COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

TUESDAY, 9 NOVEMBER 1999

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Tuesday, 9 November 1999

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

Supplementary members for this inquiry: Mr Jenkins and Mr Nugent

Members in attendance: Ms Ellis, Mrs Elson, Ms Hall, Mr Jenkins, 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.

WITNESSES

Committee met at 9.07 a.m.

BARTLETT, Dr William Bennett, Public Health Medical Officer, Central Australian Aboriginal Congress

JEFFORD, Mr Nigel, Northern Territory representative, Royal College of Nursing Australia, and Director, Council of Remote Area Nurses of Australia Inc.

LAMB, Mr Albert Robert Charles (Private capacity)

MAHER, Ms Helena, Project Officer, Central Australian Regional Indigenous Health Planning Committee

TILTON, Mr Edward, Research Officer, Aboriginal Medical Services Alliance (Northern Territory)

TYE, Mrs Julie Elizabeth, Acting Senior Lecturer, School of Health Studies, Central Australian Campus, Batchelor Institute of Indigenous Tertiary Education

WILSON, Dr John, Health Services Manager, Nganampa Health Council

CHAIR—Welcome. We travelled from Perth yesterday, so we are obviously on our last round of visits. We are looking to work through a few specifics with you today, if we could. I am looking at your submission, Mr Lamb, in your capacity as an environmental officer over many years. I am just debating where I might start. For the record, this is, as you would understand, an extension of the parliament. Hansard is taking down what we are saying and it is on the public record. You need to be aware of that. Other than that, we want it to be as informal and as productive as possible. We will try to target those issues that will help us when we start writing the report early next year.

Does anyone want to start off with a general focus? I was going to suggest just a few minutes overview of what you would like to try to contribute this morning and then we will get into a conversation about those issues. Hopefully, I can give a guiding hand on those things that we are trying to get from the discussion. Does anyone particularly want to lead off?

Mr Lamb—You already have the basis of my submission in the two submissions I have made since February. I mainly want to make the point that there is a need for education out in the field, particularly in more isolated places. The education standard is very low. In many cases the ones aged 40 and above are the ones who speak better English and have higher literacy and numeracy standards. These are the ones who had some discipline in the early part of their lives, mainly in mission schools, but they went to school.

The young ones are getting beautiful schools with computers and lots of teachers, but their education standard is very low. When we started courses for environmental health workers and so forth, we were up against a brick wall in many cases. I believe that indigenous health lies with the people themselves and with a few being taught, as I have mentioned in one of my submissions, in a pyramid type of teaching. Select a few well-

educated, ambitious Aboriginals, teach them the various things you want to teach them and let them go out to be teachers.

Apart from that—and I have spoken to many Aboriginals on this point—there is a need for the elders and the people who organise the various business meetings—not sorry business, because you cannot help that—not to frustrate any courses that the young people are trying to do. We have had Aboriginal environmental health courses at Warburton in Western Australia. We get halfway through a course, halfway through a day, when they have flown and driven in from many parts of the shire and other parts of Western Australia, and an elder will come in and whisper, and the whole class dissolves because there is business. As I say, you cannot stop sorry business, but I have spoken to a few Aboriginals and they believe that they can work their business in—the initiations and all of the ceremonial stuff—so as not to clash with this educational program. The ones I have spoken to realise that their future lies with education.

I said the missions helped with the skills but, in many cases, the early missionaries, particularly the lay missionaries, dissolved the structure and authority of the tribes. They have come in and taken over as the heads of these places—inadvertently in many cases. But the aim was to make more Christians. That is a good thing. I cite the case of Beagle Bay in the latter part of the last century, where a German Catholic mission burned bark paintings worth millions of dollars in today's money and dissolved the whole authority of the tribe because they had phallic symbols. That was part of their religion. This has come through. Some of the elders either do not care or they have lost their authority. Education will be put through them—through the educated elders.

No-one is making the children go to school. In Kiwirrkurra, which is up on the Western Australian border, education attendance was about six per cent, as against Cosmo Newberry, where it was about 95 per cent because they had discipline from the Aboriginals themselves. This is the only way in which it is going to improve. I have had 40 years in the game, and in 20 years around Aboriginal communities, I have not seen any improvement in Aboriginal health, despite better housing, more nurses, more drugs. It is not working. You have got to have a new focus.

CHAIR—It is very disturbing. So you are of the view that you really cannot get anywhere until you have got an education standard that was there perhaps 20 years ago; in fact, we have gone backwards in education in 20 years and education is one of the keys to a better life, better health outcomes?

Mr Lamb—And a better understanding. It has been very difficult to get through. In one case I was lecturing to Aboriginal health workers and I described the fact that the baby formula was sterile, the water was good, but people put the water in a dirty mug, put the formula in it, gave it to the child and the child got sick. A lady came up with a dirty mug and shoved it underneath the tap. She drank it, she looked around at me and said, 'I'm not sick.' Then I had to go over it all again and tell her about the onset time.

This is again where education with the older ones is important. I have had to go to many places—Snake Bay, for instance—and I would go to the elders in favour of going to the European administrator, because they have a better grasp and better education. I would

suggest things to be done to improve the place, and they were done. Now, over the 20-odd years, I think it has got that way, particularly inland and in the isolated places, where you suggest something be done and people say, 'Who is going to do it and who is going to pay for it?' They have lost the initiative and lost the education. Everyone has evolved from the apes thousands of years ago—or so they tell us—but the Aboriginal people have not evolved because there are too many people pushing this traditional culture to the extent that nothing happens.

We have too many high-minded people getting out amongst the Aboriginals, and these are professional people, carrying their own story. I will say that while one professional person—I will not mention his profession; he is not a doctor but he is in the medical field—was at Warakuna in Western Australia, he destroyed a whole cupboard in a three-year old house. I spoke of vandalism in my submission, but vandalism does not always sit with the Aboriginals. This man went in and he pulled out $3,000 worth of cupboards and left only the sink sitting there—only because a lady had told him she had maggots and cockroaches. So this is the sort of thing. He was being high-minded and making himself popular with the Aboriginal people, and he destroyed $3,000 worth of stuff.

You have got to get workers out there. The houses that are being built are the best houses I have seen on this particular shire by the Ngaanyatjarra services, which I am not a member of. They are three-bedroom block houses, with air conditioning and four-sided verandahs. One side is for visitors. There is a proper toilet with an entrance from the outside. The Aboriginals want it that way so visitors do not go traipsing through the houses.

There are people going out there and saying, 'These houses are no good. They are the wrong design.' The design was chosen by the Aboriginals themselves in this particular place. These people are coming and telling them they should have these low shelters and all this nonsense—it is traditional but bad health. While they are on the move that may have worked, but while they are staying in one place, that sort of traditional shelter does not work. Instead of saying, 'Look, this house is dirty,' one place has just recently spent $7,000 on having a professional pesticide person come out to get rid of cockroaches and mice. The mice are seasonal—they are mainly bush mice—and the cockroaches and flies are brought about because of poor hygiene practices. So we are back again to education.

CHAIR—Mr Lamb, perhaps we will just hold it there because there will be plenty of opportunity later on. I would like to hear from Mrs Tye, because I understand she has an interest in education and training.

Mrs Tye—That is right. I am here as a representative of the Batchelor Institute of Indigenous Tertiary Education, and I am with the School of Health Studies at the Batchelor institute. My interest is in Aboriginal health worker training, and I note in your discussion paper that there are some points regarding Aboriginal health worker training. I just wanted to point out that there are changes about to be implemented in health worker training.

At a point in your inquiry paper you talk about the development of national competency standards for Aboriginal and Torres Strait Islander health workers. That has happened and, from January next year, training will be with competency training packages. So that will be standardised throughout Australia. The competency training packages have been developed

over the last two to three years through various working parties, but there was disappointment made by Northern Territory representatives in that it did not actually fulfil the Territory's needs. AMSANT made contribution to that debate regarding that matter. Following that, there has been a customisation of those competency standards specifically for the Northern Territory.

As far as health workers go, in the Northern Territory there is a much more clinical focus. Following on from what Mr Lamb was saying, education has a big focus in health worker training. There has been ongoing debate for years with regard to the need for English literacy and numeracy, but because there is such a clinical focus, or a treatment focus, for safe practice there needs to be a standard of English literacy and numeracy.

The other thing I do not think has been resolved adequately is the actual role of Aboriginal health workers. It is stated that it is a primary health-care role, but more often than not it is a clinical role in treating what fronts at the clinic rather than looking at prevention and education within the communities. These national competency standards reflect that as well. It is actually called Aboriginal health works clinical.

There are health workers in communities in Central Australia and in the Northern Territory who have limited English literacy and numeracy who may never reach registration in the Northern Territory. There is a registration board that looks at health worker practice, and these health workers in these communities are not likely to reach registration for safe practice. But they play a vital role. There does not seem to be any way for those health workers to be recognised in their role. There is a move not to employ unregistered health workers, and I agree with that as far as safe practice goes. It is a bit of a dilemma for health in that traditionally an Aboriginal health worker in the community was chosen because they were someone who tended to be a bit older, who had some authority in the community. That continues today but, as Mr Lamb said, those with better English literacy and numeracy or education tend to be the younger people.

One of the points made in your inquiry was that students who might qualify academically for training may not necessarily be the person the community would want. Batchelor takes that on board in enrolment of students in that we work hand in hand with the community and the health industry. There has to be agreement by the community and by the health industry that they will support a person who wants to train with us. If they do not, that does not mean we will not provide training or education to that person, but we will endeavour to help them find some supportive environment.

Clinics must agree to clinical placement of those health workers. In the 20-odd years of Aboriginal health works in the Territory, even though health statistics in indigenous health have not improved markedly, I believe that health workers have contributed enormously to indigenous health. I know here in Central Australia we are not seeing as many children's deaths as we once did. Hospitalisation rates are probably higher, or just as high, but the deaths from diarrhoea and dehydration are not occurring. Health workers have contributed to those areas enormously.

One other point is that Batchelor also offers training in areas such as environmental health and mental health, but there are no jobs for the Aboriginal and Torres Strait Islander

people who come to us for training in those areas. That is a big issue, particularly in the environmental health area. Batchelor institute has seen an increased interest in training in that area in the last couple of years across the board in the Territory. That is a good thing for the communities in general, but the jobs are just not there.

Mr QUICK—One area you have not mentioned is dental health workers. Are there any indigenous people training to get some sort of basic understanding of dental needs?

Mrs Tye—Not as a course in its whole, but with the national competency standards there are competency units in dental health.

Mr QUICK—So Batchelor does not provide that?

Mrs Tye—Not as a course as a whole, but Batchelor will be providing in the national competency standards the units on dental health.

Mr QUICK—I understand there is not one Aboriginal dentist in Australia, so there is obviously a need—and, one would assume, just as great a need for dental services as lots of other areas in the medical field.

Mrs Tye—Possibly, but I am unaware of deaths or serious illnesses due to dental problems and I guess the priority has been in those more severe areas. Just for your own interest, I have a past student who trained as a health worker who is in his third year of dentistry in Adelaide, so there may be an Aboriginal dentist shortly.

Mr QUICK—You mentioned in regard to national competency that there seemed to be a lowest common denominator rather than the highest common denominator. The Northern Territory seemed to be the highest common denominator. Can you explain what happened there?

Mrs Tye—I think that is because of the moves earlier on for a registration board, and health workers are registered in the Territory under an allied practitioners act. I guess the Territory has been a leader across Australia as far as the role of health workers and their training. There have been discussions and debates re national registration of health workers, and I guess the national competency standards and training packages are a move towards that. Also, here in Central Australia there is a health worker association, so Aboriginal health workers are becoming much more proactive within their own professional role. In the process of implementation is a career structure for Aboriginal health workers here in the Northern Territory which links the gaining of specific skills and knowledge to incremental levels and levels of positions within health worker careers.

CHAIR—Can I just hold it there? That is about where I would like to leave it for a bit. I want to come back on issues like the jobs and where and why. I would like to bring Nigel in at that stage. Could you give us a few minutes, Nigel, and we will get into it and then bounce it around after that.

Mr Jefford—Okay. I will preface what I am going to discuss with a short biography. I am a registered nurse of 20 years' standing. I have lived in Alice Springs since 1982, apart

from a three-year sojourn away working in remote practice in the Kimberley—in very isolated practice. Kalumburu, where I was, is 700 kilometres from the nearest town by road. It is cut off five months of the year due to the wet season. There are severe health problems in that community, as there are in most of the other Aboriginal communities that I have worked in in Central Australia.

I am here with two hats. One is as the local representative for the Royal College of Nursing Australia. I will not read it out, but I have a fax copy of their position statement on health services for Aboriginal and Torres Strait Islander people. I am happy to table that. I will make sure the college national office in Canberra gets a better copy than the fax copy that I have received.

I will now place myself under my other hat, which is that of the director of the Council for Remote Area Nurses of Australia. The national secretariat is based here. We are a national organisation that has been in place since 1983. We represent the professional needs of remote area nurses around the country, stretching as far as Christmas Island and Cocos (Keeling) down to Bruny Island off Tasmania up into the Torres Strait, right through the Top End—and by 'Top End' I mean northern Australia—and down to the western desert areas of Central Australia, South Australia and Western Australia.

I guess there are two statements I would make that came out of the Aboriginal cultural awareness program that has been presented here to Territory health service staff and other interested people in three modules aiming to educate the health work force in Alice Springs and the surrounding areas.

One is power plus ignorance equals racism, and I think that was well illustrated by the Hanson factor that thankfully seems to have died a death, and, two, power plus dollars equals control. There have been an awful lot of words spoken about the fact that Aboriginal and Torres Strait Islander people have the power to do what they like and improve their services, et cetera, but, without the control of the dollars, there is no control. Unless Aboriginal and Torres Strait Islander people have control of those dollars then they do not have the control. I think there is a fair amount of lip service in terms of Aboriginal and Torres Strait Islander people having power, but the control of the dollars does not lie with them.

