and beyond. That is the whole point of this exercise, that we should not in any way be timid or intimidated, or coy about saying, 'This system, this jolly beggar of a federation system, is not working based on these reasons.' If we end up only defining the federation, as you say, that has been there for 100 years, so be it. But in our recommendation we should push the reality of what it actually means.

Mr HOUSTON—I will just pick up a couple of points. One is that the partnership agreements were never meant to be a prescriptive document which bound people to a particular set of steps. They were meant to be a framework that provided the parameters in which players were meant to get together and actually make some difference. If there is one undeniable benefit that has arisen from the framework agreement in Western Australia, notwithstanding the comments about it being an absolute failure, it is that it has got people together. At six regional levels there have been six regional teams which have sat down and have started to do the job about planning, and you brought in mainstream community controlled ATSIC, AAD and other players into the arena. I think we have to say that that, in one respect, is a success.

The bilateral agreement was not a yardstick of specific measures which you must take. It was creating a framework of parameters in which people were meant to get together. Within that framework, there is always going to be the reality of difference of opinion about the merit or otherwise of a particular strategy. That is fine; we have to embrace that. We should not fall into the trap of saying, 'Because there is not unanimity about the benefit of that strategy, the system has failed.' I think we need to acknowledge that.

The other thing—and this is my personal point of view—is that you should be careful when you refer to the split here. Some people think that it is the Aboriginal people versus the rest. You have to remember that Tim Agius, Stanley Nangala, John Delaney and I are all Aboriginal people. We take our roles seriously, both in terms of our role in the bureaucracy and membership of our own communities. It is a question of the issues about the system and the community sector. It is not the system versus indigenous people, or Aboriginal people, just as one side.

CHAIR—I think that whole concept is very important, thank you.

Mr HOUSTON—Another point I think we need to make is that there is often the criticism that the mainstream is not doing its job. The fact of the matter is that $142-odd million is spent annually in Western Australia. I daresay similar and more money is spent in other jurisdictions providing tertiary and secondary level services to Aboriginal people. That has got to be seen as people getting a service. You cannot write it off as though it does not

exist. We have to accept that, in some measure—albeit five out of 10, or six out of 10, in terms of quality—some services are being accessed, and we have to accept that and say, 'Yes, that is true.'

What we have to then think about very carefully, though, is that the majority of the opportunity for gain in Aboriginal health does not rest in the secondary or tertiary sector. It rests in two principal domains. It is about getting right fundamentals that everybody can accept within the primary health care sector, and it is about getting the intersectoral domain right as well. I have seen various reports, both domestic and international, that suggest that the health system is in fact in control of about 40 per cent of the resources needed to improve Aboriginal health.

This morning Paul Torzillo pointed very clearly to the fact that, if we get the environmental conditions right, we will have a significant impact on the health and wellbeing of Aboriginal people. I know that in the west $11 million is spent servicing excess hospitalisation due to poor environment, and $6 million of that goes on kids under the age of five. If we can fix the environment, and fix the environment in which those kids live, we will have a significant impact on their services. If we are smart about how we do it, before the hospital system says, 'Thank you very much; we will take those savings and apply them somewhere else,' we can say, 'Yes, we will have those back, and we will now purchase other services that are about buying for Aboriginal health gain.' I think we need to put things into context and understand that Aboriginal people do access services. I am not saying that the services are perfect; they are far from it in many respects, but those secondary and tertiary services cannot easily be substituted.

It seems to me that the solution—if I can take one shot at the solution—is that we have to very clearly define the notion of the differences between our gap closing services, the purchase of gap closing services and the development of an investment strategy which is about building and manipulating capacity within the system to deliver a greater benefit to Aboriginal people. There are most probably five or six key domains I would point to. It is about: improving our revenue streams; getting cultural perspectives right; health information—and we have not had, as you have asked on a number of occasions, Mr Chairman, a debate or a discussion about health information—increasing access to services; buying the right sorts of services in the right locations rather than just allowing the historic model to dominate; strengthening those intersectoral linkages particularly and specifically, rather than as a blanket solution; and it is about reforming the health system. It is about actually reshaping the construct of the health system so that it delivers the sorts of programs required by Aboriginal people.

Mr DELANEY—I think, in all sincerity, that we would not get what we ask for and what we expect because we have been asking the same questions for yonks. But we need to look at what we have and work on the strength of those. I will talk about New South Wales because that is what I know most about. We have two bilateral agreements there. I can tell you that the housing agreement in New South Wales is no Claytons job—it is as good as we are going to get. When we got the land rights act in New South Wales in 1983, we all protested. We thought that was a Claytons one, but we have lived with it.

There are two of these bilateral agreements and they are signed off by ministers—state, federal and territory. I will speak about the health partnership. The majority of people sitting around the table whom Tim was talking about this morning are all Aboriginal people. Harry Quick asked how this forum could talk about Redfern representing Wilcannia. In fact, people from those communities sit at this table, so they can represent their community. There are about two non-Aboriginal people with speaking voting rights there; the rest of us are black. I am ex officio with my position as the health portfolio commissioner for ATSIC, and I speak with voting rights now.

