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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

WEDNESDAY, 10 NOVEMBER 1999

DARWIN

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Wednesday, 10 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

AH CHEE, Ms Donna, Cooperative Research Centre for Aboriginal and Tropical Health 1183

ANDERSON, Ms Pat, Cooperative Research Centre for Aboriginal and Tropical Health 1183

ANDERSON, Professor Ian, Cooperative Research Centre for Aboriginal and Tropical Health 1183

ASHBRIDGE, Dr David, Cooperative Research Centre for Aboriginal and Tropical Health 1183

AUSTIN, Ms Maisie, (Private capacity) 1122

BARCLAY, Mr William Mathieson, Chief Executive, Tiwi Health Board 1122

BROWN, Ms Louise Gweneth, Education Coordinator, Tiwi Health Board 1122

CARROLL, Dr Peter John, (Private capacity) 1122

CURRY, Mr Robert Jeffrey, Member Aboriginal Health Sub-committee, Northern Territory Branch, Australian Physiotherapy Association 1122

DOWDEN, Ms Michelle Catherine, Community Health Educator, Galiwinku Community, Ngalkunbuy Health Centre 1122

GALLACHER, Mr James Walter, Policy/Research Officer, Aboriginal Medical Services Alliance Northern Territory (AMSANT) 1122

GOOD, Professor Michael, Cooperative Research Centre for Aboriginal and Tropical Health 1183

HILL, Professor Gregory, Cooperative Research Centre for Aboriginal and Tropical Health 1183

HUGHES, Mr Paul, Cooperative Research Centre for Aboriginal and Tropical Health 1183

JONES, Ms Trish, Senior Policy Officer, Territory Health Services 1122

KEMP, Mr Dave, Cooperative Research Centre for Aboriginal and Tropical Health1183

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LINDNER, Mr David Arthur, (Private capacity) 1122

MAHER, Mr Patrick John, Northern Territory Branch, Government Liaison, Australian Physiotherapy Association 1122

MATTHEWS, Ms Sally, Cooperative Research Centre for Aboriginal and Tropical Health 1183

McMILLAN, Mr Stuart John, Educator, Aboriginal Resource and Development Services Inc. 1122

O'DONOGHUE, Dr Lowitja, Chairperson of Board, Cooperative Research Centre for Aboriginal and Tropical Health 1183

PURUNTATAMERI, Mr Marius Matthew, Member, Tiwi Health Board 1122

RAE, Mrs Cheryl Jean, Regional Director (Assistant Secretary) Operations North, Territory Health Services 1122

SALTER, Mrs Mary Eileen, AM, President, Deafness Association Northern Territory Inc. 1122

TIPUNGWUTI, Mr Charles, Cooperative Research Centre for Aboriginal and Tropical Health 1183

WALKER, Dr Alan, (Private capacity) 1122

Committee met at 9.01 a.m.

CHAIR—I declare open this public hearing of the House of Representatives Standing Committee on Family and Community Affairs. We are now in the final round of the inquiry into indigenous health. We can take evidence in camera and in confidence if we need to. We need your advice on that beforehand, and we need to approve that as a committee. All other hearings so far, to my recollection, have been on the public record.

We have this week, thus far, been to Perth, Alice Springs and now Darwin on this third day of the working week. As you would appreciate, we have gathered an absolute mass of information over the last couple of years. As this is the summing up, we really do not want to revisit too much of what has been said before. We are looking for your input of what we should do and, hopefully, many of you have had a look at the discussion paper that has been put out.

I want to quickly remind you of a list of things we would like to focus on, but it is not exclusive as additional matters can be raised. Please raise anything that you feel has been left out. I think the people from the Deafness Association have already put a submission on that, and we look forward to their contribution in the morning.

Those issues include things like dental health, mental health, hearing health, diabetes and renal failure. A balance between the needs of urban and rural remote in the Northern Territory will need to be struck there. Then there is the impact of other factors like dispossession, poverty, discrimination, the need for indigenous people to take greater responsibility for their own health and their community's health and wellbeing. Of course, there have been a couple of comments in recent times in that area. Noel Pearson said some pretty provoking words earlier in the year about welfare and poisoned water holes. I think Bob Collins's report on education in recent weeks, which is from the Northern Territory, has given us food for thought as well.