Ownership is probably the next biggest issue. Puggy Hunter, who many of you probably know—has he spoken before to this committee?—gave a keynote address at the National Rural Health Alliance conference in Adelaide earlier on this year. Probably his most salutary comment was that people in cities wake up with an idea and then they dump it on Aboriginal people. Next time you wake up with an idea, keep it, because Aboriginal and Torres Strait Islander people are constantly faced with impositions of ideas, systems and methods of delivery of not only health but also education, community services, transport, housing and infrastructure that they have no part in deciding what is the best system that they want. They have no control over what lands upon them. I could stay here all day and give numerous examples—which I will not.

CHAIR—We will draw some of those out as we go.

Mr Jefford—CRANA is predominantly working in a multidisciplinary inter-sectoral framework. The national programs that we have on offer at the present moment are in the areas of support, education and training. Regarding support, we have a 24-hour cumulative and critical incident stress debriefing service for all—and I stress the 'all'—remote health practitioners and their families, so that is medical officers, Aboriginal health workers. A component of that service is available for Aboriginal health workers. What is interesting is that other professions in remote areas are using this. We produced a booklet which the Australian Red Cross use. The NT police have just ordered 100 copies of that. The service gets calls from teachers, shopkeepers as well as health professionals that are living and working in remote areas. It is funded by the Commonwealth, and I must thank the Commonwealth—and this is a bipartisan thanks to both the previous Commonwealth government and the present Commonwealth government—in recognising the need to support those practitioners working out in the field.

As to education, OATSIH funded the development of a postgraduate program to masters level with two exit points, a graduate certificate and a graduate diploma in remote health practice. Again it is multidisciplinary. That commenced last year under the umbrella of the Centre for Remote Health which is based here in Alice Springs, and that is a joint university facility of Flinders University of South Australia and the Northern Territory University. That has had two intakes and they are already booking up with regard to next year's intake. Feedback from students—and I sit on the committee that oversees this program—has been extremely positive. That includes a medical officer and a physiotherapist. Predominantly they are remote area nurses but again it is a multidisciplinary service.

Training—again the Commonwealth has funded a national program whereby we facilitate an up-skilling in remote emergency and trauma management around the country. That has been re-funded for four years as of the beginning of this financial year. All three of these services aim to improve the support, education and training of remote health professionals and, with regard to the bush crisis line, their families.

Can I just state that 25 per cent of the population live in rural and remote Australia, but they do not receive 25 per cent of the health, education and training that occurs in this country. Unless there is an equality of provision of service, no matter what the distance, no matter what the difficulties—whether or not they be cut off in the wet season—things will get no better. Four tomatoes four years ago in Kalumburu cost $4. For every kilo of freight, it cost $1.70 extra for freight costs, because for five months of the year everything had to be flown in. The average turnover in that shop was $1 million a year. Of that, $200,000 went on cigarettes and $200,000 went on soft drink. That left $600,000, which, divided equally, meant that each person each day had $4 for food, and that was without fuel, whitegoods, tapes, petrol or clothing. That was if it just went on food.

There is no doubt that the dynamic of Aboriginal and Torres Strait Islander health is not just environmental health, it is not just housing infrastructure, it is not just education and it is not just health, and unless there is an umbrella that covers all of those areas in an equal way, then there will be no improvement. As to the power plus dollars equals control, unless that occurs we are going to be sitting here in 10 years time. The latest release of AIHW statistics shows there has been no improvement over the last 10 years.

CHAIR—We will draw those things out as we go, Nigel. Thank you for that. I welcome Ben Bartlett and Helena Maher. Ben, you have come in in the middle of it. Did you just want to pick it up as you go or do you want to just make an opening statement of a few minutes after which we will go into general discussion? Obviously, you would be aware that this is our last round, and we are just trying to see what we have missed and are endeavouring to pick up new information. We have just been advised that we have a national competency in remote nurse training now, so we have learnt one thing this morning. Over to you, Ben. It is your call for just a few minutes.

Dr Bartlett—I have to agree with a lot of what Nigel is saying, but there is a big contradiction in that, over the last 10 years, whilst the issues of principle have been argued in terms of power and control of people over their lives and, more specifically, over the delivery of primary health care services, there has been a plethora of institutions focused on education, training and counselling support such as CRANA which is very solidly out of the control of Aboriginal people. So it is like winning the argument, but having the structures that it has created slipping away from under people's influence.

The framework agreements have been set up to overcome the buck passing, really: the cost shifting, the arguments between jurisdictions—the Commonwealth and the states. There is an NT forum which has been set up with the four main players being Commonwealth health, OATSIH, Territory health services, ATSIC and AMSANT—the Aboriginal Medical Services Alliance (Northern Territory)—which is the community controlled primary health care sector. There are other things that have mushroomed up that are totally outside that forum.

There is, for instance, a fly-in, fly-out women's health service that has been established which you may know about. It was prompted in the Top End where there are some serious problems that some communities up there have in terms of access to women practitioners to do pap smears and that sort of thing. They are having meetings in Central Australia about this matter without it having gone anywhere near the NT forum. There is already division between Territory health services and the community controlled sector around women's health with the Alakura down here that has been set up for over 10 years now. The Strong Mothers Strong Babies project, which has been promoted heavily by Territory health services, has come down not recognising the Strong Mothers Strong Babies program in Central Australia has been the Alakura.

There are constant contradictions about where power is. When the Aboriginal community attempts to organise itself to have power, the community development professionals and a lot of the health professionals dive under that and say, 'They do not represent the community, we go down to the least organised part of Aboriginal society and we will work with them.' This fragmentation of the Aboriginal community is a major reason that a lot of these problems are persisting and we are going around in circles. That leads me to look at your options for what needs to be done.

We would think that the establishment of a new body to basically take responsibility for primary health care, which is a bit like the funder/purchaser-provider split models that people have talked about over the last few years, is an idea that people have warmed to in discussions at congress. So, instead of having arguments all the time, the people who know

how to do this stuff can get on and do it and be given the resources, both from the Commonwealth and, in this instance, the Territory government, to move down that path. It seems to me that probably the framework agreements and those forums need to continue, but that we need to move to get a single authority responsible for delivering primary health care, particularly to Aboriginal communities.

CHAIR—Thanks very much for that. What I want to do now is go through a list of things that we particularly want to focus on. It is not prohibitive; it is just a guidance because with this subject, as we all know, it is a case of how long is a piece of string? So I want to go through a list, and if something rings a bell just jot down a note and come in on it, and we will try and flesh it out as we go through the morning.

I remind you that we need the general feedback on the discussion paper, which we have just been doing. The issues that you might think about are dental health, which has been touched on; mental health, which I do not think we have mentioned this morning; hearing health; diabetes and renal failure; the balance between the needs of urban and of rural and remote communities—and that is one that the committee is really trying to wrestle with. You would appreciate that the largest number of Aboriginal people are in New South Wales, but, as we were reminded in Western Australia yesterday, eight per cent of people in New South Wales live in remote areas; in Western Australia it is 50 per cent. The service delivery approach is significantly different and, whilst the severity of the core issue is not dissimilar, the methodologies are somewhat different. So we are searching for some input on this balance between urban and rural and remote communities.

The obvious issues are dispossession, poverty and discrimination. There is also the issue of how do we encourage Aboriginal and indigenous people to maximise responsibility. Part of that was in Nigel's comments in terms of control and ownership issues but, very much in Ben's comments, there are the contradictions. I have been aware and I am sure other committee members have been aware of that word 'plethora' of training agencies and processes. We have the national competency coming through, and that is to be welcomed. But my impression—the committee's view will be fleshed out by other committee members—is that it is a bit confusing because in that plethora not only is there a range of agencies but there is a range of delivery models—on the spot with the community, or distance, whether you go to Adelaide or Batchelor, all of those sorts of things. The question is: how do we best make recommendations in that area?

There is the old perennial of current welfare arrangements on health and wellbeing, and how they make an impact. Ben just touched on service delivery issues, on a single body and on Commonwealth-Territory arrangements. Our terms of reference are very specific, and I go back to them just about every day to remind me how, under our Constitution, there are certain constitutional issues which we do not have power over. We are certainly aware of some of the difficulties that are created by the division of power. Eighty per cent of health services are delivered to Aboriginal people by the states and territories. So we really want to talk about what you see as the impact—and there is your point, Albert, about education and how the Commonwealth-state division impacts there—because we have to deal with the bigger jurisdictional issues in this as well.

Mr Lamb—I worked in the Northern Territory up to about 10 years ago, and in Western Australia more recently. Education delivery is good. They have got some nice schools in various places, they have got good staff, except that quite often—

CHAIR—I will hold you there and we will come back to that. I just want to finish my little piece. I make that general point in terms of the jurisdictional issue, that we think about what the Commonwealth can reasonably do, what we as a federal committee can reasonably do. There are the (a), (b), (c) and (d) options in the discussion paper and we would suggest that (e) might an alternative which is perhaps nearer to Ben's option. We had a pooling arrangement suggested to us yesterday in Western Australia. The state and the Commonwealth would say, 'There is the money,' and rather than say, 'We want that dollar for that particular purpose,' they would say, 'We want those dollars focused on how we get the best outcome and we do not want to be too restrictive. We are really interested in those outcomes.' So if the Commonwealth is racing around saying, 'Out of each dollar, we are only going to spend 20c here and 50c there and 30c there in various areas,' how does that restrict the best outcomes?

I will also run quickly through some things I would like you to think about and perhaps touch on later. One is data issues, that is: what is our evidence for a lot of this stuff; what is our preoccupation with it and should we be so preoccupied; how much duplication is there in data collection; what should be the accountability process; how do we learn from the data and is it substantive enough to give us confidence it is telling us what is actually happening out there?

The work force issues we are going to deal with or we already have dealt with. Environment health we have already touched on. Nutrition has certainly been touched on by Nigel. There are issues in transport, including access issues. Cultural awareness is one that I am really grappling with. I am hearing Albert's comments about almost abuse of the cultural process, if that is not too harsh a word. Where do cultural matters impede good health, how do they, what should be the sensitivity and how do we appropriately deal with those matters? The cultural issue is one that I am really trying to grapple with.

That is about all I want to say. If any of those things have jangled with you, then feed in as the morning goes on. I reckon we will go for about 40 minutes, then have a break, stretch our legs and come back to it.

I now welcome Edward Tilton. Are you prepared to take a couple of minutes to talk about AMSANT and about the general issues for you? Then we can go into general discussion.

Mr Tilton—As you may know, AMSANT is the Aboriginal Medical Services Alliance in the Northern Territory. It represents the community controlled sector in the Territory and that is a fairly substantial primary health care service delivery sector in the Territory. In Central Australia, up to 45 per cent of the population are serviced by—

CHAIR—Can I say we have been to Tennant Creek, Alice Springs, Nhulunbuy, Maningrida—that will give you an idea of our spread.

Mr Tilton—Yes. The AMSANT executive are not able to be here today. Although they have looked at the report and are generally pleased with it, they have not been able to come up with any firm responses that they have resolved on.

CHAIR—Not many people have, I can assure you.

Mr Tilton—No. I think overall people are quite pleased to see the recognition of the role of the community controlled sector in the report. They are very interested in talking about the four options, particularly options (a) and (d). The proposal under option (a) is the continuation of existing arrangements. People are quite supportive of those possible modifications to the existing arrangements that have been put forward in the report. With respect to (d), this new approach based on the pooling of funds, that is something that people are quite keen to look at in more detail and possibly to look at ways of developing a model under which that could work and be successful. Those essentially are the main points.

CHAIR—That is fine. There will be plenty of opportunity to add to the discussion. What I want to do now is to open it up and invite Annette or Harry to pick out things that they noted from the opening comments and then we will try to direct traffic from there.

Ms ELLIS—I have got a couple of questions for two people. I would like to start off with Nigel. One of the things that we have been finding as we go around, and it has become a bit of a bane for us to try to work it out, is this nutritional problem. You touched on it very well, Nigel, in your descriptions of the remote community you are working in. One of the problems we have identified is actually how you get a satisfactory operation of a community store in some communities. We have found that in some places they just will not tell us how they operate and in some places they are a little bit more open. You have got two levels of concern: one is the cost of getting the supplies into the place and the other one is the financial control and influence within a community to operate the store. It seems to be a bit contentious in some areas. I was just wondering if you had a view. It is a contentious issue.

Mr Jefford—It depends on who controls the store.

Ms ELLIS—Exactly.

Mr Jefford—If the community controls the store and has in place good mechanisms, then the store generally does well. By good mechanisms I mean good financial controls, the same as for any store. The major problems that I have been informed about by community people have been where stores are running at massive losses, where a member of the family is on the till, another member of the family comes through and half of what is going through is not charged or a third is not charged or all of it is not charged. That is because of enormous pressure through communities that exists within those communities by families, individuals, groups of families that are linked through passage of time and history. That is one area.

There was a change, for instance, at Kalumburu, where the mission, which had been there since 1908—and that is an issue in itself, but that is a personal view—had control of the store, had control of the community until 1982. Then the community formed its own

council and started to make its own decisions. The mission dropped them like a hot potato. Of course, they had not trained the community to manage anything because the mission had done it previously. But until the time I was there, the mission had control of the hot food section—chips, all the rubbish tucker, basically—and that income was not recorded in the shop takings; that income was recorded in the mission takings. The same thing occurred with the after-hours shop down on the mission grounds, where ice-creams, lollies and soft drinks were sold. None of that income was recorded in the community process. It was all recorded and we were not privy to it. So that $1 million turnover was very much minus that component.