What comes out of there and goes to the minister is determined by Aboriginal people—no-one else. So there lies an opportunity for us to put our case before the minister. The previous minister, Dr Refshauge, would sign off only on something that was jointly signed by the two groups: the department of health people—they are all Aboriginal coordinators—and Tim, head of the Aboriginal health branch. Andrew would just sign it and it was gone, because the Aboriginal people made that decision.

I will talk about the Aboriginal housing office. The housing office board is a 12-member board: six ATSIC elected representatives representing the six regional councils in New South Wales, and six appointees by the minister—all Aboriginal people—as well as the chair appointed by the minister. They are all our people. So the determination of decisions are going to be made by those fellas. We asked the same question as Graham did a while ago—and Helen can verify it—about the allocation of the money. You allocate the money to the state premiers or the chief ministers. Can't you put some proviso there to ensure that this element is included in that?

Obviously, Andrew Podger said the minister cannot wield sticks. We talk about the importance of Aboriginal housing, of infrastructure in line with health. So I think we have got two elements here. All states and territories have got it now. The Territory was working on the partnership long before Chief Minister Stone signed off on it. He was the last one to sign it. I am a member of the central Australian health forum and that is why I have got first-hand information on what happens.

The public servants and the community control sector being congress and the NTL service were working anyway. They were working along those lines and doing it jointly. While I might sound like a selfish old black man, I know how to fix the problems. You can jump up and down as long and as loud as you like but you are not going to be able to get that. We understand that. I am saying that we do have a platform here. We have Stanley, Shane and Tim sitting around this table. That is indicative of the whole process of the framework agreements. The same thing exists in the Territory and South Australia.

Our own people are entrusted. They can have their differences of opinion and there were differences of opinion around the table yesterday. But at the end of the day, they have got to come up with a solution that satisfies all of our community. From my involvement in political affairs, which has been fairly lengthy, this is about as good as we are going to get. So it is up to us blacks now to lay down the gauntlet and unify. Our representation to the minister in Queensland should be Stanley, Shane and Tim. It should be done in tandem with the community controlled health sector.

These fellas have got to get together, sit around the table and discuss that and come up with solutions for this body. You are not going to get it for ATSIC because we do not have a role with them. We have a strong role in the environment and the infrastructure. Dr Nelson emphasised that earlier. We cannot fix up the health of the community unless we do that housing stuff that Brendan Nelson and everyone else was talking about. We have got the formula there. It is up to us to utilise the strength of this committee to progress that a bit further for us and lend strength to it. Where the partnerships of bilateral agreements are flagging, that is where we have to lend the support. It is not wielding a stick, but it could be the chairman talking to the minister or to both ministers and then going to talk to the state ministers for Aboriginal affairs and the ministers for health or housing or whatever.

We are not talking about wielding a stick. We are talking about coming up with a positive solution that can be achieved within the parameters of the allocation of funds we have got now. That is my contribution. I have been studying it and Helen can tell you that I have had a lot of arguments with Andrew Podger about this whole thing. No-one has been more passionate about it than Helen, Andrew Podger and me. We have been trying to do something about getting this into gear and getting the activities going. We have been trying to get Puggy, Shane, Tim, Ngaire, Les and Stanley together so that they can sit down and tell the whole world what we need, because they have got it at their fingertips. If we do not take the opportunity now, we may never get the opportunity again. We have got it at our fingertips and it just depends on how we progress it. We have got to do it together. We have to come here and tell you collectively what we want. It has got to be a universal and unified opinion that we put on your table.

CHAIR—John, that is terrific, and the wisdom in those comments are well—

Mr DELANEY—There is just one more thing. In New South Wales as well, we have Aboriginal representation on the area health boards. There are 19 of us. I am on the south-west Sydney area health board. I am also a member of the Tharawal Aboriginal Corporation which runs the AMS there. We are able to develop local strategies here and we have local framework agreements. There is a medical service at Mount Druitt, developed with Wentworth in the Blue Mountains and Western Sydney. That is all there in writing.

We do rub shoulders with local practitioners. Some of those, certainly in south-west Sydney, are on the area board as well. So we do have a capacity there to talk to the professional people who practice privately in the health sector. We had a meeting in Queensland and spoke to Premier Beattie just after his election. I told him that he should contact Andrew Refshauge and have a look at his health formula. The housing agreement had not been signed off at that time, but Queensland is working on that.

CHAIR—That is terrific; thank you. Julie has not spoken all day; you might like to explain your perspective. We had a discussion earlier in the week. Maybe you could tell us where you are coming from.

Ms YEEND—Certainly; I will be very short because I recognise everyone has to go. I am from the Office of Indigenous Policy in the Prime Minister's Department, where I head the Reconciliation and Equity Branch. Within my branch, we have responsibility for briefing

the Prime Minister, the Minister for Aboriginal and Torres Strait Islander Affairs and the Minister assisting the Prime Minister on Reconciliation on Aboriginal health issues.