Another one is impact of the current welfare arrangement on health and wellbeing. Many of you would be aware of the various service delivery options that we are talking about; that is, all of the state, all of Commonwealth—options A, B, C and D. We are hearing options E, F and G, and we really want your contribution on that and what the new approach should be that we should recommend to the Commonwealth.

Lastly, these are just secondary issues but they are equally important. These are issues like the appropriateness of data collection and how we utilise that, work force issues, training Aboriginal health workers—all those sorts of issues. The cultural issues around that are very important. I freely confess that I struggle with the most appropriate way to deal with the cultural differences. There are environmental health issues—which are, of course, perennial—and other health issues like nutrition, transport, racism and cultural awareness, which I have mentioned, et cetera.

They are just a few things that we have put down for the committee to consider when we go sifting through, trying to find the best way ahead, that we wanted to add to the body of knowledge we already have received over the last couple of years.

[9.07 a.m.]

AUSTIN, Ms Maisie, (Private capacity)

BARCLAY, Mr William Mathieson, Chief Executive, Tiwi Health Board

BROWN, Ms Louise Gweneth, Education Coordinator, Tiwi Health Board

CARROLL, Dr Peter John, (Private capacity)

CURRY, Mr Robert Jeffrey, Member Aboriginal Health Sub-committee, Northern Territory Branch, Australian Physiotherapy Association

DOWDEN, Ms Michelle Catherine, Community Health Educator, Galiwinku Community, Ngalkunbuy Health Centre

GALLACHER, Mr James Walter, Policy/Research Officer, Aboriginal Medical Services Alliance Northern Territory (AMSANT)

JONES, Ms Trish, Senior Policy Officer, Territory Health Services

LINDNER, Mr David Arthur, (Private capacity)

McMILLAN, Mr Stuart John, Educator, Aboriginal Resource and Development Services Inc.

MAHER, Mr Patrick John, Northern Territory Branch, Government Liaison, Australian Physiotherapy Association

PURUNTATAMERI, Mr Marius Matthew, Member, Tiwi Health Board

RAE, Mrs Cheryl Jean, Regional Director (Assistant Secretary) Operations North, Territory Health Services

SALTER, Mrs Mary Eileen, AM, President, Deafness Association Northern Territory Inc.

WALKER, Dr Alan, (Private capacity)

CHAIR—Welcome. Mary Salter, as you put in a submission to the committee, would you like to be the first cab off the rank by making an opening statement about deafness?

Mrs Salter—Yes. I would like to do that. I had better point out, first of all, that I have a very serious hearing loss, but do not worry because you have a wonderful system here and I lip-read very well.

Having said that, I think I speak on behalf of the approximately 9,000 Aboriginal indigenous people who have a hearing loss. Most of them do not have as severe a hearing

loss as I do. They have a mild to moderate hearing loss caused through endemic otitis media—middle ear infection. This has an enormous effect on all aspects. I think you are talking in the inquiry about training health workers and things like that, but you are losing a tremendous amount of young indigenous people from almost the word 'go' at school. I think there is hardly an indigenous child who does not have one ear perforation before the age of one year. This would be borne out, of course, by the reports that are put in by the Menzies School of Health Research. It is a frightful problem.

In his report, Bob Collins refers to one teacher talking to a class of children where 90 per cent of the children have no eardrums. You are losing out a tremendous number of intelligent children who could be trained up for Aboriginal health work. I have a feeling that health and education are indivisible. You are just losing so much up here.

I was a bit horrified to not see any kind of report on hearing loss in this inquiry. I certainly should like reference to it included, because this hearing loss has an effect not only on school learning but also on job possibilities afterwards and behavioural problems. I know very well, from my work with the Deafness Association, that there is a good deal of suicide attached to deafness. I am wondering what sort of input it has on deaths in custody. It is an enormous thing up in the Northern Territory, far more so than anything else. I really think that you cannot possibly carry out an inquiry into indigenous health without taking this on board. So that is all I want to say.

CHAIR—Thank you very much. That is very valuable and is something that we certainly will need to consider in our report. Would members like to ask questions?