Also, the levels of inherent stress need to be recognised. That was reflected in us as workers there and in the community. There was a study done by Dr Linc Schmidtt from the University of Western Australia comparing what was considered to be a stressed community in Oxford in the UK, his own daughter's primary school and Kalumburu—measuring the amount of cortisol that was excreted in urine. I can tell you now that the level for the two communities in the UK and in Perth were down here and the level secreted in Kalumburu was way up here, just because of the inherent stress of living in that community. That was reflected in the amount of cigarettes that were smoked and in the amount of soft drink that was also part of the diet.

Ms ELLIS—Can I take it a bit further because I think this is one of the intrinsic problems that we have to deal with. If we as a committee, for argument's sake, made some form of recommendation about freight equalisation to try to level out the delivery of goods to the stores, and our intention in doing that was to try to ensure equitable, cost- effective access to good food, to nutritional food, which is what the prime reason for doing so would be, do you have a view as to how we then break that other next step, which is the $200,000 to cigarettes and $200,000 to soft drink, to use your example? How do we then cope, without being overly dictatorial? It would be a bit of a shame if freight equalisation happened and no nutritional benefit of any measure came out at the other end. How do we deal with that?

Mr Jefford—First, I think you have to look at working with the communities. In fact, you would have to work on an individual basis because somewhere like Kalumburu is going to be different from somewhere like Hermannsburg or Elcho Island, depending on who is shipping that amount of store produce in.

Ms ELLIS—And who is running the store and who is dictating what is sold.

Mr Jefford—And if you are doing it so that an independent operator makes a more massive profit but keeps the same level of prices. Kalumburu has changed in the four years since I have been away, in that the community control the store. There is a much higher price on soft drinks and cigarettes and that actually subsidises a lower price on vegetables and more basic products that are in use every day. Bear in mind—and I do not think I am wrong in saying this and I am happy to be corrected—that community members do not go and buy a week's worth of shopping. You are looking at 28 people living in a house. There are husbands with wives and kids. They do not go and buy a week's worth of shopping and sit it in the larder and it is theirs. It is not theirs; it is everybody's. There is that system in place. So people go up to the shop and buy breakfast and they will go up to the shop and

buy lunch. If the store is open in the afternoon, they will go and buy lunch in the afternoon. It is also depending on the income within the community over the week as to how much food gets bought and what other factors are inherent within the community that impinge on that dollar value.

For instance, with Kalumburu, because it was so far away, there was very little alcohol. It was a dry community with no alcohol. It was such a long way to go and get it that people stayed in Kununurra, Wyndham or Derby and drank it. I do not think I did, in two years, any trauma work related to alcohol in that community. However, there was heavy gambling to the point where people would gamble a can of beans against a bottle of sauce. It was a major social event. There has been a report done on this, specifically relating to Kalumburu. It was a major social event on a Thursday and a Friday. It brought the community together and divisions were forgotten.

It was very difficult, when you see $2,000 in the pot amongst 10 people or 12 people, not to join in because $2,000 was a lot of money considering the average income within the community. Of course, once someone won that $2,000 they would pick five of their mates, hire an aircraft at $700 return to Wyndham and go to town. Not always, but certainly a reasonable amount of times that would happen. What would then happen is that those people who had lost their weekly wage would then impinge upon those who did not gamble and who had food. You have this cycle of peak and trough of dollar within the community and not all of it goes on food. I do not know how, without community consultation, you address that. Certainly I think subsidisation of freight costs, providing good systems are in place, is a viable proposition.

Ms ELLIS—Mr Chair, I wanted to change tack.

CHAIR—There are a couple of things I would like to look at. Can you just hold it for about four or five minutes? I would like Helena to say a couple of words and John Wilson has come in as well. Forgive me for being a bit erratic. Could you each give us a couple of minutes on where you think we are at, if you have had a chance to look at the discussion paper? But it will come out as we go through, anyway.

Ms Maher—I am the project officer for the Central Australian and Regional Indigenous Health Planning Committee, which is the committee that has been set up in Central Australia under the framework agreement. It is a working group of the Northern Territory Aboriginal Health Forum. I have been the project officer for that for nearly 12 months and CARIHPC has been established for longer than that—for about 18 months. It actually preceded the signing of the framework agreement.

There are two things I would like to say. There are a couple of points that the discussion paper talks about in terms of the framework agreements. I would like to reflect on my experience of working as that project officer. I think that there is one point at which I think we have had some success in CARIHPC and that has been in developing a model for the implementation of primary health care services. To give you an example, we had a second round of remote community initiative funding of about $440,000 to spend in Central Australia. We had a working group set up under CARIHPC which had representatives from AMSANT, the Northern Territory Remote Workforce Agency, Northern Territory Health

Services, OATSIH and myself. We developed priority criteria that looked at need, capacity and infrastructure. We looked at every community and made a sort of adjudication about where we thought the funding would best be spent. We are fairly confident that we can go ahead with those services if the Minister agrees with our recommendations. I want to put that up as a good model for developing services.

The other experience of CARIHPC has been a lot of frustration. The frustration is about where we have not really been able to influence policy happening at the Commonwealth and state level. I will give you two examples of that. There was initially an agreement—not a written agreement but a verbal agreement—and it was being discussed that the current DMO services would be cashed out and that would be used to employ GPs in communities. The recognition of the need for GPs is something acknowledged in the framework agreement. Then that agreement to cash out DMOs fell through. I was terribly frustrated in trying to influence that. I am putting that up as an example of something that we could not influence.

The other thing is renal failure and diabetes. In Central Australia, renal failure would have to be one of the priorities for Aboriginal people. There was a renal working group—and this precedes me—that followed on from some research that was done called, *Living on Medicine*. That looked not only at the medical aspects of what was happening to people suffering from renal failure but also at the social and cultural disaster, really, for Aboriginal people who were having to be brought in from remote communities to live on a machine here. So the renal working group was set up. It had expert representatives on it and developed a regional renal plan. There has never been any ownership of that plan within the departments that have responsibility for renal services. While I would say that I think CARIHPC worked in terms of primary health care services, there are other frustrations that we have had.

In your comments in the discussion paper you talk about the advantage of the framework agreements in making explicit the roles or responsibilities of the community and the government levels. What we would say is that it is difficult, that at the moment the framework agreement operates as a sort of gentleman's agreement, really, that there are no sanctions and that we do not have any way of enforcing the commitments that are made in that, and that is a problem. What we would say is that your note about having the community actually reporting to government about how things are working could be a good idea, basically. That is all.

CHAIR—Thank you. That is fine. John, would you like to say a couple of words?

Dr Wilson—I am the manager of Nganampa Health Council and have been in that position for about 4½ years. I do not live here in Alice Springs; I live out in a remote location that some of you visited recently—about 470 kilometres from here. I do not have a submission to put today; I am happy to contribute to discussion and to answer questions as appropriate.

CHAIR—Fine, John. Thank you.

Ms ELLIS—I just want to know whether anybody else would like to ask anything on the shops and nutrition stuff before I rock on to a different issue.

Mr SCHULTZ—Yes, thank you. One of the things that the committee found in one community we visited was that, when the indigenous people went to the store to cash their cheques, they were actually required to buy a percentage of their food at the store as a mechanism for getting the cash for the paper. It was forcible acquisition by the store owner and, to me, it indicated that people would be forced to buy food that they did not really want. My thoughts about that tended to send a message to me that they were buying non-nutritious food rather than nutritious food because of the compulsory need to spend a percentage of that cheque at that store. I think that that practice is really outrageous in many respects—firstly, from a profiteering point of view and, secondly and more importantly, because of the danger of people acquiring foodstuffs that have absolutely no nutritional value whatsoever. The committee has discussed this issue, and it is obvious that we need to do something about it. I would just like a comment about that.

Mr Jefford—I must admit that my experience with this here in Central Australia has been predominantly with pastoral companies—properties that have communities that have stores as part of that pastoral empire, if you like. I am aware—and I am going back some time now to the early nineties—that, again, that pastoral company had a million dollar profit each year from the store, and the only people who bought from the store were the occasional tourist and the community. Yes, pastoral properties do control stores and they do control the prices, and it is a matter of choice. For those people who do not have a vehicle and who are not able to drive 457 kilometres to the nearest shop, that is the only choice and they have no option.

Mr QUICK—It is not just pastoral companies.

Mr Jefford—It is not just—

Mr QUICK—We have been to places where it is like a Christmas club. The prices are inflated so you can support the local football team and a whole lot of other activities. You have corrupt store owners that are operating with the knowledge and acquiescence of the Aboriginal communities. They will rip off three or four hundred thousand dollars and then move along to another community in another state or territory. As politicians, we are blamed for a lot of the things that are happening, and we hear ad nauseam, 'We want community control.' At what stage are some indigenous communities going to put their hands up and say, 'Enough is enough. We want to have the best'? There are a whole lot of programs—healthy babies and that sort of thing. But it is all ad hoc. Is there a best practice community?

Mr Lamb—I have said, I have been working in Western Australia, around the Warburton area. There has been some measure of success, and it comes back again to my main theme of education. People now understand what 'use-by date' means because there is a system in Western Australia—and maybe in other states—whereby use-by dates are being passed and the food is going from the store in European places like suburbia and going to a collection point. Then it is sent out to charitable organisations or bought at a cheaper price and sold at an inflated price out at the settlements. People are starting to realise that now.

More education is needed about meats. Forequarter chops have fat that thick, and the so-called traditionalists—the Europeans, that is—are saying that Aboriginals like fat on their meat. Kangaroo tails have a different sort of fat, as Nigel will tell you. It does not harm

them, but beef fat and mutton fat do. That is one of the health things that they are beginning to understand.

At Kintore many years ago, after talking to one of the health workers, one of the ladies went back and got meat from a butcher who left meat out to go a little bit sour—fat meat. She went back to Kintore and they boycotted the store for a short time until it produced decent meat. The meat was black in many cases. They were selling stewing steak for grilling steak at inflated grilling steak prices. The problem is again nutrition. It is all linked together, but it all comes back to the root of education.

Mr QUICK—Western Australia might have the best idea; Northern Territory is hopeless; Queensland is even worse. How do we get a national approach? We are talking about indigenous health across Australia. What is happening to the Redfern Aboriginals?

Mr Lamb—There are use-by date laws throughout Australia. To the ordinary consumer it says, 'The use-by date is 30 June. You should not use it after that'—it might be yoghurt or something like that. In fact, unless the environmental health officer, who has usually got the last say in any case, can say, 'Well this food has been adulterated; it is substandard', he has not got a case.

Mr QUICK—When was the last time an environmental health officer went out to places like Docker River? You would never see one there in a lifetime.

Mr Lamb—The Territory health department did regularly send environmental health officers, but they cannot enforce the use-by dates law. If the officer sees a use-by date passed, unless he can prove that the food is substandard, there is nothing he can do. Take cheese, for instance. It gets past a certain date and taken to a place where there is no refrigeration—many of the Aboriginal houses have no refrigeration—and in a matter of hours or days, it will go mouldy.

Mr SCHULTZ—It is also an abrogation of responsibility, because much of what is going on goes on in crown land too, which is a very convenient let-out for the local government people and others who control some of those issues.

Dr Bartlett—Some of this stuff is about regulations that the rest of Australians take for granted, whether we are talking about housing, stores, or whatever. When it comes to Aboriginal communities, everyone just turns a blind eye. It is the same with education: where are the truant officers chasing up kids who are not going to school? There is an abrogation of responsibility by all jurisdictions about many of these matters. I am all in favour of community control when it comes to primary health care services, which is the area I know. And, in general, people having control of their lives is an indicator of better health.

We have communities in the Territory, by and large, whose demographics show that 60 per cent of the population is under 25. You take away the old people, people with chronic illness and disability and the people who are caught in the grip of alcohol or other substance abuse, and you do not actually have that many mature age adults left to take responsibility

for the full plethora of responsibility. So if you define community control as local community control for all things, it will never work.

Mr QUICK—How do we involve the land councils who have some of that expertise to say to community aid, 'Okay, you do not have the expertise but we will, in the sense of indigenous well-being, provide you with some expertise.'

Dr Bartlett—The land councils do that to some extent. Land councils have developed some ideas about use of contracts with store managers, for instance, that can tie some of these issues about store management in. I think there is an issue here of how do you get some sort of professionalisation of store managers. That is how the health industry works out who is doing a good job and not to a large extent. There are professional standards. There are no standards for store managers or town clerks or community advisers or whatever you like to call them. There are no standards whatsoever. There are plenty of stories around about advertising for a town clerk and you get half a dozen applications, but then you say there are going to be police checks and they all withdraw.

Mr SCHULTZ—What you are saying is that there is a need for common service standards, including minimum standards, right across all services for indigenous people, both mainstream and community control.

Dr Bartlett—Yes.

Ms HALL—With the statements just made about the fact that you start looking into the community and you find that there are very few people that are there really that can take control of the situation so you need to have other people to help, don't you think that the problem is going to continue on and on and on until such time as the community itself is actually taking control, rather than people from the outside all the time coming in and saying, 'Well, it would be really good if you could take control but, because you have got substance abuse, because you have got people that are sick, you need help from us outside to do it,' the problem is going to continue? That is very much a paternalistic type of approach, isn't it?

Dr Bartlett—No, I do not agree it is paternalistic. It is a matter of understanding how societies work. And, within our society, you do not have to find someone in your street to fix up your plumbing. You can ring whoever you like in an urban environment, or a relatively urban environment like Alice Springs, to find and choose a range of plumbers who will compete. There are no plumbers in these communities, so how does the community deal with those problems? It requires some systems that society at large needs to set up that includes Aboriginal Australia in them. There has been plenty of work. The Western Australian Health Department did stuff about the responsibility of councils to provide rubbish removal to communities. You cannot expect small groups of people—200, sometimes less—to take responsibility for the full gamut of human existence in a settled living environment.

Ms HALL—But don't you think we should be moving towards making these communities more self-sufficient rather than dependent?