I only have half the staff resource looking at that, and the Chair, when I explained that, was a little surprised, but that is consistent with the Department of Prime Minister and Cabinet ordinarily briefing the resources in coordination with indigenous health. These are in Helen Evans's area and we liaise very closely with them. That is one side of what I do.

If I put my other hat on, I am also the secretary of the Council for Aboriginal Reconciliation. Many around the table might know that the council has recently released a draft document for reconciliation which, along with the words, has four strategies to advance reconciliation—one dealing with indigenous disadvantage. With that particular role, I was very grateful to be here today to hear that a number of people have suggested putting the responsibility for outcomes in Aboriginal health right down to the CEOs of particular organisations. That is one of the things that the council was suggesting might be a way forward. It was interesting to hear that the number of the things that had been thought of and that we had discussed with Helen seemed to be common around the table. I am very grateful for the opportunity to have heard what has been said.

CHAIR—Thanks Julie.

Mr AGIUS—Have you got any Aboriginal staff in your unit?

Ms YEEND—Yes.

Mr AGIUS—And what do they do?

Ms YEEND—There are two Aboriginal staff. They are in the reconciliation area: one looks at the sustainability of the people's movement for reconciliation; the other staff member is looking particularly at the document for reconciliation. So we have two reasonably senior Aboriginal members of staff. The proportions are not what we would like but, within this branch, it represents the general role in the community.

Mr HUNTER—Having had a broad overview, I will go back to Graham's question. I agree with what has been said about the so-called relationships between the Commonwealth and the state. From our point of view, we tend to rely on the goodwill of the states and territories to actually participate, and that is how it has always been. We are always relying on someone else, and that is still the same today.

The thing that has to be remembered is that these departments and governments have signed off on, on behalf of their state governments, an all of government approach. All we seem to be talking about are the health departments. I bring this up in Western Australia constantly—and Shane is well aware of this: how do those health departments impact on the other departments that are also supposed to have a responsibility for Aboriginal services? I do not see any avenue. I do not know if anybody else has any avenues within their state forums, because this is not only a health problem. I bring this up in Western Australia because we are supposed to have a department called the Department of Aboriginal Affairs—that is what it is called now, but it keeps changing its name. Years ago when it was

created, it was supposed to have a coordinating body within Western Australia. But we have never seen that and I live there.

There is still this question that I keep asking, and I get told the same thing: that the health department is looking after this, and that is fine. At the end of the day, the housing mob, the old aged mob, the pensioner groups, the women's groups and all these other services are all tied up together. They tell us that the governments have signed a bilateral agreement, or whatever you are going to call it, for this so-called all of government approach. Every time we put up the name Aboriginal, we end up back with OATSIHS, and we end up back with the Aboriginal affairs programs in our states.

I have made it quite clear—even at the state level with Shane, our commissioner and some non-Aboriginal people that are senior in the health department—that I do not see why the responsibility should be on only Tim, Shane, Stanley and the other people, because there are other parts of the departments that are responsible as well. I am still confused about what the government has signed off on; it was supposed to be an all of government approach. That still has not become clear when we are talking about housing, et cetera, because I do not see any area where we have made an impact. I have been involved in Aboriginal housing, and I know how it works in both Western Australia and South Australia. Those housing boards are very clear of their rights, and they will do what they want to do. We are going to be talking until the cows come home about the coordination of programs and things that affect our life out there.

So you cannot fix one part up and hope that someone else up the road will fix something else up. Take water as an example. Out there, a lot of our people are drinking water, but we do not know what they are drinking. They punch holes in the ground and suck the water out. There is no water testing going on out there. We have heard about all the border problems and about the communities that are lost within the so-called 'who is responsible?' business. We have heard about the issue of the oversupply of doctors in cities. I think it has already been said that there is no difference within the city or town, the Aboriginal population has the same restrictions. We have heard about the education departments and their responsibilities.

So if people think that somehow these things are going to work without some sort of progress to make them work, I do not think there will be any shift unless there is a major change and major recognition. Hoping for a change overnight will not happen. Those of us who live out there with these services are nonplussed. We try to get services to our people and—I do not know if people realise this—sometimes we provide the only services available to non-Aboriginal people. Some of our services have up to 40 per cent of non-Aboriginal people coming through our doors. There is no extra recognition for these expert services that they are getting. People mainly vote with their feet and they come to us. We have seen doctors in some places sitting down doing nothing because there are not many patients going there or there are too many patients.

We try and work out what is best for the community. We know that we do not have the powers to go around and tell the community to do that. We thought that was what the bilateral was going to do, even in a planning framework.

CHAIR—Thank you very much.

Mr EDWARDS—I just want to let people know that, while members have had to shoot off, we have the opportunity to read the *Hansard*. People who have gone will be catching up on that.

CHAIR—We are going to wrap it up.