Ms ELLIS—I would like to ask Mary a question. We have, in visits to a number of local communities, had pointed out to us the difficulty of not only treating the problem but having the staff or the workers there to have the time to educate the parents, particularly mums, on how they can attend to that ear problem daily or more than once a day, with cleaning and so on; that it can be attacked at that level but it takes an enormous effort. One of the biggest problems is people saying that they just do not have the time. The workers that are there are so overstretched that they do not have the time to drive the mother, or whoever it is, to understand the severity if they do not attend to it. Would you like to comment on that angle?

Mrs Salter—Yes. There are several organisations that are tackling this. What you say is exactly true. I think you are perhaps proving my point—the leaching out of potential Aboriginal health workers who would be able to help in this area enormously by being educated. The appalling statistic—16 indigenous school children going to university compared to 469 non-indigenous people up here—speaks for itself. You are losing the opportunity right down at ground level to give these children an opportunity to better themselves and to educate themselves so that they can go into the communities and work. This is one of the problems. You are getting an awful lot of non-indigenous people going in and telling them what to do. They do not want that. They want to be able to do it themselves. The best way they can do it is to educate their children so that they should be able to do it.

I do appreciate what you are saying. The people in the field work very hard on this. We in the Deafness Association are at present engaged in a working party looking at the effect of hearing loss in the NT justice system, which is very considerable, as you can imagine. You have problems in courts, in correctional services and in all aspects. We are carrying out a working party and we hope to give our results to the NT Attorney-General early next year. This is a kind of piecemeal effort. What I am pleading for is this: if it means throwing money at it, so be it, but the problem needs to be attacked much earlier on in schools. When you get people like Bob Collins saying that there is a teacher standing in front of a class trying to educate a class when 90 per cent of the children cannot hear, that is dreadful. This is the problem we have got. It is much greater here than anywhere else and I think it should be looked at.

Ms ELLIS—Can I just say regarding that comment that this really came home to me on one of the very first visits we had to a remote community. Towards the end of the afternoon the school children arrived. There was a group of about eight or 10 primary school age kids—little people—who all raced in and were very keen to say hello to us. A group of us sat on the floor with them and there were these beaming brown faces looking at us. We were talking to them and they were not responding. Someone said to me, 'It's probably not that they're shy, it's probably that they can't hear you.' I was horrified, I have to confess.

Mrs Salter—Yes.

Ms ELLIS—That was the first inkling I had of a hearing problem in the community. I must admit that it has stayed with me.

Mrs Salter—I think somebody from the Menzies made this comment to me: quite a lot of these children are perfectly happy to stay on after school and work, probably because they have not heard the bell for going home. That is awful. Half the children are not hearing properly with a mild to moderate hearing loss and a quarter of the adults grew up with that. It is a very serious problem and it must be included.

Mr Gallacher—Mr Chairman, could I say that I work for the Aboriginal Medical Services Alliance of the Northern Territory, which is the peak body of the Aboriginal community controlled medical services. Two of our main members will be here this afternoon wearing different hats. Our executive secretary, Pat Anderson, will be appearing this afternoon as a member of the Cooperative Research Centre for Aboriginal and Tropical Health. She and John Liddle, who is also the director of Congress in Alice Springs, will talk to you briefly from an AMSANT perspective as well as from that of the CRC. It is just that they do not need to double up.

CHAIR—We have a lot of people to try and get through. I am wondering whether the fairest way is to go around the table for a two- or three-minute presentation and let it flow from there so that members will come in with questions. Could we keep it fairly concise and have two- or three-minute statements on anything that you particularly want to say and leading from that members will come in. Can I ask members to be fairly concise in their questions. We want to keep it fairly free flowing but we do not want to let it drift around too much. We really want to get into how we actually resolve some of these issues that we know we have to work on.

Mr QUICK—Can I suggest the contributions are based around A, B, C, D, E and F. That would be a lot more beneficial to us rather than you talking generalities. As I said yesterday in Alice Springs, we have to come up with the right model and I would like to think that you people who are out in the field have been there long enough to know if the current model sucks and that we need to have a new one. If that is so, we want to know what it is and we want you to be jack blunt. If you are going to upset the Northern Territory people, that is fine, but put some justification into it. If you think the Commonwealth have been dragging the chain, get stuck into us as well.