Dr Bartlett—Yes, but it is not a matter of dependency. Part of self-sufficiency is having an infrastructure in which you operate that is about law, about civil society, about these things. Aboriginal Australia is left outside that. We all depend on it. We grow up never having to think about where the power comes from, never having to think about where the plumbing is going to come from. We turn a switch and it is there. That is what I am saying, that those sorts of systems that are a matter of local government and legislature have by-passed Aboriginal Australia.

Mr Jefford—Briefly, the UPK report—the work is still going on and John obviously is integral to that down at Nganampa, and I will stand corrected, John, if I am wrong—shows that 80 per cent of new houses that were built were faulty. There were major faults, be it plumbing or wiring, construction—and these are not being built by Aboriginal people; these are being built by contractors coming in and making an awful lot of money. Those kinds of things need to be guarded, and guarded strictly, the way they are in town.

When the footings are done, someone comes along to inspect. When the slab is laid, someone comes along to inspect. When the plumbing goes in, it is inspected. I can guarantee that, with respect to the money that was spent in Kalumburu during a massive upgrade of facilities—it was $5 million to $10 million—firstly, there was no Aboriginal person employed to be part of that process or taught construction and laying of sewage pipes and, secondly, I have had stand-up arguments with plumbers putting pipes together not using sealant to seal those pipes.

Mr JENKINS—Can we try to flesh this out because I think it is very interesting. We can throw around terms like community control or local solutions for local problems with local resources. Everybody might think that they actually know what we are talking about. Yesterday, the Western Australians gave us that infrastructure report. When I picked it up it fell open at the page where it collated the communities that did not have a hard waste disposal in their community. With respect to where it was provided, the figure was as low as 30 per cent. You probably think that that just happens. I think that Ben described very well when somebody does it. We might get involved in our local council to make sure it is done properly, but for the majority of us it happens, and it is not happening in some of these communities. I suspect that this is part of the remote and even urban indigenous communities. If we look at indigenous communities in urban areas, yes, the authorities again walk away from them. We do not insist that things happen. I am trying to work out now: at what level is the community control?

Dr Bartlett—I think that is the critical question. As you know, I have been out of Central Australia for a few years and have just come back. I have had the luxury, in a sense, of being able to think a lot about the previous 10 years. It seems to me that what happens is that part of the paternalism of our system is built into our community development professionals and our health professionals who say, 'We must have community control.' They dive down to the least organised part of Aboriginal society. That is a destabilising situation. There is a need to bolster regional, state, territory and national leadership within the Aboriginal community. That is part of what community control is. That is how our society works, and even if you are an anarchist you still have to wear the fact that there is a national parliament and all that sort of stuff.

That does not mean to say there are not also issues of local control; there are some things that are best controlled locally in the community. If everything has to be controlled locally in the community, then it all tends to fall apart, or it depends on a competent whitefella being there, or on a particularly strong local Aboriginal leader.

You can look at examples in Central Australia. Areyonga, at the moment, has done some fantastic things. It has built its own swimming pool by managing its capital works and being able to take $20,000 and put it into the hole in the ground. The community now has a swimming pool and the rule is: no school, no pool. They have built up rules to encourage education and that sort of thing. To some extent that depends on a particular individual who happens to have a bit of a civil engineering background, so he is able to do that. When he goes, which he inevitably will, the question remains: is this a sustainable model? We need to do some work on being able to generalise.

The UPK has done stuff in the Pit lands which has been a model. It cannot apply to everywhere because the circumstances are different in terms of how communities are constituted, et cetera. There needs to be some sensible recognition of the different layers of community control and governance and to strengthen and support that. I think there is too much of diving under to find the poor blackfella who is out of control that we can then colonise again. We can feel better then and it affirms our work because we have someone to hold our hand or something, but it is actually destabilising the whole society.

Mr QUICK—In the whole issue of land rights, I was on the ATSIC committee looking at the Reeves report and the Land Rights Act of the Northern Territory. The land councils have a huge bank of expertise, and if they have not got it they buy it in. The land councils could have engineering and planning and building and construction as one of their little subportfolios so that they have got links with local government, if they are going to build 27 houses out at Kintore, rather than someone from Alice Springs go out and keep an eye on it, the land council has got the expert to say, 'We are not going to sign off on the contract until that is the same standard as a house built in Redfern,' or in Hobart, where I live.

So there is no excuse to say there is this continual waste when they construct whatever service it is out in these remote communities and people are getting done left, right and centre. The indigenous community can actually say, 'If it is not going to be done by the white fellow, we will put in place a structure. We have got anthropologists at call, we have got legal experts at call, we have got linguists at call, we have got all the expertise but, stupidly or foolishly or unwisely or whatever it is, we have not got people whose expertise is there when we are actually building infrastructure—sewerage, roads, telecommunications and whatever else'.

CHAIR—Land councils may not regard it as a core business, but do you want to respond to that?

Mr QUICK—But everyone complains to us, and we hear innumerable stories about people coming in and building houses for three times the cost of a house in Taree and they are all shabby and they do not work and the health standards are poor. We have been out to places where you suddenly get three inches of rain and people walk through faeces and

polluted water. But surely, if we are not going to do it, the land councils should put in place structures to do it. They do it in lots of other areas.

Dr Bartlett—Land councils is one possibility, but I think that Aboriginal people fought to have their citizenship of this country recognised and they have some rights in the mainstream of things as well. As far as I am aware—I am no expert on this matter—land councils have not played a significant major role in infrastructure development. In land management, yes, and you have mentioned anthropologists and lawyers. That tends to be the expertise that land councils have, but as far as I am aware they do not have a lot in the way of engineering, construction and design stuff. That has tended to be the Tangentiere Council and Julalikari Council and resource agencies that have had that. But then they are split up and there are no standards, there is no body that exists as far as I can see that holds that together for, say, central Australia or for the Territory.

Mr QUICK—The reason I am raising it is that we are here with four options, or five options or seven options. When we leave here we have to put down a report that hopefully will come up with appropriate solutions to solve the whole issue of indigenous health right across Australia once and for all. We are here to pick your brains, to say, 'We have been sort of waffling around this topic. We want models that will work and we might need to change the funding arrangements, say to the Northern Territory government, "You are bloody hopeless. You haven't provided all this stuff. We are going to take it off you, even though you provide 80 per cent of it." We give it to the Commonwealth or we give it to another superstructure.'

We want to pick your brains to say that when we leave here we have got a model that you know will work in the Northern Territory—no excuses, no buck passing, no-one saying, 'It is TAFE's problem because we do not have adequate training, the change to Abstudy because David Kemp has thought of this new whizzbang idea.' We cannot pass the buck any longer. The model we come up with will work. There is a national registration for store-owners and if you do not have that registration certificate you do not get a guernsey—end of story. We have freight equalisation—end of story. We need to pick your brains, to say to you, 'Put up or shut up,' and that is as blunt as it ought to be, because we are not coming back here again, and we are going to write a report. With the Reeves report we came up with a series of recommendations, and some of them were revolutionary. They upset the government, they upset the Northern Territory government, but they pleased the Aboriginal people because they could see some sense.

So this is what we want to use you here for today, to put up and shut up, but the model you put up is a workable model. Do not worry where the money is going to come from, that is our problem, because we are going to have to put the recommendation.

Ms HALL—This is our draft report. We want to make sure of the recommendations that we have put up and the options that we have put up. I am interested in hearing from you what you think of the options that are put there on pages 15, 16 and 17.

CHAIR—Just before you do, we started off with very useful discussion about control and what was realistic, particularly in smaller communities where the infrastructure was not there. Then we went on to the standards and across to use-by dates, standards and the reason

for nutrition and back to environmental health. We quite often will end up back with environmental health. Harry has given an impassioned plea for progress and gives us an agenda to remind us what we are here to do. What I wanted to do is to try to pick up the training issue. We have nurses and Nganampa. We have, I think, from Helena's point of view, some very valuable work that you have been doing. I do not want anyone overlooked in the teasing out of issues. Ben, I think a great service which Harry Jenkins picked up on is in this blend of what we call paternalism versus effective administration.

I am actually so rural that I can remember when we first got power on. When the lighting plant failed, I can actually remember putting on water reticulation before that fell out of the sky. It was the same with the telephone. I am actually closer to a lot of Aboriginal communities than I had realised in terms of my background because, until I got into this job, I had never lived in a town. It is quite revealing for me in thinking about those basics that Ben has touched on. All that is to say that, Jill, you had some specifics, but in the next 10 minutes or 15 minutes I just want us to broaden it out; I do not want us to bog down on that. What we have done is useful in picking up this dilemma that we are wrestling with all the time—paternalism versus effective administration. Jill, over to you. I wanted to make sure we hear from the other people here.

Ms HALL—Will I continue with what I was talking about on the proposed models, or did you want to talk about other things?

CHAIR—It is your call.

Ms HALL—I mentioned the models that are detailed in the report because, like Harry, I am very interested in getting some specific feedback on this report. There are a couple of other issues as well that I am interested in. There are some options that have been mentioned here supporting the existing arrangements: states to assume greater responsibility, the Commonwealth to assume responsibility or a new approach. Then when we were in Western Australia yesterday there was an alternate approach put forward by someone over there. I would be interested in some feedback from those people working in the field as to what they think is the ideal model for service delivery.

Dr Bartlett—Can I say that we need to be clear about one thing in this, and that is that you do not deliver some of the stuff you are talking about, Harry, the infrastructure stuff, in the same way that you deliver primary health care services. We have interpreted the options that you have here as applying to the delivery of primary health care services. I do not know that we would necessarily see these options as appropriate for some of these other issues that are the backdrop to better health, if you like.

Mr QUICK—Docker River always stands out, because the road is abysmal, you cannot land the Flying Doctor Service there at night and they have sub-basic resources in staff. What I am saying is that a lot of things that you cannot put under the financial label of health impinge on that.

Dr Bartlett—Absolutely.

Mr QUICK—So, this report is not just about health, it is about the holistic thing. What infrastructure do you need as part of the community supply of health?

Mr JENKINS—This is a bit of a threshold because the discussion paper has been about the things that have been central to the way that the health dollars have been carved up. I think that Harry has to realise that what he is now saying is, I believe, correct. But we will have to go further than what is in the document, which is the thing that Ben is picking up.

CHAIR—That is right.

Ms HALL—That is right.

Mr JENKINS—The framework agreement is about health dollars—

Dr Bartlett—Health services.

Mr JENKINS—Health services. The thing that struck me about the discussion so far, when you were all going around at a pretty rapid pace, was that a lot of the things that we understand as being crucial do not necessarily get into any of these documents. When we look around the room, we are not having people that have that responsibility. Prior to the visit to Nganampa, I always thought that the health council did all these 'you beaut' things directly with environmental health, but you are relying on other people to do it. If we want to have agreements that put that into place, we have to realise that it is a new form of agreement.

Dr Bartlett—To go back, in some of the work that Helena has been doing actually looking at the capacity of communities to take up better health service delivery, things like who is responsible for the air strip, for evacuations and things like that is a headache because there is a lot of buck-passing about that sort of infrastructure, which clearly the health services cannot deliver themselves.

Ms HALL—It needs to be formalised and the communities need to know who is responsible for it to be able to have control, linked in with all those other issues. If there is not a direct line of control and involvement in all those areas, then you will not be able to improve the overall health because you can continue to pass the buck from now until eternity if there is no responsibility for those issues written in, as well as for the direct primary health service delivery.

Dr Bartlett—I agree. That is a job that is yet to be done. We need to get some of these options improved, because there is no doubt there is still buck-passing. For instance, the Territory health service provision of what they used to call grant in aid communities are now called service agreement communities. The negotiation of that service delivery still happens totally outside the framework of agreement structures, despite our attempts to drag it back in. They are some of the worst serviced communities. Apatula is one of those in Central Australia, and it is one of the worst serviced communities.

We think some form of option D has a lot going for it in terms of getting government agendas out of the actual task of resourcing primary health care. So if you had a Territory-

wide body that was able to take the funds from THS and take the funds from the Commonwealth that are available for primary health care service delivery, then it would be possible to form appropriate contracts with communities or with THS—who may still deliver some services—to ensure that an appropriate level of servicing is provided within the dollars available.

The whole issue, again, about community control is a problem area in that some communities are able to deliver that. Where they can, they should be given every encouragement because it is a learning thing, it is a developmental thing. There is no doubt that their potential outcomes will be better. However, there are some communities who are totally in the grip of alcohol, for instance. It is bizarre to even contemplate having a discussion with those communities about how they want their health service delivered because there is no-one at home, I am sorry. Those people need a health service probably more than some of the other communities that get it. The violence—those health problems—mean that they need a health service desperately.

It is a local body that is not caught up with the political agendas and it has the resources so that it is better able to make those decisions about when they are going to say, 'Right, we are putting this service in; we are not going to worry too much about consultation and that sort of thing because they need a service,' whereas in this place there is a different process to go on because of where people are at and what they are interested in focusing on.

Ms HALL—Could I finish—

CHAIR—Yes, and then Annette, Alby, and I want John Wilson to come in. I want to go to Harry Jenkins, too, to pick up that other point he was mentioning.

Ms HALL—Could I extend option D a little bit further? Do you think that that would work if you were to pull in some of those other issues? You have this body, and it also looks at the environmental and infrastructure issues.

Dr Bartlett—No, I do not think it would work.

Ms HALL—You think it needs to be separate.

Dr Bartlett—The history of the national Aboriginal health strategy and the tripartite forum where that was attempted was that we had land councils, housing associations, lands and housing. There was a great plethora of agencies on the tripartite forum and they spent their time fighting about it. Primary health care services deserve their own focus. Better housing and infrastructure also deserves its own focus. Then how you communicate between those sectors is what needs to be done. You do not give the health department responsibility for agriculture.

Ms HALL—Do you have any ideas on what you think the best linkages between those services are?