Mr SMITH—I could just start by saying that, if you are going to have some points in your recommendations or frameworks—and this is not in any order of priority—I would imagine that there would be something that would talk about identifying and clearly stating linked or joint housing and health outcomes—not just about stock but healthy housing and health related issues. I would imagine that you would have something in there about not only articulating those outcomes but talking about some formal links between health and housing to overcome the fact that it does not just seem to work to have a good relationship. Sometimes it might need to have MOUs or some reason for people getting together and maintenance. There would probably need to be something in there that talks about a 10-year vision in regard to where we are going rather than just simply year by year and some goals you might be looking at having at the end of 10 years.

There needs to be something in there that talks about the rural and remote area issue, particularly the recognition that some of the only providers out there are the community sector providers. There needs to be a recognition of that, both in terms of monetary recognition and development of skills and a particular effort going into skill development, incentives and a recognition. There probably is a need for something on recognition and responding to the higher costs in rural and remote areas, particularly in terms of maintenance and management in the housing area. There is going to be a need to talk about how you identify need, how benchmarks are related to need and what are going to be agreements at a Commonwealth state community level in terms of those things in the provision of data.

There is going to be a need to talk about agreements. People have talked about bilaterals. A lot of the language today has been about partnerships and those seem to be trilateral partnerships—that is, between Commonwealth, state and community. The partnership language has not just been about purchaser provider—in other words, we work out what the programs are and you do it—but partnerships are really about jointly working out what is to be delivered. Those agreements probably are going to need to encompass some sort of annual strategic planning process, so that you have the words but also have the annual action as well, which is linked to your 10-year vision. The partnerships are going to be need to address duplication at Commonwealth-state level. That is a way of addressing duplication by building partnerships. Picking up what Puggy was saying, you may want to think about: does this committee want to confirm the December 1992 COAG statement about coordination and service delivery to Aboriginal and Torres Strait Islander people? Those are the seven elements that I would see.

CHAIR—That is terrific, Barry. Thank you.

Ms O'KEEFE—I have some comments too and they are in a totally different vein. I would suggest culturally appropriate health care program provision with a focus on

prevention. The committee should look at the Ottawa charter on primary health care, which provides some principles surrounding this, and the Jakarta declaration, which gives some strategies to achieve this. It is a multi-pronged document that deals with primary health care from a number of levels and is probably applicable to all of the areas we have discussed today.

I would recommend that the committee look at the grassroots upskilling of the indigenous population to deliver non-formalised primary health care information, including how to access current services. I recommend that there is an uptake of the use of nurse practitioners in all areas, particularly remote and rural, as an adjunct to other services. The community needs specific programs run that are community controlled and an increase in resources. By an increase in resources, I do not mean posters, pamphlets and stickers because there is an overabundance of them. I mean people and feet on the ground where we need them, whether they be people who are specifically trained in the area formally or through an informal process through whatever avenue.

Just to reiterate, there is need for staff attraction, retention and appropriate remuneration. One of the words that was discussed is 'kudos' for working in the bush and in rural and remote areas and some recognition of the hard work that is going on out there by poorly resourced services.

CHAIR—Terrific, thank you.

Prof. TORZILLO—I would urge you to look at some of the reasons that previous reports have failed. One of the reasons that lots of previous reports have failed is that they have been huge documents, poorly focused, that were discussing a whole range of defuse issues and trying to take account of everything that anyone ever said to them. I would urge you not to do that again. I would urge you not to go looking at a whole range of documents internationally and repeating stuff that is written a million times. I would urge you to focus on a few key outcomes which you think government will influence. I think there are a lot of things discussed in the second half of the day to day that, with respect, you will have almost no impact on whatsoever.

The second principle I would urge is that Aboriginal health for the last 15 years or so has been bedevilled by discussion about structure and process at the cost of discussing outcome. The way to get around the mire of problems about structure and process and agreements is to focus on outcomes, whether you are talking about health service delivery or infrastructure. You can place those demands on the Commonwealth in its funding of community controlled services and on the states that you give money to.

In regard to the area of environmental health some principles could be followed. There is a big problem about who pays for maintenance right around the country and it is linked to problems about rent collection et cetera. One way to help this is to prioritise maintenance into health related and non-health related, define dedicated ongoing money for health-related maintenance, and let the difficult money like rent pay for the rest. Secondly, the only way to measure whether any of these agreements about housing and infrastructure deliver is to measure the end point. I would urge you to think about tools to measure whether houses are working for Aboriginal people or not. Thirdly, in relation to the tender process that occurs, if

Commonwealth money is involved in housing and infrastructure programs, just introducing the concept that there has to be adequate supervision in the tender bids would make a huge difference. If every tender bid had to have adequate supervision, and that was part of the cost, that would make a big difference to programs in the bush.

Fourthly, we should not forget that communities will need technical assistance to assess bids from builders, project managers and the private sector. If they do not have it, they will not know how to make some of the technical decisions. Fifthly, I want to talk about the user-pays questions that I have discussed. Another thing I want to say is: work force is a big issue. You might add most value by looking at the money story. We are going to need more money to sustain doctors, particularly, and also nurses in remote areas. We are going to have to determine who pays for health worker training and health workers now. In the latest break-up in training employment, as a player in the field, I have no idea who is going to be responsible for paying for health worker training in the future. I think that would be an important question to ask.