CHAIR—I think that is very valuable. You have already introduced yourselves and your organisation. You might have one key point to make but then come back to what Mr Quick has suggested. I can only support what Harry Quick has said: please be as direct, concise and blunt as you need to be to get the message through to us because we need to hear it loud and clear. Mary, can I say to you that deafness is not always about the ears, it is sometimes about the brain.

Mr JENKINS—In relation to Mary's contribution, I think it is very interesting because, from her reading of the discussion paper, she thought we had overlooked deafness as an issue. The discussion paper might give that impression but one of the problems we are trying to come to grips with is that a lot of people are telling us to avoid body parts funding, specific programs about different things, and come up with a model that is overall and, as a part of that, set priorities. In the discussions we have today, I would be interested to get people's reactions as to how we do not overlook problems, such as those that Mary has raised.

CHAIR—Thank you, I think that is great. As you can see, there is a fair commitment from all the members here. We need to know and we want to know.

Mrs Salter—I take that on board and I appreciate what you are saying.

Mr Gallacher—From AMSANT's perspective, one of the key things we are interested in is the issue of coordination. We sit under the framework agreement that was signed by the four partner groups to that last year which has been, we think, an effective forum. Being a forum, where essentially there is not a voting situation and where people have to get agreement, it is sometimes very difficult to get agreement. It has been a struggle to get all of the partners to bring all of the matters concerning Aboriginal health policy to the table.

I will give the committee one example of that. The Northern Territory government proposed a youth suicide strategy. The Aboriginal medical services have done a lot of work in terms of youth suicide. This matter was not down to be raised at the Northern Territory Aboriginal health forum and it was a last minute effort to get it raised there. The government set itself a priority to develop a youth suicide strategy and basically missed out on seeking a contribution from the Aboriginal medical services perspective at the Northern Territory Aboriginal health forum. Issues of coordination are quite important to us. From the perspective of the Aboriginal medical services, we need all the issues on the table at the health forum if we are going to be able to better coordinate the delivery of services.

CHAIR—Are you saying the framework agreement did not allow it or it was not brought to the table?

Mr Gallacher—The framework agreement does not have any enforceability. You cannot make the federal government or Northern Territory government bring issues to the table.

CHAIR—That is a very important issue to us because that is exactly what has been coming before this committee.

Mr Gallacher—However, there has been a great level of cooperation in terms of coordination of service delivery in other areas with Territory health services. It is a matter for AMSANT, I think, of making sure that all levels of government know about the health forum which is developed through the framework agreement. We have recommended a number of times to both the federal government and the Territory government that there needs to be some education within their public service about the framework agreement and about the Northern Territory Aboriginal health forum. I will leave it there on coordination.

Dr Carroll—I come in a personal capacity to talk on a specific issue that is in some sense related to the point Mary has brought before you about communication and the inability of patients to communicate with doctors. My submission relates to language. A copy has gone to the members, but I will briefly summarise some of the key points because I suspect some of the other people here will not have received that.

There is a diversity of Aboriginal languages spoken in the Northern Territory. The bureau of census reports that, on a Territory wide basis, at least 60 per cent of Aboriginal families speak a language other than English in their home. When you break down those statistics to a regional level, in some regions of the Territory that percentage is 95 per cent and higher. So in the remote communities of the Territory the Aboriginal language is alive and well. This creates an incredible difficulty for professionals that have come from outside the area in terms of being able to communicate effectively with patients.

How might that be done? I think there are two ways forward. One is in relation to Aboriginal health workers. You have had evidence before you of the importance of health workers and how health workers are able to communicate more effectively with the patients than the medical staff. However, from a linguistic point of view, I think it is important that health workers be given some training in interpreting because knowing two languages does not automatically make one a skilled interpreter. That is an issue in relation to training health workers that I think will need to come up a bit later in the discussion.

The second aspect of what might be done is establishing an interpreter service. Earlier this year, the Northern Territory antidiscrimination commissioner, Dawn Lawrie—she has now retired from her position—conducted an inquiry into the provision of interpreter services in Aboriginal languages in the Northern Territory. Her recommendation was that an interpreter service was needed and that not to have it was discriminatory. The Territory government is moving slowly in that direction. A press release was put out a few weeks ago by the Chief Minister announcing the establishment of a register of Aboriginal languages and a booking service. Some of the government's critics say that that is too little, too late, but that is a separate issue.