Dr Bartlett—At that sort of state—

Ms HALL—At a level so that you are getting an overall whole of government approach.

Dr Bartlett—There should be plenty of opportunities to set up cross-department committees. The Territory government have done this with petrol sniffing. Whether it produces an outcome remains to be seen, but it is at least an attempt to recognise that petrol sniffing is not going to be solved by one particular section of government, it does need an all of government approach. That is a good example of how that stuff needs to work. People that are worrying about roads and sewerage need to be able to liaise and communicate with the health care sector, but if you put it all in together it will fail again.

Ms ELLIS—I have a question from a different angle. I just want to pursue this a bit further with Bev, or with anybody for that matter. One of the intrinsic problems is that, if you are aware that you need to be doing certain things in certain communities to improve their health status, and it is primary health care stuff, then inevitably there will also be those other things attached to it, particularly sanitation, water and so on—those basic things. What really concerns me—I want to go back to what Julie was saying—is how we create absolutely reliable, watertight linkages so that it cannot happen that in any one given period the government level concerned says, 'We don't have the money this year to do that, and we don't have it for the next year either. We are out of money for sanitation and sewerage; we can't do it.' I am putting it very simply, I suppose, but I am really concerned. I do not know how we create those linkages.

I take your point that, if you are going to put money into health, make sure that it is focused on health for that specific reason. I understand that, and I understand that if environmental infrastructure issues need their direction then they get it. But the linkages between the two are almost more vital than the money going into either. I am frustrated as to how we can be sure we do not set up just another bureaucratic, interdepartmental state, territory, Commonwealth committee that meets twice a year. We need it bigger than that. It needs to be heavier than that because the funds simply must be hand in hand. Have you or anybody got any further comment?

Mrs Tye—On that point I have a little bit of anecdotal evidence. I think you cannot separate them where they must be strongly linked. I was at Utopia, which is a community here in Central Australia. I was working with the health workers on the national health worker competencies that are being implemented next year. There is a competency unit called 'Respond to community emergency' that the health workers must be able to fulfil to certain criteria. We talked about it and I asked, 'What would you consider a community emergency?' I put this to the nurses there as well, and there was nothing forthcoming. So I asked about one of the local communities with a population of about 100 in a family group. I said, 'What if the bore broke down and the community had no water?' That was considered a joke. It was considered normal because it was always happening and they could go for three weeks without water.

Ms ELLIS—Exactly.

Dr Bartlett—On the community level, we got a lot of feedback at the health summits that we have had. A lot of the communities are small and there is that demographic problem I mentioned before. They see their community council as their vehicle for community

control. They do not want to set up a plethora of committees. At that community level it largely is fairly integrated in places that work well anyway. It is with the bureaucratic stuff where you need some straight lines to support that integration.

CHAIR—Can I just make an observation? Harry Quick spoke about the Reeves inquiry. I was left with the impression after being on a significant number of committees, that there was the local government, regional council, land council and one other layer in the small communities. I was encouraged to hear you say that the region was well integrated but there was a significant layer of these various groups in the territory.

Dr Bartlett—Yes, there is, but at a community level. For example, there is a community council at Papunya. I do not know if there is a land council office at Papunya, but it is for a regional jurisdiction. It is not for Papunya alone. There is the community council and store committee at Areyonga. They are the only two local community bodies in that community, as far as I am aware.

CHAIR—That was just a throwaway. I thank you for that.

Mr Jefford—I had discussions with a medical officer in Central Australia about five or six years ago and, given the abysmal way in which the Commonwealth, states and territories were handling this and the health statistics that were coming out on Aboriginal and Torres Strait Islander people, we believed the only way forward was to bring in the World Health Organisation. I am also aware that not in the too distant past, MSF were having discussions in the Northern Territory. Medecins Sans Frontieres consider it serious enough—a 'war zone'—for them to come in.

I can give a good example of this intersectoral collaboration business happening. When Colombera was in dire straits, 100 per cent of the community had hookworm and the anaemia related to that infestation. There was a massive amount of infrastructure improvement. All these departmental bodies from Western Australia and the Department of Health and Aged Care, as it is now, came in and sat down. There were three senior Aboriginal people amongst that group. They sat there and listened, and a very senior woman, Mary Pandilow, who has an Order of Australia Medal, got up and said, 'I've have listened to all you mob. I can see what you are trying to do. But, unless you are able to stop people wiping their arses with their clothes because we cannot afford the toilet paper, you ain't going to do nothing.'

It does not matter what you do from this kind of perspective; unless the community have ownership, have the power, the control, the dollars and the support structures to be able to carry out these issues themselves, with those support structures being environmental health officers or nurses or teachers or anthropologists et cetera, you are going to end up with that kind of situation constantly.

Mr SCHULTZ—It is shame that the people out there that are engrossed in putting their hands on the little pockets of money that are supplied by government have not got the same commitment that this bipartisan committee of parliamentarians has to the real concern of resolving the problems associated with indigenous people in this country.

Mr QUICK—Nigel, would you see that the Tiwi model should be replicated right across Australia—cashing up and saying to the community, like they have done in the Tiwi islands, 'You set the strategies, you have got the money, you set your own priorities, end of story'? Is that the way to go? Is that model F?

Mr Jefford—That model, as it stands at the moment, is to be commended. It depends who is driving that model. If it is person specific—it does not matter who the person is—and that person either passes on or leaves the community, that model may well fall in a hole. I hope it does not; I hope it continues ad infinitum. But the whole issue surrounding remote areas and remote health, remote education, et cetera, often is person specific, and what you have today may not necessarily be what you have tomorrow. There is the question of that fluidity of putting systems in place. Let us say D is the model that is put in place. It may not be the model that works in two years time, six months time or 10 years time, so you have to—

Mr QUICK—I would ask Ben: how do we have the Tiwi model with 27 variations so it does work and if Ben disappears Helena carries it on and if Helena disappears someone else carries it on?

Dr Bartlett—It is important to say the Tiwi are a homogenous Aboriginal group, which makes a big difference to how it can work. You cannot replicate that part of it.

CHAIR—They remind us of that. They do not claim to be brilliant about it. They acknowledge that is a key factor for them.

Dr Bartlett—Indeed. An anxiety I have about the model is the cashing out. We are doing some work now for different population groups in Central Australia to try and ascertain whether the level of cashing out that they are talking about is actually going to be sufficient to meet the need. We are not convinced at this stage that it is, so there is still a funding problem. There is a lot of vested interest in the Tiwi model, and that is part of what we are seeing. The Northern Territory government and the Commonwealth both have a lot riding on Tiwi as a model. So we are holding our fire a bit about whether it is going to work or not.

CHAIR—You are suggesting that the vested interests are in making sure it works and whether in fact it is working more of its own accord, and therefore how do you apply it to others? Is that what I am to read into it, or am I reading too much into it?

Dr Bartlett—No, we are just cautious about rushing ahead and saying something because there is a real desire—it has come out in this discussion—to have a model, and not only a model but a national model. That is very problematic because the situation in indigenous communities varies enormously, so a national model needs to allow enormous variation, depending on the nature of the community and their histories. The zonal stuff that people are talking about now as part of a possible cashed out model means that it often incorporates a number of communities that are historically enemies, so how we use those zones is influenced by that on the ground.

Mr QUICK—As part of D, should we have a recommendation that we use the Northern Territory as a model and set up the TIHS—Territory Indigenous Health Service—with enough money in the bucket to do what they want to do?

Dr Bartlett—I am sure my bosses would be delighted.

Mr QUICK—I am serious.

Dr Bartlett—I am, too.

Mr QUICK—Then the other states and the ACT continue on the hodgepodge we have got—

CHAIR—You will have to cut it there, Harry, because other members have questions and there is the time factor.

Mr SCHULTZ—I want to raise the issue of education and how it can work with the lack of sufficient numbers of indigenous health professionals. I refer to page 19 of the discussion paper, paragraph 3.5, where it says:

> There was also considerable evidence that there are difficulties associated with the recruitment, training and ongoing support provided for all these staff, and that there are inadequate numbers of Indigenous people training to become health workers and health professionals.

I understand that there was one proposal to increase the numbers of indigenous health professionals. That was for a program to identify likely students late in primary school or early in high school and to provide funding and other support, including cultural support, to encourage those students to continue their training. Is this a viable proposal and what difficulties could be foreseen if it was supported? In other words, it would use the facilities of our education resources to get indigenous people at a young age—within the primary school system and high school system—and train them to appreciate those sorts of issues and get them interested in becoming health professionals at a later stage.

Dr Bartlett—I suppose you cannot help but say that the first problem is dealing with the education problems overall, which are a major determinant of better health, and that it is in crisis and is going backwards.

CHAIR—Albert started on this this morning. Can we just hold it there and perhaps talk over smoko. It is a huge issue but I would like to get back to it and to bring Julie in as well because it relates to her area and also to Nigel's. I am trying look at how to link the two models, the health model and the model for the rest of it. Harry Jenkins, did you get anything further out of it? I do not want to lose that while it we are in this session.

Mr JENKINS—Ben's comments about the tripartite process were helpful. This is the report from yesterday. The number of agencies that were involved in it indicates that that was the sort of approach that they adopted. You had ATSIC, the Aboriginal affairs department, Commonwealth Health, Western Australia Health, the Western Australia Municipal Association, Homeswest—they all got down there and they created this document as a resource for others to make decisions. They set priorities about what they thought were

the needs for environmental health and asked the decision makers to take into account this body of work. That is a guide to one way you might go about it.

CHAIR—We can come back to it, but I just did not want to lose it because I thought you made a good point yesterday. Shane Houston, whom no doubt many of you would know, made the point that they made studies of various Aboriginal communities and then related that back to the environmental health factors, if I am correct on that. There was a comparison of Aboriginal communities and what had been done, particularly in the environmental area, and then comparative outcomes were looked at. There was a degree of that sort of analysis in order to say what was working and what was not, to say—and this was Harry Quick's point—what were best case scenarios. That will do for a while, folks. We will stretch our legs, have a cup of coffee and a yarn about things.

Proceedings suspended from 10.59 a.m. to 11.29 a.m.

CHAIR—Inevitably we end up leading back to the eternal issue of health and environmental structure—the health hardware, as it is known at times. There were a couple of suggestions the deputy chair and Harry Quick made. I think it started off with the education and training of Aboriginal health workers. Just from chatting with Nigel there before—and Harry Quick's frustration comes through regularly about wanting to move it forward—there is an eternity, it seems, of thinking you might have a problem and then the more you get into it you realise you have not got a solution. Can we, in some reasonably methodical way, work through the training and education of health care workers in the next half hour or so, picking up from you, Alby, and then we will go around and see how we go and where we end up. One of you might like to recap the question.

Mr SCHULTZ—Sure. What I wanted to raise was the issue of education and how that can be linked in with the lack of sufficient numbers of indigenous health professionals. I referred to page 19 of the discussion paper, paragraph 3.5, which refers to the difficulties associated with recruitment, training and ongoing support for staff and the fact that there are inadequate numbers of indigenous people training to become health workers and health professionals. I talked about the proposal to increase the numbers of indigenous health professionals, a program to identify likely students late in primary school or early in high school, and the provision of funding and other support, including cultural support, to encourage those students to continue their training. The question is whether this is a viable proposal and what difficulties can be foreseen if it is supported.

Mr Tilton—The first issue is obviously the basic education system that is available for Aboriginal people. I think it was maybe two or three years ago, in the whole of Central Australia, just one Aboriginal person completed high school, their high school certificate. The reasons for that are very complex, but the lack of any decent educational facilities away from Alice Springs and the necessity for Aboriginal kids—who might have some kind of aptitude—generally speaking having to come in to Alice Springs to continue their high school creates enormous problems for them and their families, and it is actually very difficult for people to do. So while there is not that basic educational infrastructure, it is very hard to even take it to that step of identifying people and so on.

The second thing I want to say is that I think, in talking about the number of indigenous health professionals, you need to be a bit more specific about which health professionals you

are talking about. In terms of Aboriginal health workers, obviously it is clearly vital that they be local Aboriginal people, recruited and trained in their local Aboriginal communities. In terms of nurses and doctors, while it would be ideal to have indigenous nurses and indigenous doctors and that is certainly something that should be aimed for, it seems to me that the crucial factor is having those doctors and nurses, and indeed the health workers themselves, working under some kind of system of community control.

It would be good if there was an Aboriginal person sitting here doing my job, but the history of Australia and so on means there are actually very few Aboriginal people with the kinds of skills that I have, and the ones that do have them tend to go very rapidly into quite senior management roles—quite properly.

So what is important for health professionals like myself more on the research and policy side at this stage is that we be under the control of the Aboriginal community in some sense. When I came to Central Australia I had not had any cultural awareness training or anything like that, but what I did have was Aboriginal bosses who told me what to do. That is the best cultural awareness training you can get, really.

I think there are those two issues: firstly, the state, in the broader sense, has to take responsibility for providing an education system which can actually allow Aboriginal kids to get to high school and get through high school, and then they have those options perhaps further on; and, secondly, there is the issue of looking in more detail when we talk about health professionals at who they are and under what structures they work.

CHAIR—What did those Aboriginal bosses say that was particularly valuable to you? Are there one or two points that are in your mind about your Aboriginal bosses—'They suggested this or gave me this direction'? Is there anything in particular that you remember?

Mr Tilton—It is just the general thing of having one's own preconceptions of what would work or should work in a situation challenged, I suppose. It is not that people do not listen. Part of our job—and that of Ben and Helena and all the other people who work in these capacities—is to give advice. At the end of the day, if we are working in a community controlled structure, then it is the Aboriginal community that is in the position to say, 'Thanks for your advice but in fact we want to go this way.' There are lots of examples on a daily basis where that occurs.

CHAIR—Thanks. Does anyone want to follow on? Helena, do you want to come in on that one at all?