Lastly, I think that no strategy for improving Aboriginal health will have any credibility with the Aboriginal community unless a cornerstone is delivering an effective and comprehensive primary health care system to all rural and remote communities. If that is not done, nothing else will work. That ought to be a focus of the Office for Aboriginal and Torres Strait Islander Health and ought to be a focus of the state activity.

CHAIR—That is great. Thank you, Paul.

Mr BARCLAY—I would like to say a couple of things about the micro area rather than the macro area because that is all I happen to know about the matter at this time. Coordinated care is not the be-all and end-all. It is not the only answer; there are many, but in its context it has been successful. Do not risk it. Use the experience wherever it may work. It would be a great shame if the ground rules were changed before the final evaluation has been completed. I guess you could just ask the question: why start it in the first place if you are not going to wait for that?

Finally, Helen said earlier that hard data is needed, and I agree with her. Hard data will not be in for a while yet, but I will bring to your attention one small fact. I mentioned this morning that we have reduced hospital admissions in the last 12 months. Last week, we received a cheque for $166,840 from Territory Health Services in respect of reduced admissions to the Royal Darwin Hospital. That money was extracted from the Royal Darwin Hospital budget and it really hurt. That was success personified. That is what we have achieved in those 12 months. To have that in cold hard cash is a measure of success, if you like, and possibly constitutes the hard data that has been looked for. That is all I want to say.

Mr PURUNTATAMERI—Most of the speakers have said what I was about to say. To endorse what Bill has just said, looking at it from a broader perspective, health is also tied up with education and employment because, if you are not healthy, you cannot work. The important thing is that more control—as Paul and a number of other Aboriginals fellows have said—should be handed back to the Aboriginal people. We have made mistakes, but at least they were our mistakes.

CHAIR—We all make mistakes.

Mr PURUNTATAMERI—And we all learn from them. That is the important thing. I keep referring to our people because we are trying to do things for ourselves. We still rely on non-Aboriginal people like Bill and outsiders for their expertise, but the important thing is that, if control is given back to Aboriginal people, they will then have the opportunity to do something about it for themselves.

CHAIR—Thank you, Marius.

Mr AGIUS—There are a few things that you can be assured of in Aboriginal health or Aboriginal affairs, and that is that in five years time these black faces around this table, and probably Paul—we hope not—will be saying the same things.

Based on our experience, there have been many reviews and inquiries. In fact, the best cartoon caption that I ever saw involved a row of those big road trains. On the back of those road trains were all these reports, reviews and inquiries. They had pulled up at this community. There is a blackfella standing in the community scratching his head with all these road trains pulling up. The driver was saying, 'Where's the new clinic going because this is the material?' That basically say it all.

The other thing that you can be assured of is that there has been very slow progress in Aboriginal health. However, we have to acknowledge and recognise that there have been achievements. People have indicated those achievements today and have referred to various achievements. It is obviously not happening at a pace that satisfies the community.

What can we say today that has not already been said? What will you report that has not already been reported? We have reviewed the problem, but I am not sure if we have ever reviewed the real cause. I do not think that your terms of reference reflect the real need and allow you to review the real cause.

I recall, as a young lad, getting involved in Aboriginal affairs, regrettably. My elders dragged me along and said that I had a responsibility. I hope that our youth do not have to inherit that responsibility. If this committee, this inquiry, wants to make a mark then here is your opportunity. Otherwise, it gets thrown on the back of the road train with every other report that has been done.

One of the things that may have been already mentioned is mechanisms to ensure that the community is involved in processes which enable the community to participate in policy development, strategy and whatever. As I said earlier, I believe that there is a good concept in New South Wales and we are about to review it and we hope that we can get it right.

Institutions need to reflect a real commitment. I do not think that we need to sign documents because if the commitment is not there, no document is going to make people do things that they do not want to do.

We had a discussions at our last meeting of the HAHU members. We said that it was time that we stopped reviewing what we have done wrong, or focusing too much on that,

and started looking at where we actually want to be in the year 2010 and 2020. I would hope that one of the projections would be that the life expectancy of Aboriginal people have increased by at least 15 years. It seems we get caught up in worrying about what has happened previously and we forget about looking further down the track.

The other thing that has been alluded to today is that Aboriginal health should not be dependent upon which government of the day is in office, that it is the responsibility of both the Labor Party and the coalition to agree on some long-term strategy. If we are talking again about three-year strategies and five-year strategies, forget it, because, as I said, one of the assurances of Aboriginal health is that we will back here in five years time.

Ms GREEN—Firstly, we talk about the spheres of government and their responsibilities to indigenous people, but a lot of the time we talk about Commonwealth and state governments and we criticise state governments and we criticise Commonwealth governments. We tend to forget that there are three spheres of government and that local government is the only level of government closest to the community, the only level with a direct representation at the community level.