Aside from what the Northern Territory government is doing, there is an important area for the Commonwealth, and this is one of the reasons I have come before you this morning. The Commonwealth government provides an interpreter service and translation service with the acronym TIS. It operates by telephone all around this country, but it only operates in Asian and European languages. It has not made any attempt to reach out to Aboriginal languages. I understand the service is developed within the portfolio of Immigration and Multicultural Affairs so it is understandable why that has not happened. But my basic submission to you, as a group of Commonwealth politicians, is that the Commonwealth is essentially discriminating against Aboriginal Territorians because it only provides an interpreter service in Asian and European languages and does not provide any service at all for Aboriginal Territorians. They are the essentials of what I want to say. I am happy to answer questions throughout the morning as appropriate.

Mr Curry—We represent the Australian Physiotherapy Association. As physios, our principal task in Aboriginal health and in remote areas is the maintenance and return of physical functioning for people. Therefore, we work mainly in age and disability care in remote areas. These services, historically and currently, remain extremely limited. By example, some areas have no access to some of the therapy groups like speech therapy. They have very limited access to audiometry, or audiology, which relates to what Mary has been saying. There is very little assessment in some areas and very limited ability to treat effectively. In the Darwin area, for example, in remote areas, there is one physiotherapist for 12,000 remote area people. That is an extremely limited service and it does not line up with any other figures outside of the Northern Territory.

I think people are aware of some of those problems. Therefore, we are more interested in a model that might resolve some of those issues. We favour the establishment of a model of basic primary health care services, an agreed level of service and then funding for that service. I know the current funding systems are complicated but I do not think that is impossible to achieve. If we clearly establish what a community requires, we should be able to fund those basic levels of services. I am talking about primary health care services and not just primary medical services.

We are aware that the general practitioners are extremely supportive of having physio and other types of services in those remote communities to promote their work as well. There was an extensive project in northern Queensland that looked at primary health care services for Aboriginal communities. Are you aware of that? Has the committee had access to that report?

CHAIR—No.

Mr Curry—It elaborates a whole range of primary health care services. It was an extensive project in 1996 from North Queensland. That obviously mentions the whole range of allied health services that communities should have access to. We believe the current funding arrangements are not effective. We have not seen a great embellishment of our service and therefore it is still a very limited impact.

Let me go back to Mary's comment that we do not need more white health professionals out there. In many ways, I agree with her but, in a proper model of service, remote area

Aboriginal people need assistance to gain some skills. If we work on a proper model, and if we can get adequate resources—

Mrs Salter—It depends on the model.

Mr Curry—Yes. It is a partnership model which we promote and we hope to trial it at some stage. I will leave it at that.

CHAIR—Thank you. We will be in North Queensland in just under a fortnight's time so we will certainly pick that up.

Mr Curry—The Aboriginal medical service there will have full details on that.

Ms Dowden—I work as a community health educator at Ngalkunbuy Health Centre, Galiwinku, Elcho Island. My background is nursing and my position is funded through Commonwealth money. That position is coming to an end in December. It has been a three-year funded position. I have obviously not done a report yet but I would like to give some positive feedback to the committee about the benefit of community health education.

I have been using a model of delivering family group education over thematic diseases. We had a successful scabies prevention program where we managed to get the incidence of scabies down from 30 per cent to five per cent. This was a community generated initiative because they are quite concerned about renal disease in Galiwinku. At the moment we are working on thematic education around the area of diabetes and anaemia. We are doing quite a lot of work with the store and with the community in general in trying to promote healthy living environments.

That has been possible because my position has been away from the clinic and away from clinical services. I think I would be correct in saying that my position would be the only one in the Territory which is totally community education focused. It is difficult for nurses and health workers to pull themselves away from clinical work. There is a need, I think, for all communities to have specific positions which are just community health education. Everyone talks about prevention, everyone talks about education, but there is no action. That is what I have come on behalf of the clinic and on behalf of the community to speak to the committee about. At the moment, we are in the process of trying to work out how I can maintain my position after December without specific funding. That will be harder in the whole health budget.