Ms Maher—Just picking up on that point where you asked about what difference it makes to work for an Aboriginal boss, I guess the thing that I would say is that in the last couple of months I have had the pleasure of doing community consultations with Ben and with John Liddle, who is the director of congress, and that has been quite an education for me. I am comparing that with my experience of doing consultations. I worked for both Territory health services and the Commonwealth Department of Health before I worked for the congress.

The difference is in things like the credibility and the authority with which someone like John Liddle speaks. He has been developing health services in Central Australia for 21 years, and I do not think there is anybody in any department anywhere in Australia who can draw on experience like that. And there is his credibility as well. That engenders a lot of trust. Also, he is accountable to those communities in ways that the bureaucracy is accountable to the ministers, ultimately, and to their management. We are not talking about being culturally appropriate because Aboriginal people do not like you to ask too many questions or something like that. What we are talking about is more the issue of the credibility and the authority being there much more.

Mr SCHULTZ—We have been to a number of clinics in isolated areas that only have one nurse, and that nurse, in some of those clinics, is on call 24 hours a day, which indicates to me that it is a problem either associated with the lack of finance available to employ another nurse, or another two nurses, or it is directly related to insufficient trained nurses available to go there. That was the reason why I raised the issue. Would anybody like to comment on that?

Mr Jefford—First and foremost, on a national perspective, there is a nursing shortage around the world. It is not a profession that people are putting down as their first choice to come into—and that is into mainstream health. In all of mainstream health—and I was part of a national nursing work force forum in Canberra about three or four weeks ago—it is well recognised that there is a problem. It is about third or fourth choice for most people entering nursing.

Secondly, for them to go rural or remote is way down the patch. Evidence that we collated in the early part of this year from every tertiary institution shows that not one of those tertiary institutions in their 1997-98 year had anything to do with rural or remote health as part of core curriculum. The occasional elective in their final year on Aboriginal health is all that was offered. So I think the tertiary sector—and a very small number, too, that I know of—are actually changing their core curriculum to incorporate rural and remote health. And I make the point again that about 25 per cent of Australians live in rural and remote Australia.

There has always been a nursing shortage in remote areas—always. There have been bush nurses. To quote the Victorian Bush Nurses Association, 'We have been here since 1900.' So there have been nurses working in an isolated practice and in remote areas—and there is a distinction between the two as well as a marrying of the two. There has always been a shortage. Yesterday I heard from three what we call RANs—remote area nurses—in a community where all 13 are prepared to walk off purely and simply because there have been three acts of violence in the last three weeks. Those three nurses have left. The other 12 are prepared to leave, purely and simply because they fear for their safety.

It is very easy to blame the community—to say it is the community's fault, that they are not protecting the nurses. There are several issues. One is, apart from getting people to go out there in the first place, those that do go out there range from brilliant to not so brilliant and not so good, and that is the same whether you were to walk into this—

Mr SCHULTZ—We can relate to that in our profession.

Mr Jefford—That is the same whether you walk into the North Shore. There are nurses who are brilliant in intensive care and nurses who are not so brilliant. The unfortunate aspect of remote area nurses and Aboriginal and Torres Strait Islander health workers is that they are in a goldfish bowl. Everybody can see what they are doing, where they are going, who they are doing it with. They have very little escape from it 24 hours a day, seven days a week. I have been in that situation. I was on call for those 24 hours seven days a week.

Mr QUICK—How do we change it?

Mr Jefford—Let us say you have a single sister community and you want to put another sister in there: it is not just a matter of finding $60,000 to pay for that individual. You have to find them accommodation. You have to find them relief. You have to find the support, education and training that is being provided or not, as the case may be, by their employer. Some employers are very good—not many.

Mr QUICK—We have been out to places where accommodation is a container. Surely, we should look at the places that are doing it best and say to them, 'What structures did you put in place,' and then say to other places like Docker River where you have got one on 24 hours a day, 'Community Z have got this structure; is there any opportunity for you to replicate that?' If they say yes, there is, but it is financial, where do we get the bag of money from? We are here today to listen to the sad stories but, more importantly, for you people who are experts out in the field to tell us—

Dr Bartlett—It is not just nurses, of course.

Mr QUICK—I know.

Dr Bartlett—It is any health professional working in remote communities. There is no doubt that there is a community dynamic that is important to it. There are some communities that have managed to employ nurses, to take responsibility for them, to look after them very successfully. When we are talking about models and options of how you deliver primary health care, the reason community control is a very important part of primary health care in its ideal form is that the community does take some direct responsibility.

There is one community where, unfortunately, a doctor was raped earlier this year. The community had a very sophisticated approach, I thought, to providing that doctor—she left the community obviously—with quite a lot of support. The magistrate unfortunately let this character out and he went back to that community, but essentially the community made some attempt at least—I am not sure how successful—to put him under some sort of house arrest. That was a very important action for that doctor to feel good things about that community rather than just blaming the community.

The process of encouraging health committees, groups of people in the community to take responsibility for the health service staff that are employed, is really one of the important things. Without having gone into it, my understanding of where these incidents happen and nurses leave the community, which Nigel was referring to, tend to be in communities that have no sort of organisation around their health service at all. These things happen, and the authority for the nurses is right outside the community anyway.

CHAIR—It varies. Committees will go up and down and it will vary. When the committee is functioning well you can expect a lot of things like that, one function flows on to the other. One health service closed a couple of years ago because of the violence. It ebbs and flows depending on the quality of leadership.

Dr Bartlett—That is right, and what else is going on in the community. With petrol sniffing you tend to get a bit more violence than when that is not happening. I want to also say something about health workers because I think really people talk about health workers in this generic way and in fact we are talking about a number of different beasts here. In the Territory, Aboriginal health workers are registered. There is an Aboriginal health worker professional registration board, the same as the nurses and doctors and a number of other professionals have. They have a clinical role. They are not just drivers, liaison workers or cultural brokers which they often are in other jurisdictions. So that is one issue.

The other issue within the Territory is that there are two distinct types of health workers. There has been a lot of effort to get a proper education system set up, career paths, Aboriginal health worker positions in bureaucracies, educational institutions, et cetera. So there are health workers who clearly want a career path. They want to play a role outside their own local community. That is fine. For that they certainly need literacy and numeracy and some high educational standards.

The other health workers really have a different sort of role altogether. They are people who are of the local community. In the ideal primary health care setting the community chooses who their health worker is. Who do they choose?

CHAIR—Can I just interrupt there. I would like you to define primary health care because in a conversation I have just had over smoko, we asked: does primary health care really exist? Does it really exist in Aboriginal health care situations? Isn't it more dealing with acute and critical care?

Dr Bartlett—Acute care is part of primary health.

CHAIR—That is the aim. You mentioned in your own statement a little while ago about ideal. But does primary health care really exist in reality? If it does, how much?

Dr Bartlett—It varies how much but it does exist in reality. In clinical care, acute care is part of primary health care. In fact, it exists in a more holistic way more often in Aboriginal communities than it does in non-Aboriginal, because non-Aboriginal primary care is essentially primary medical care that is based on private general practitioners. Kintore has a primary health care service which provides that clinical care. It also runs a scabies program in recent years. It also has some focus on some chronic disease management stuff.

CHAIR—These are European terms, aren't they? They are white fella terms.

Dr Bartlett—A lot of Aboriginal people would say that we created primary health care in this country. In 1971—before Whitlam, let us recall—was when Redfern got going. That was before the Alma-Ata which a lot of people say is where primary health care started. The congress started in 1973. These Aboriginal health services were set up in the early 1970s.

The inspiration was from the community, within the community, and they have been delivering primary health care within all sorts of constraints—both community and budgetary constraints.

Mr Jefford—I agree with Ben, and I think it principally occurs in communities where there is community control. It occurs to a lesser extent where state or territory governments have control, because minimal resources are put into those areas. You are the last cab off the rank for any resource; it does not matter whether it is a physical resource, such as Aboriginal and Torres Strait Islander health worker, a registered nurse, a medical officer or a piece of equipment. To a certain extent, in those kinds of environments it is finger in the dike stuff. Nurses do not step out of the clinic and go around and do environmental care; they do not go and do first aid in the schools; they do not go and give councils reports on what is happening within the clinic setting—how many evacuations, et cetera—because they are too bloody tired, they are on their own or they have minimal support structures. They do not get the education, training and support that they deserve and that their colleagues in metropolitan and regional Australia do get on a regular basis. That is why there is such a high turnover within not just the remote nursing work force but the remote medical work force and the remote Aboriginal and Torres Strait Islander health area. Julie could talk about the stresses that health workers face.

Dr Bartlett—I just want to finish this thing about the two types of health workers, because I think it is critical to solving the problem. The problem is that the people in remote bush communities whom the community want to be health workers are often senior people who have poor literacy, who do not want to leave their community, who have no interest in what the bureaucracy is doing and what educational institutions are doing; they just want to live in their community and play a health care role in their community. The difficulty is that the strategies that have been developed over the last decade for Aboriginal health worker education have forgotten those people. That is why we have too many bush communities now without any health workers. That means the nurses do not get the support, they do not have people to relate to, et cetera.

CHAIR—That is why the doctor—

Mrs Tye—I agree with what Ben has just said there. It is not just the educational aspect that has influenced that, but the move to professional career pathways, the actual acute care that we talked about, this push for this clinical role. And it is not just a clinical role—you can ask 10 different people what the role of the Aboriginal health worker is, and they will give you 10 different answers; there are perceptions are they are everything to everyone, and that influences stresses on health workers—it is their workload where they are taking a clinical role, which is very much alongside the nurse in that community. Nurses come and go; health workers do not. They are there constantly. You talk about support structures. There is no housing provided for health workers in remote communities; there is for nurses and doctors.

CHAIR—We have evidence that sometimes there is a bit of an issue between doctors and nurses, but we will come back to that.

Mrs Tye—Health workers operate under much the same systems as other health professionals in the community. They do on-call. I have often said to health workers and colleagues that, if there is such a thing as reincarnation, I would not like to come back as an Aboriginal health worker, because in my experience it would seem that in a lot of remote communities the responsibility for health sits with the health worker. Would you agree with that, Ben?

Dr Bartlett—Yes.

CHAIR—The demands are extreme. There is preventative health, primary health and acute health. It seems to me that the preventative side is insignificant. You can tell me differently.

Mrs Tye—Acute care and preventative health care occurs. I agree with Ben that, yes, there is primary health care. I make the statement that in a lot of communities it is rhetoric because, as Nigel was pointing out, acute care is the major focus. If you have been working eight hours in the clinic, bandaging and fixing acute situations, what energy do you have to go around with health promotion activities? Prevention programs—your immunisation programs—are occurring, but in the main the focus really is clinical.

With the introduction of the national health worker competencies and the training packages that are being implemented next year the focus for health workers and their basic training in this area in the Territory is still very clinical. Competency units have been developed and standardised across Australia. Because of registration and the focus of their work being clinical, the NT has come to agreements with ITAB, et cetera, that we would customise these competency units. The customisation process has not changed the actual units; it has made units that were optional for other areas compulsory in the NT, so that that clinical focus is not lost.

I hope that the implementation of these training packages does not go on for too long before that is actually reviewed, because I foresee problems, particularly in the clinical area. The demands on skills across the board for pre-registration of health workers—that is, their basic training prior to getting registration—are enormous. Health care should be appropriate to the community that health workers are working in. If the training packages are demanding that they must be competent in suturing, yet the set-up where they are does not provide for that suturing—it does not have the equipment—how can they be competent in that area? It means they would have to move away from their own community to a larger community to get that experience. So we are losing a reasonable amount of flexibility and making the role of the health worker appropriate to that community.

As far as training goes—and speaking for Batchelor—there seems to be funding for health worker education through ITAB, the national competencies, et cetera. Our funding is calculated in much the same way as for mainstream Australia, and there are things that are not taken into consideration. Students have a limited time to complete a course before their Abstudy support is cut. It is not only that: if it takes a health worker three years to do what is normally a one-year full-time training course, by the time they are onto the second half of that training the units they enrol in to study determine that they are a part-time student, so they do not qualify for full-time Abstudy support. So there are those funding issues.

On top of that, NT DAA and ITAB determine with the registered training organisation how many hours and what funding you will get for that. The question over here is that there does not seem to be enough training for health professionals. The demand for Aboriginal health workers is there, and—through restrictions on the number of hours we can deliver, the amount of Abstudy support, et cetera—we are not satisfying that demand. There are also considerations about school leavers doing health worker training. My understanding—and correct me if I am wrong—is that you have to be a certain age to qualify for Abstudy. I think it is a bit older.

Ms HALL—Sixteen.

Mrs Tye—Is that definite?

Ms HALL—Yes.

Mrs Tye—There is that consideration as well. The Batchelor institute was approached by a community a few years back to deliver health worker education to a group of young people in their community—not necessarily because the parents wanted them to be health workers, but because they wanted something for them coming out of school. These kids had been away to boarding school and had come back to the community, and they wanted something for them.

But, with that, there is also that conflict that health workers have tended in the past to be people who have authority in the community. So, in one sense, a younger person coming in and doing their health worker training is a good set-up for down the track when they do gain status in their community, et cetera, but it also puts added stresses on those young people when they do not have that authority in that community sense.

Mr Lamb—I have heard a lot about the services, but the root cause of all disease is usually in the home or in the environment. I do not blame the sisters for not being able to get out and do environmental health work, but we have not got enough environmental health officers actually on the ground to train the environment health workers to help individual householders and the communities to prevent some of these things. For instance, at one place in Western Australia there was an outbreak of Ross River fever, a mosquito borne disease. The sisters were hard hit with other diseases too. They could not get out and see what was happening. The simple thing was that there were five empty houses where the cisterns in the toilets and the traps underneath the floors were just black with mosquito larvae; they were breeding continuously. All it needed was a worker to go out at least every 10 days—that is, the life-cycle of the mosquito—to go and flush those toilets, cover them up or even put a bit of diesel on top. That is where the environmental health worker comes in. This is where the thrust should be, and not so much on curing the disease. Because we do not do any curing; we leave that to the sisters and the doctors.