I have a whole page here justifying why local government is great but, in the time that I have been working in local government, I have understood that there are still a lot of problems out there. One of the main problems is the way in which financial assistance grants are given out to local governments. I have a table here with 22 categories of local governments which FAGs are allocated to. I will just pick one: 'rural remote extra small'. One of those 'rural remote extra small' communities receives $270 per person in New South Wales; Victoria receives none; Queensland, $1,258 per person; Western Australia, $1,918 per person; South Australia, $125 per person; Tasmania receives none; and the Northern Territory, $184 per person. That is what people in the local governments in those communities have to cope with. So why is it any harder for a rural remote small community or local government in Queensland and Western Australia to cope with than it is for one in New South Wales or the Northern Territory?

So no-one really understands the way in which financial assistance grants are allocated and derived, with their disability factors and everything else. It has taken six months for people to explain to me what horizontal equalisation is. I think I have got it, but I would not swear to it because it is all so confusing. If local governments cannot understand it, then the only ones who can understand it are the Grants Commission, and I think they are fudging a little as well.

Local government is always seen as a poor cousin, but it should be included in any discussions involving its constituents. Local government has only observer status on COAG, the Council of Australian Governments, but the whole thing needs teeth. We talked about the 1992 commitment but COAG, like any other representative body or whatever of parliament, cannot do anything unless it actually has some teeth. We have talked about the teeth of funding and making governments responsible by putting pressure on those that fund.

The Australian Local Government Association has been involved in Aboriginal affairs since 1991. I might add that that is only through external grant funding, which is the same with the state associations in each state and territory. ALGA employs Aboriginal policy

officers, and at 30 June those policy officers go, along with the external grant funding. There is no commitment to maintain those positions from any level of government. A lot of good work has been done out there between the state association, Aboriginal policy officers and the Aboriginal communities. So all the good work that has been done is going to go down the tube. There is a National Aboriginal and Torres Strait Islander Reference Group—of which ATSIC, the Council for Aboriginal Reconciliation, DEWRSB, and DETYA are all members—but nobody seems to know what we do. So if you are in Alice Springs on 8 and 9 July, please come along and see what we do.

There are deficiencies in the local government services. A letter was sent to ALGA requesting that we come along to discuss a key issue raised during the inquiry into the role of local government in providing appropriate health, related infrastructure and support to indigenous communities. Yes, there are deficiencies because local government does not have the funding to address the backlog of indigenous environmental health issues or other issues of health. Until that backlog is addressed, local government cannot take on its responsibilities.

It is no good saying you have to be responsible if there is no way of being responsible. Then it just keeps saying the same things over and over again. We must not forget that the state and territory governments still neglect their obligation to indigenous communities. The barrier between the Commonwealth and local governments is the state government. That is all I really wanted to say.

CHAIR—Thanks very much.

Mr NANGALA—I endorse the majority of what the previous speakers have said. Rather than become repetitive, I will make a short, sharp and terrific statement. Some of the 'wow' factors I believe that we should be focussing on even within your report should form the stepping stones for us to reach into a new millennium when we are targeting indigenous health. We have to shy away from the rhetoric. We have to chuck that in the bin now because we have had it instilled in us for so long.

I was just trying to think of some key central words that I would like to see in the report. The three famous ones I am looking at are unity, prosperity and sustainability, which are very important. They have to be transparent in whatever jurisdiction we are from and also from the community where we have to work. Setting in place a paradigm shift in the way we do business in targeting indigenous people's health is very important. From your report that might come through other peak forums, such as MACATSIA. We have the ATSIC people here. From a government legislative basis, we should be looking at a legislative change process that allows an across government factor to be built into the way we recognise that health sits in the framework of every other portfolio that targets indigenous health and issues central to practically everyone round this table. They mentioned the need to have an appropriate planning and coordinating mechanism. Legislation needs to occur across each jurisdiction within that area. Finally, I just thank you for this opportunity to share.

CHAIR—Thank you very much.

Dr STRASSER—I agree with what most people have said. We are all saying the same things. If we can get them to all work together, we will get a better outcome. In particular, I would like to pick up on the words of Paul and Tim that we need to reflect for future needs and that money needs to be put into primary health care as a main focus rather than secondary or tertiary health care. We need to bear in mind that there are changes in the mainstream health service going on at the moment, so that it is moving from hospital based care to community and home based care. There is an increasing amount of technology being used and we need to be smart and take those changes into consideration.

The other change is in the expectations of health professionals and the ratio of practice to professional to personal lives that they want to lead. For rural general practice, it used to be considered that you went there effectively for life. We have plenty of studies that show that there is a life cycle. You go there for five years—if lucky, it may be eight or eleven—but you tend to move around. My understanding is that quite often the doctors working in Aboriginal medical services do move around from one AMS to another. However, we really do have to attract them with rich rewards, but facilitate them also so that they can move in and out of Aboriginal health as it suits their career. That is something that is not well addressed at the moment.

CHAIR—Thank you very much.

Mr HUNTER—Talking about the infrastructure and the idea of doing something about it is all right but we always have to, at the end of the day, get someone to do it. Picking up on what Ngaire talked about with the indigenous doctors, NACCHO is dealing with about 30 or 40 different subcommittees where different amounts of money have gone to and there are elements of Aboriginal money in these subcommittees. Part of NACCHO's job is to try to track it down, put a claim on it and remind the so-called divisions and all of these other mobs that they have a responsibility. Shane touched on an issue where services have up to 20 or 30 bank accounts. The same principles are applying in a sense from NACCHO's point of view when we are dealing with these many committees, trying to talk to a whole range of different people in all the different committees with their own ideas and trying to convince them of what process should happen. Within that framework then you have to take it back. If you take it back to the next stage from NACCHO to the state level and then right back to the community, there is no way that the community is going to engage these numbers of people with all these ideas that they wake up with in the morning.

All these things we plan when we are talking about what should happen out in the communities. But there is a shortage of doctors and professional people. This has a major impact on any policy that the government comes up with. We have struggled in a lot of the areas—not only in the remote areas but in the cities as well—trying to attract doctors, nurses and Aboriginal health workers. The bottom line for that is that back in 1995 I sat on the joint health planning committee with about $25 million and had submissions for nearly $90 million worth of projects. I know that we never solved those problems and a lot of those submissions have never seen the light of day. The point is that to take this so-called planning any place you need the work force. To get these things moving out in some of these places needs commitment. We keep touching on this infrastructure stuff, but the reality is—and I have had this discussion quite openly with OATSIHS—there have only been a few fully built AMSs built around Australia since that time that we got the money for 1995.

The infrastructure problem out there is a major problem. We are restricted in trying to attract doctors. You cannot get them out there. When you do get them out to these places they are living in substandard conditions. We have got not only remote nurses in remote areas but the same again in the cities and then you have got the old faithful—the old health workers. We have a tendency to tell the old health worker about how they are the backbone of a lot of our service and they are. But when you go and ask them what sort of conditions they are working under and what sort of conditions they are living in in some of these communities there is nothing to write home about. There is no housing. There is no future development for the health worker. There is a different range of what people think they should do. There is no great recognition of the business. As NACCHO, we tried to do these with the college. We tried to do cross-cultural training. We did the cross-cultural training back in 1993-94. That has just come into practice and started getting some legs in 1997. We are cranking that up again. We are trying to get awards for our doctors where we get funded on a different rate, so we are flat out trying to be in the ballpark to even attract doctors to us, let alone keeping them.

When I sit on these other committees for doctors, they keep talking about this great idea of primary health care. They say, 'We should put them out there so they can get all their experience and maybe come back one day and work with us.' That is fine, but we do not have the infrastructure in some of our services out there for us to accept some of these projects and new ideas that are coming from the government even about basic programs, such as putting a person in a room or giving them a vehicle and looking after them.

CHAIR—It comes back to talking to you about what is there.

Mr HUNTER—Yes, there needs to be some sort of audit of what needs to be done. If there needs to be some major shift—I will take what Paul said—it has to be pinpointed. I agree with him about the reading of the wills of some other people, I suppose, and hope that one day someone will eat the whole book. Maybe if there were a position on some of these things—plain English sort of stuff so it does not confuse anybody—they would be chomped off by a strategy to address them, and the community knows that there are going to be some outcomes along the road.

The staffing of our people and the training of our health workers, which stays with us forever, is what we really need to be serious about. We need to be serious about what the government suggests, and I do not care what government it is because we have seen them all come and go. As Naomi says, it is the 'French Follies'—same tune, different dancers. That is just the way it is. I see what Tim touched on. Yes, I hope my son and my daughter are not sitting here asking the same stupid questions.

CHAIR—No, the questions are not stupid, I can assure you.

Mr HUNTER—We seem to think they are because no-one takes any notice of them, and that is really the sad part of it. I always talk about how they tell us that we have hearing problems.

CHAIR—Others have hearing problems too.

Mr HUNTER—You white people have the hearing problems because you do not seem to hear us.

Mr HOUSTON—A number of issues have been covered, and one of the things I think we need to do is be careful that the committee does not try to be the agent that solves every problem in every community. It is physically impossible for you to do it, but the committee is uniquely placed to be able to foster some fundamental systemic reform that would enable the people out there who are purchasing and delivering services to actually be able to do it better. It seems to me that what we have not touched on as much as I personally would have liked to is the issue of equity; that is, the questions of inequity in the distribution of resources, the achievement of an outcome and some emphasis on the question of how much we should be spending on Aboriginal health based on the notion of equity. The committee could usefully raise these issues and offer some clear direction there.

The other issue could very much be around the matter of the targeting of resources. States as much as the Commonwealth—but the Commonwealth more—tend to adopt blanket solutions that we will tackle this body part this year or next year. Fundamentally, that does not provide the level of flexibility in some respects for the available resources to be targeted for those areas that require the most attention. Priorities vary considerably within jurisdictions and between jurisdictions.