CHAIR—Just focus on the community.

Mr Lamb—We are about prevention, but there are not enough—and Mr Quick brought this up too—people going out. I learned at a conference in Cairns a couple of years ago that under Western Australian law—and, apparently, throughout Australia—the Local

Government Act does not put any onus on local authorities to provide any service to Aboriginal communities within the shire.

CHAIR—We were covering that earlier.

Mr Jefford—Kununurra saw themselves as having a responsibility for Kalumburu, Oombulgurri and Warnum—remote communities that essentially come under that East Kimberley kind of jurisdiction—under the Public Health Act to in fact employ an environmental health worker under the guidance of their environmental health officer. But that was fairly far-sighted of that town council.

Mr Lamb—Kiwirrkurra has still not been serviced for the last 15 years.

Mr Jefford—That does not surprise me.

Mr Lamb—And that is within the east Pilbara.

Ms ELLIS—Can I just ask a question specifically of Ben, but to Nigel and Julie if they wish to come into it—that is: what if we suggested that Aboriginal health become a medical specialty?

Dr Bartlett—So, more money for the doctors? That is how it would be interpreted.

Ms ELLIS—I want your reaction to it. What are the advantages, and what are the disadvantages? Are there any advantages?

Dr Bartlett—There is an issue about career paths for both. But for non-Aboriginal people working in Aboriginal health, I think that is an issue. I am cautious about calling it a specialty, because of what is really required. Why do you want doctors in Aboriginal communities? It is general practice. That is really what communities want doctors for. When doctors try to get too involved in telling the community where they should plant orange trees or how they should deal with this or that problem, then often you find the communities want to get rid of them.

Ms ELLIS—So there are no advantages to the idea?

Dr Bartlett—I think it needs a lot of thought about how to do it and whether to do it. I know the College of General Practitioners has an Aboriginal health stream in their training program, including the possibility of doing an Aboriginal health registrar's position in the senior years, so it is sort of like a sub-specialty within the general practice scheme of things.

Ms ELLIS—Would that be the way to do it?

Dr Bartlett—I suspect that is the way to do it, rather than creating yet another specialty as such.

Ms ELLIS—That is why I asked the question. The reason for asking the question is also based on the fact that we understand only too well not only the difficulty in getting either

GPs or qualified nurses out there, but also for GPs in particular to then have that service and experience. Let's face it, they experience almost anything in terms of service delivery out there, and to see that as an advantage not a disadvantage if and when they decide to re-enter mainstream medicine and not remain in the remote or rural community. At the moment a lot of the comment is, 'We have been out of the circle for so long that we do not see a way of re-entering it, so we will not go.'

Dr Bartlett—I think that is true, but part of the difficulty is that Aboriginal health is not a rural and remote issue.

Ms ELLIS—I understand that.

Dr Bartlett—For instance, doctors go to communities for two or three years. The most I have heard of is eight years, which is an extraordinary length of time. That individual is now in Adelaide in a general practice, so the experience that that person has gained in Aboriginal health is not being tapped by medical education or professional development in any sense. That is then the difficulty. You get young doctors going mostly for two years into Aboriginal health before they have families and before they go back and settle down in their private practices in Melbourne and Sydney.

Ms ELLIS—Should that fellow be scooped up and put somehow into the education process of the medical profession?

Dr Bartlett—I think so. We have to find a way of tapping experienced people into orienting younger people in the profession, doing some of the college training and that sort of thing. There is no real system at the moment where that happens. It is pot luck really. I know that in New South Wales with some of the college education, if anyone has been into an Aboriginal community they are seen as being experienced enough to run some education on it. That is not very good.

Mr Jefford—The initial view—and it still is in a lot of cases within mainstream health—is that, if you went to work remotely you were mad, a missionary, a mercenary or a migrant. We think we are rescinding that view reasonably successfully, in terms of preaching to the wider health audience through a number of forums over the last number of years. I will table the remote area nurse national competencies which have just hit the floor. It is all about having similar structures, be they state or territory governments or community controlled organisations. For instance, Ngaanyatjarra health has a copy of this and intends implementing it with regard to their staffing so that best possible practice is in place by the best possible people.

Unfortunately, it still occurs. I am aware that in the cape district of Queensland people are employed on three-month contracts. They get off Qantas, go on a scuba diving holiday and then want to cuddle an Aboriginal baby, so they go up north for three months. That is all that is being offered—three-month short-term contracts. Aboriginal and Torres Strait Islander health is not going to improve with that kind of focus by employers across the system. That is the Queensland government; the Apunipima Cape York Health Council is a different matter.

Ms HALL—Could we talk a little bit more about the issue of training and specialties? I think that that has been covered. One of the questions I was about to ask you concerned the specialty, developing that expertise and the valuing of having worked in indigenous communities. Once you do have that higher level of recognition for the work at a specialty, or a speciality stand within GP registration, it is then valued and people want to work in that area.

Even if you have to add a status element to work in remote communities, maybe it is worthwhile, because along with that status you will get research along that line. Along with the research, it will become a much more high profile area of medicine. I am caught in that dilemma. Yes, it could end up with there being more money in the pockets of doctors, but it could also end up leading to better health and greater commitment by workers who are working in that speciality area. Perhaps you might like to comment on that?

Dr Bartlett—It is a dilemma. I do not know how familiar people are with Marmot and Syme, and those people who have been looking at the determinants of health. Marmot did a big study in the United Kingdom that looked at public servants. We have always known that poverty is not good for you, but what he found was that the people in the second rung, which are your professionals with high levels of autonomy and high levels of income, had twice the mortality experience compared to the people on the top rung. Nigel mentioned the cortisol levels before. A lot of the questions about poor health status relate to people's poverty and people's marginalisation in the mainstream. Some of the other work that is being done is about relative poverty. So there is absolute poverty, but there is also relative poverty.

In Aboriginal communities, the wages of Aboriginal health workers are up to, let's say for argument's sake, $35,000 these days, which is much better than it was 10 years ago. Doctors at that time were probably getting $50,000 to $60,000 in remote communities. Now they are getting $120,000, so that the relative gap between what doctors are getting in remote communities and what health workers are getting is widening. Is that making people sicker? I do not know. I am just saying that we have to be fairly circumspect.

It is the same when people are talking about nutrition. Is nutrition just our anxiety because of our risk factor paradigm that public health is locked into at the moment? Maybe that has nothing to do with it. The fact that people are poor and they are stressed because of the stressful living, the cortisol levels that Nigel referred to are up here somewhere. That may be the real reason people are sick. I am raising impossible questions, I know, but I think we have to be careful about how much we promote doctors and nurses as solutions compared with dynamics within the community and the role of health workers. But it is a problem.

Ms HALL—The other matter I wanted to ask questions about is Aboriginal health workers, the burnout factor, the support and the high staff turnover in all sections of health in rural and remote areas. It is good that there is the association, but what other strategies are being put in place to help those workers in the remote communities who are finding it difficult? You have mentioned a number of factors here today; the support and the place they have within the community and the extraordinarily long hours that they have to work. Is there any formal structure that could be put in place that would help them cope with those

aspects a little better than they can now? Julie, I know you spoke about that a little earlier, but it is now open to anyone.

Mrs Tye—Just on health workers and the burnout factor, the response there to too much stress that is health workers do not come to work. They stay at home, which then adds to the stress of the other health professionals, whether it is nurses or whatever. As far as health workers, I believe that the equities are not there. Health workers are a profession in their own right. They have huge responsibilities in their community, but they do not have the support structures that nurses or doctors have. As I mentioned before, they do not have housing. Often in communities there is no formalised child care, and those sorts of issues. So they vote with their feet. When they are tired, when they are stressed, when they have had enough and when the demands are too great, I guess they do not come to work.

Ms HALL—You would say that we need to work with communities and with state governments to see that those structures are in place, that there is adequate child care and that we look at housing. What about a stronger formal support network that is in place now at a similar level for doctors and nurses? Would you see that is something that could be cultivated through Batchelor College?

Mrs Tye—We could play a role in it. I think that the health worker association that has been established here in the centre is a starting point. They have become quite a voice for health workers, but they are just a small area of the whole health worker issue.

Ms HALL—Could you tell us a little bit more about that health worker association, the kind of support, the number of times it meets and the members?

Dr Bartlett—It started by us attempting to colonise the division of general practice staff some years ago and set up a central Australian division of primary health care which we were not ultimately allowed to do. The Commonwealth health said it was for doctors only, but the intent was to get some resources to help set up some support structures for Aboriginal health workers primarily. But they did fund a primary health care network and that evolved into the health worker association. That is where it came from.

Mrs Tye—Having said that, I cannot answer how many times they meet per year, et cetera.

Mr Jefford—The health worker association was actually in the same building as us. They had a funded secretariat. That is now in the same office structure as the Division of General Practice. They are now on the board of the Division of General Practice, and it is the only place in Australia where other than GPs are on the board. The Council of Remote Area Nurses sits on that as an observer and, as of a couple of weeks ago, that is likely to be accelerated to a full voting position on that board.

In terms of support, there is the bush crisis line which is a CRANA initiative funded by the Commonwealth. Again, it has received another three years of funding as of the beginning of this financial year. In full consultation with Aboriginal and Torres Strait Islander people, including the Central Australian and Barkly Aboriginal Health Workers Association, the Apunipima Cape York Health Council in the cape district and NACCHO, it has two

indigenous co-counsellors to whom the principal counsellor can refer an indigenous caller, if so identified, to either a male or a female indigenous co-counsellor.

There were some concerns that the two co-counsellors who are based in the Cairns area, were able to satisfactorily meet the needs of say someone at Umuwa. I think that is yet to be tested. We do not believe that we are the body that should necessarily run with this ad infinitum. It is has been going for about six months now—not the bush crisis line but its indigenous co-counselling counterpart—and we believe that, if successful, that can be hived off into its own supportive structure on a national basis, controlled by dollars controlled by Aboriginal and Torres Islander people.

Mrs ELSON—My concern is with something that Albert said earlier about one particular community where there was six per cent attendance at school. I wondered what advice we can be given as far as putting something in our report to help encourage better attendance. I know it is the elders in the community who are recommending whether children go to school or not, because we have seen it ourselves as we go around. What can we recommend as a committee in this report? You cannot force people to go to school if the elders in the area are telling them not to go.

CHAIR—We have about three problems, don't we? We have a jurisdictional problem.

Mrs ELSON—That is right.

CHAIR—There is some reference to Abstudy, but I do not think that is the basis for that sort of issue.

Mrs ELSON—No, I am talking about primary school. We have seen it within primary school. I do not know whether Albert has seen it within primary school or senior school when he was talking about the six per cent. That really concerns me, because some Aboriginal leaders have told us that they encourage their community to go to school because they believe the only way that they can get services back into their community is to know what is available out there.

CHAIR—Was it Dr Bartlett who said no school, no pool; or no pool, no school.

Dr Bartlett—It was no school, no pool; not no pool, no school.

Mrs ELSON—It concerns me that we drift over the top of that rather than look into that side of it to get answers for our Aboriginal communities.

CHAIR—It is excellent, Kay, and these are the fundamental things we are dealing with. It is part of what Albert asked right at the beginning: have we made any progress in 20 years based on that simple proposition?

Mr Lamb—It all stems from the responsibility of the elders or the leaders of the particular group. I gave as the other case Cosmo Newberry, which in the same survey showed about 97 per cent attendance because the Aboriginal family, who are the traditional owners, also run the place. It may not be truly democratic, but it is as much as the election

of minor councillors, but it is run by Aboriginals. They have got an European sister there and European teachers. They have had some very good teachers there, and it is a good school. But the attendance is mainly because of the strict discipline imposed by the elders of that place.

They have the same attitude towards any substance abuse, and they hand out a few hidings. Vandalism is down to about 0.5 of one per cent, because the parents pay for the vandalism caused by the child. The council says to the parents, 'You chastise them or we will.' It may sound a bit brutal to social services people, but it works. Dog control is on the streets. They have a .22 rifle, out of the way—bang. Again, it is coming back to responsibility by the Aboriginal people for the Aboriginal people, and the Aboriginal people telling the Aboriginal people what to do, instead of that white fella doing it.

Mrs ELSON—But what if the Aboriginal leaders are telling them not to go to school? How do you turn that around?

Mr Lamb—This is where again the word education comes in. You have to try and educate the elders to say, 'Look, impose that discipline, impose that responsibility.' I hope there are no anthropologists present. They and a few others like them are the stumbling point to these things. In one community where I was working I was involved in a dog program where they had 25 dogs to a house. I got talking to the older Aboriginals who had their say, and they agreed to reduce it to three. Along came a cultural person and said, 'Oh, you have a doggy dreaming place here.' They preyed upon the vanity of the elders and said, 'Look, this white fella is taking away your authority.' It was their decision to reduce the dogs to three, but because this person came in and intervened, they have still got 20 or 25 dogs to a house.

CHAIR—Still got doggy dreaming.

Mr Lamb—And it is all bulldust about the doggy dreaming, because I have spoken to many of them. The only dogs they had before the introduction of the white fella, particularly in the inner part of Australia, were the dingo. They agreed that they would not have more than three dingoes in the family. They would kill each other because they are wild dogs.

CHAIR—Kay, do you want to ask a supplementary or general question?

Mrs ELSON—Yes. I still cannot see a solution.

CHAIR—Do you want to go around and develop it a bit, or what?

Mrs ELSON—The only solution I can see is that the people who are running successful communities should venture out and advise the communities that are not encouraging education. I do not think we as government can make a rule to make anyone go to school if their elders do not tell them.