We need to develop a system which allows us to say, 'This is how much money we should be spending on Aboriginal health. Here are some processes at a jurisdictional or national or local or regional level that allow us to target those areas that will have the biggest impact.' Let's get out of the notion of spending money on political windfalls which are at the lower end of marginal return for Aboriginal health. Let's start investing in things that actually produce some bang for the buck. Let's start investing in those projects that will deliver the optimal outcome for Aboriginal people. That is the third area where we need to start to think smart about the areas in which we spend our money. It is not just a question of epidemiology, it is not just a question of community view. Importantly, least of all it is not just a view of what the clinicians think. I can be that blunt.

It seems to me that these three issues are three systemic reforms that the committee could well and truly embrace: the notion of developing a better picture of equity, the issue of developing a sharper focus on targeting, and the question of being able to engender greater attention to the notion of buying the best bank for Aboriginal people with available resources.

CHAIR—Thanks, Shane. Commissioner, do you want to add any more? You put it so well earlier that I did not know whether you wanted to add any more.

Mr DELANEY—I would just add one thing. I think that we, the indigenous people around this table, need to be guided by the aspirations of our community and see the best deal we can get out of what is coming our way. Like I said, I could solve everything, but it is going to cost this and other governments for initial influx into the situation. But I am just aligned to the fact that we are at the whims of governments anyway. I think we will expect that, whatever we have, we go back and do the best job we can. I spoke about the efforts of the Aboriginal medical services and the monumental jobs they do with limited resources.

Other than that, I just thank you for the opportunity for being here, with all the experts and my sisters and brothers around the table as well. It has been a learning experience.

CHAIR—Thank you very much. Helen did you want to add anything in particular?

Ms EVANS—No. I think people have covered all the issues there. I just wanted to add one final comment building on Shane's point that the committee might consider addressing the adequate and appropriate quantum of resources that should be put into Aboriginal health. I think that, if we could get an agreement on that and a long-term commitment, that would then allow everybody at all levels to get on with the job and not have to go into an annual bargaining basis. That would be a huge step forward.

CHAIR—Great, thank you.

Mr JENKINS—I would like the opportunity, by way of thanking people, to say a few words. I hope I do not sound patronising. I am a white fellow who grew up in the northern suburbs of Melbourne. I represent an electorate that covers the outer northern suburbs of Melbourne with negligible Koori population. I have been a member of the national parliament for a while and, until we started this inquiry, I knew appallingly little about indigenous health.

When the inquiry started and we started to look at things, all I could see was despair, and I really worried about that. But the people who have shared their experiences with us have done it very generously. What they taught me was that I had to look—or try to—through indigenous eyes. Because of the cultural context in which I grew up I cannot do that exactly. When I got over that hurdle and started to observe certain things, I saw that there are a lot of positive things happening, and happening not just because of the actions of individuals but, more importantly, because of the actions of communities, which I think this is all about. Today was yet again in the spirit of that journey of discovery.

Tim, I hope our book is not on that road train. I hope that in five years, when you sit around a table like this, something will have been ticked off the list and that the committee's report will mean a difference. The thing that I have tried to do as an individual member of the inquiry is to use this to explain to and to educate the people that I meet, or that I represent, about what is really required. Even if that is just an element of this inquiry process, I hope that you see that as positive. Sincerely, thank you all for sharing your time and your experiences with us.

CHAIR—Terrific, Harry, thank you. Annette?

Ms ELLIS—Can I just endorse what Harry said because he put it so beautifully. The one comment I would make is that this has really been a peaks and troughs thing for me, and I think many of my colleagues on the committee would agree. We have gone into some communities and we have come away with wings on our feet. Then we have gone into other environments where the wings have been cut off a bit and we get a bit depressed because things are tough in some areas. But it has been the experience of seeing the dedication by the majority, if not all, of those workers out there around the countryside that has given me the strength to keep going and to keep the faith of my conviction that we can make a

difference. Putting party politics aside for a second, there is not one person on this committee that does not feel that and believe that. We have talked about it amongst ourselves so often. There is this steel determination that somehow this report simply must be the last one and that if ever there is one done again it is going to be appraising the rates of success and documenting them accordingly.

I want to pay tribute particularly to the workers that are doing it tough. It has been inspirational to see some of the people working with almost no resource in the most appalling conditions with one thing in mind, and that is the care of their people. That has been the biggest message for me. Like Harry, my exposure to the indigenous communities at this level up has, until now, been extremely limited. It has been the most marvellous educational experience for me. But my tribute goes to the workers out there in the field who, despite everything, have nothing but the betterment and the benefit and the health of their own people at their heart—and that is what keeps them going. Every time we have seen that example, the wings on my shoes reappear and we bounce into the next community. So I want to thank you all very sincerely.

CHAIR—Thanks very much, Annette. I cannot top what they have said. They have said it absolutely brilliantly and that sums it up perfectly. I would just say that I know that you can do it and I know that we can do it, and that has been reinforced today.

Committee adjourned at 5.13 p.m.