CHAIR—We have got the jurisdictional problem for a start.

Mrs ELSON—Yes, that is right, but it could be a recommendation in there though to encourage other communities.

CHAIR—But Dr Bartlett, Nigel and Julie might like to have a go at it, too. Can we keep it down to a minute or two each, because we need to start thinking about winding it up.

Dr Bartlett—It seems to me that there is education and there is education, and where you have got communities who do not value education, that is often where people do not see the importance of sending their kids to school et cetera. That is quite common. I think that what we have tended to do is to impose an education system on Aboriginal communities based on the way we think about it, which is primary schools, secondary schools et cetera, and the adults are not brought into that. I think the strategy that can be pursued is to have an education strategy that includes adult education with children so that the adults start to get some commitment as well.

Mr Jefford—Can I say that 25 dogs is not a problem if they are 25 healthy dogs—the same as 25 people living in a house is not a problem providing they are 25 healthy people. It is what is put in place to ensure that that occurs.

Mrs Tye—On the education point of view in primary schooling, I do not know if it is outside the jurisdiction of this inquiry, but the Collins report came down a few weeks ago—

CHAIR—Yes, I am aware of that.

Mrs Tye—It might be worth your while having a look at it.

CHAIR—Yes. I am sure it will get some prominence, and in fact it was Dr Kemp working with Bob Collins on that.

We need to start winding it up. What I would like you to think about is the priority of things for this committee when we go back to see where we should be headed mainly, accepting holistic, accepting everything that has been said this morning. Can we just go around the table in about a minute each, the five or six particularly, on where you think the priority is, and there might be an odd member that wants to ask a particular question.

We have not even really touched on Commonwealth-state relations—the Territory hospital system, for example. We have not even really touched on data inaccuracy or otherwise in individual discipline areas, but certainly it has got some relevance. There is a lot of untapped stuff we have not talked about this morning, and no doubt we will talk about it over lunch. What would you hope this committee might focus on? As Harry Quick keeps reminding us, you are the people out there working with it. Dr Bartlett, if I could start with you, on the issue of preventive health, primary health, critical care, acute care, maybe you would help me with the definition of where we head with that. Over to you.

Dr Bartlett—In relation to the definition of primary health care, we would say comprehensive primary health care is important, which means a horizontal type of process rather than a vertical one. There has been some work done to try and identify what are the core functions of primary health care. This has been an issue since about 1994 and I think in

the Territory there is some broad agreement at least within the community controlled sector about this. Basically, defining things as curative and preventive is not how things work on the ground. All clinics do some curative work and they do preventive work as well. Pap smears, immunisations, those sorts of things are clinic based services. That is how we have tried to define it. You have got clinical services, which includes sick care, evacuations, specialist care—there is a whole range of stuff in that, potentially—and then you have got support for the service, which is largely management support and education support. Finally there is what we have tended to call special programs, which is dealing with a lot of these others—whether it is violence, substance abuse or whatever—which require community action to get anywhere in. We think that that could be a funding template, that all communities have to get a certain resource to provide clinical care.

The support for it is either regional, or some may be local, with special funds available for issues that the community really wants to take up. There is no point the epidemiologists saying, 'Nutrition is a problem and therefore we need a nutritionist' and send a nutritionist out to a community when that is not what that community is worrying about. That is the sort of framework of how we have tried to identify primary health care.

In terms of priorities, I think it is very difficult to prioritise. As industries have developed around all of these areas, you will always get people who want to see what they are involved in being the No. 1 priority. Improving health is an all government, all of society business, so I do not think the health sector deserves priority necessarily over housing, environment or education. They all need to be there and they all need their own focus. But there is no doubt in my mind that within the health care system primary health care is the most important thing to start getting right. The hospital expenditure is blowing out because primary health care services are not in place consistently across Aboriginal communities. When people put the funding issues, the Territory government often says, 'We are spending this much on Aboriginal health,' but much of that is actually in hospitals. That is grabbing people as they are falling off the cliff. So primary health care is an absolute priority, as far as I am concerned, within the health sector.

Ms Maher—I agree with everything Ben said. When you are thinking about the problems, you should think about two things. The first one is the resourcing levels. I think the Deeble report has shown quite clearly that the amount of money going into Aboriginal health is inadequate. With a lot of the problems that you are talking about, support for single-practitioner nurses and all of that sort of thing, basically we are operating in a pay-less service. Historically the NT government seems keen sometimes on saving money, cutting more money out of the Aboriginal health budget, and that is a big problem.

The second problem is, once you have got the money how do you spend it, how do you do it, how do you deliver the services?

CHAIR—Have you got some specific examples of the Territory health budget being cut in Aboriginal services?

Ms Maher—For example, there was the service agreement where the community at Santa Teresa this year had their recurrent budget cut by—

Mr Jefford—Twenty per cent.

Ms Maher—Ten per cent, and it is not a very big budget in the first place. They have got 540 people there. Now they have got staffing of two nurses; the health workers are employed by CDEP. I do not think that is adequate. The model that we think has been the most successful is the community controlled model.

The other thing I would say is in terms of coordinated service delivery. The framework agreement has set out the roles and responsibilities of the different levels of government. When you are talking about support services for single-practitioner nurses, I think that there is a role that a department like Territory Health Services can play in providing that regional support across all models of service delivery that are operating in Central Australia, not just in its own THS clinics. That is an issue where we are trying to put nurses into communities that historically have not had nurses, for example, at Areyonga, or that had nurses 15 or 20 years ago and had that service withdrawn. Now the community is worried, and I think that they are rightly worried, that the expectations on that nurse will be great and they will burn out. But if we can provide them with adequate regionally provided supports then that makes a big contribution to sustainability.

Mr Lamb—I feel there could be some scheme which involves the elders of the people, and particularly in those places that do have good services, that is a resident sister and doctors visiting, that it is not the responsibility of the European or the government to provide good health for them. They should start at the grassroots themselves with diet, with hygiene and with control of dogs. I am sorry I have to disagree with Nigel on this point. I believe that if you have healthy dogs you will have dogs more liable to bite. At one place, a school principal was set upon by nine dogs. Out at Yuendumu years ago, a little girl was nearly killed by dogs. At Mutitjulu a lady was killed by dogs. They had been through a dog program, there was a bitch on heat, there were about 10 dogs chased her and the lady got in the way and she died.

I think it can be done through education of the community elders. Let us start from the top, the elders, and put the blame on there. The press blames everyone; everyone blames us for the health of the Aboriginal. It is about time that they took the blame themselves, the responsibility themselves, and they must not be scared to do it. I believe that in the pyramid teaching, which you suggested yourself, someone from a successful community can go out and teach the other people. You would have to be very careful that you did not get people who opposed each other tribally, or skin wise, but even that could work. I am a firm believer in the pyramid teaching method, and that is where you teach people who are acceptable to the communities to teach other people. But it has got to start with the elders and the leaders of the communities, and this blame and accountability has got to start with them.

Mr Jefford—I will start off with a couple of quotes. One is by Chris Sidoti, the chair of the Human Rights and Equal Opportunities Commission, who gave a keynote at our recent national conference. He said that we are no longer a society, we are an economy. I think that needs to change, and that with economic rationalism, as employed by health departments especially, certainly in my experience, unfortunately those that are furthest away from the CEO's desk are those that get the least amount of support, education, training and services.

Secondly, Nick Williams, who was a medical officer and probably is the medico that Ben may have been referring to earlier who had spent a lot of time here in Central Australia, gave me a quote one day: 'He who identifies the problem owns the solution.' That is also paralleled by what Puggy Hunter says. So you sitting in Canberra, Perth or Melbourne, if you see a solution as a result of statistics or reports, et cetera, and you go in and dump that on remote communities, you are going to own the solutions to whatever happens within that community.

The equity issue Helena has already referred to, and there are issues such as the amount of money that is paid to Aboriginal and Torres Strait Islander health workers, that is paid to nurses. We are going from $20,000 to $24,000, $28,000, $30,000—a little bit up depending on what grade. With overtime, the average income of a remote area nurse in Central Australia is $67,000 a year, and then you take a massive leap upwards with the medical profession in terms of $120,000, $140,000. There is the question of the equity of providing a flattened structure with those kinds of imbalances in terms of what the doctor gets, and Millingimbi is an example where the senior nurse was turfed out of the house in order to make way for the doctor. There are those kinds of inequalities. When I was working in Central Australia, a health worker at Yuendumu had been living in a humpy for 17 years while she had been a health worker. I am aware she has got a house now, but that was because we hopped up and down about that. I managed to get some funding. So there is the inequity.

The accountability: who are we accountable to as providers of these services? At the present moment we are accountable through a top down approach, as opposed to being accountable to the people who are receiving this service. That is part of Alma-Ata, accountability, accessibility and affordability. And there is the power issue. Without power, without dollars, communities will continue to be disempowered and will not have a say. I will use the example that exists at Mutitjulu, where the majority on the board of the national park are Aboriginal people, and they get the say. They determine what happens within that park structure. There needs to be a majority of Aboriginal people, with all due respect, sitting on this kind of committee determining the likely outcomes—and I am sorry, Harry, if you come onto this committee with an idea that it is going to end up with the end solution to Aboriginal health, I wish you well. There are a number of really strong positives happening within the industry that can be used as exemplars, but it is not going to be a final solution. It has to be a solution that has a degree of flexibility and fluidity built into it to march on with time.

Mrs Tye—Just briefly, my interest has been in the education area—health worker education. The issues I would like to highlight once again are equity issues for health workers, that for health worker education the funding formula that comes through education, particularly for health worker education, should be re-examined in the light of it being health and such an issue, and looking at other criteria—the impacts on communities not funded, or make the formula typical of mainstream because of the examples I have given earlier.

As far as health goes, I think in the centre and here in the NT with health worker education, health services, there has been, I feel, in the past quite a bit of competition, or a competitive edge, whereas I would like to see a much more coordinated approach through industry agreements with industry, industry and training organisation agreements, and

training organisations and training organisations. I know there is a move towards that in the light of the National Competency Training where we are all doing the same thing rather than competing and reinventing the wheel, et cetera. I feel that there needs to be a much more collaborative approach in all those areas, particularly in the area of health worker training that will have some impact on health.

CHAIR—Julie, can I just share with you something from yesterday when we had Professor Thomson, who set up a web site on Aboriginal health. I do not know whether you are familiar with it or not, but some may be.

Mr Jefford—Is that the clearing house?

CHAIR—It was quite a remarkable experience to see this reinventing of the wheel. We all do it; I do it in my office too often, and we try to strive to overcome it. He is trying all the time to update the new technology and the information that is available. It is quite remarkable how you can draw all this information together, and of course you have got to have the time to go through it. I just share that with you; it is quite interesting. I do not know whether you are familiar with it but it is something that is happening in the west.

Mr Tilton—I will be brief. There are a few points I want to make. Firstly, one thing we need to recognise, I think, is that often we hear the idea that nothing is changing in Aboriginal health, that nothing is ever changed, and I think—

CHAIR—Give us a good news story, Edward.

Mr Tilton—Well I am not necessarily going to give a good news story, but I can say that, if we look at the history of Aboriginal health over the last 30 or 40 years, you can see it has changed. In Central Australia in the mid-sixties infant mortality was around—in one case—nearly 300 deaths in the first year per live births, so one in three Aboriginal kids was dying before their first birthday. Obviously, that is something that has improved immensely in 30 years, mainly through the extension of primary health care services from just the large communities to now a point where a lot of communities have at least some basic access. The community-controlled sector has been really instrumental, I think, either in actually delivering those services or in providing the political input, the impetus, for government to do that.

Of course, at the same time during that period there has been a great increase in so-called lifestyle diseases. That creates a whole new challenge, and I guess that is what a lot of the discussion today has been about—about environment, education and nutrition. There are new challenges, but there is no reason to think that they are not soluble in some sense. So I suppose we would like to get away from the idea that nothing is changing, nothing is happening, because things are changing and happening.

Secondly, I think a part of the lesson of our history is the importance of government recognising the expertise of the Aboriginal leadership and supporting that, whether that is at a local community level or whether it is at a territory or national level.

There is one recommendation in your report which AMSANT would be quite opposed to. That is the idea that funding for NACCHO and its state affiliates such as AMSANT be split up amongst all the individual health services and that they would then fund the AMSANT or NACCHO operations, instead of funding being directed directly to NACCHO or AMSANT.

Given the crisis that so many health services face on a day to day basis, as we have been hearing, there is a very real danger that money would just get absorbed in those day to day crises and that political leadership and health leadership, which has been developing over 20 or 30 years and has, I think, made such a powerful impact, could be completely undermined. I think that would be quite a retrograde step.

Thirdly, the collaborative structures. Again, I think that the framework agreement in the Northern Territory is not ideal and its operations have still been problematic in many areas; nevertheless, it is a step forward. It has provided arenas for that Aboriginal health leadership and for the bureaucracies at different levels to interact and to work towards some kind of solution.

Lastly, I just want to revisit something. I do not think there is any clear answer to this last one but it is an important point that I think came out before from what Jill Hall and Ben Bartlett were saying—this balance between government responsibility and community control. There is a tension there that I do not think you can resolve by coming down completely on one side or the other. There are certain government responsibilities. The government has a responsibility to provide health care to all its citizens. At the same time, it also has a responsibility to support Aboriginal people in their aspirations for self-determination and so on, quite apart from the fact that that is also a most effective way to deliver those services. But there needs to be some way—possibly through these kinds of collaborative structures—of working out where the government can come in and just say, 'This is what we are going to do. You are going to get this health service. Whether or not you can take control of it yourself is our responsibility.' It is a question of how to do those kinds of things in a way that in the long term encourages and supports the ability of the Aboriginal community to take control and to make those services their own.

CHAIR—Thank you very much.

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

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

Committee adjourned at 12.48 p.m.