CHAIR—Thank you. That is very valuable.

Ms ELLIS—What is going to happen if you do not stay? Can you explain the framework? You have explained what you have done but there is just you. You have been working with family units but have you been working with people to transfer your knowledge to someone within the community?

Ms Dowden—The way I have worked is to create the story around each disease with the health workers, so it has been a peer education model. It has been a story that everyone has been comfortable with delivering. It has also been working with ARDS in Nhulunbuy to

develop a language around the story. It is not just me who delivers the story and does the work; it is a peer education model. There is a possibility for that work to continue but you still need someone in that position to coordinate. It is early days. There is lots of enthusiasm in the community for it, but you are looking at a long-term commitment to that position.

Ms ELLIS—What is the size of the community?

Ms Dowden—There are 1,800 people.

Mr QUICK—Can you explain what you are doing in the store?

Ms Dowden—I wish people were still here. We went to a council meeting last month and gave them a presentation about diabetes and fatty food and the fact that the stores mostly have fried foods available. What happens in Galiwinku is that most people do a lot of hunting on weekends—some do it during the week—but, essentially, during the week they go hunting at the store. They hunt at the store for chicken and chips—crap, basically. As a result of that presentation, some resolutions were passed through council that they would work to ask the stores to sell less fatty food, to sell more lean meat, rice and vegetables at major meal times—breakfast, lunch and dinner—and that they would ask for a committee to look at food products that come into the store. That letter is due to go to the stores today or tomorrow.

That will probably cause some ructions because stores in communities talk about profit and about choice. What we try to say to them is that they are not providing choice for Aboriginal people in communities. There is 70 per cent fatty food available to 30 per cent good food available. We also have community market days once a week where we encourage people to go and hunt and sell their produce. That happens every Friday at the football. That has shown that Aboriginal people prefer good food.

CHAIR—That is excellent. How was your position funded and what was the lead-up? Can you just give us a glimpse of the funding process.

Ms Dowden—I was not involved in the initial submission, but it was a submission written for a health educator. There was a variation to that submission in that it was initially written for education of health workers, but the variation was to take it out and for it to be community health education. It took a long time to implement the funding for that.

CHAIR—By the Aboriginal health service in your region?

Ms Dowden—Yes.

CHAIR—And coming out of Commonwealth funds?

Ms Dowden—Yes.

CHAIR—Thank you. No doubt we will get back to you.

Mr QUICK—How many other people like you are operating in the Territory to your knowledge, on a similar basis?

Ms Dowden—Other people in the room could probably confirm this, but I think mine is the only designated position—definitely in the East Arnhem region.

Mr QUICK—Can we ask people here whether there are more.

Mr Curry—I certainly think most workers have a role in health education but I do not know of other specific people.

Mr Gallacher—There are other health worker educator positions located in some of the community controlled Aboriginal medical services.

Louise, in fact, who is now at Tiwi used to be a healthworker educator at Daniladilba. But in more remote communities there are people who are health worker educators and a lot of communities choose the way that they might use that person. They might have said to Michelle, 'We want you to conduct community education outside of the clinic' and so on, which is part of what we say is the delivery of comprehensive primary health care. Others might decide that they want to use the educator to train health workers in clinical duties, for instance.

Mr QUICK—It is basically hit and miss. If you are lucky enough to get some Commonwealth funding you can take away the clinical side and do the educational side.

Mr Gallacher—Community control is about people deciding in the community what they want to do with the person.

Mr QUICK—But basically community control is, 'We only have so much money. What can we not afford to leave out?' and therefore the indigenous people are getting a second class medical service. What I am saying, and I think the rest of the committee is saying, is should every community over and above 500 should have a Michelle Dowden as part and parcel of a basic core service for indigenous people? If so, that is what I want to hear.

Mr Gallacher—AMSANT would say yes to that.

Mr QUICK—That is what I want to hear.

Mr Gallacher—We would say yes to that.

Mr QUICK—Thank you.

Mrs ELSON—Michelle, in Galiwinku, how many other Aboriginal health workers would be interested in looking after the community once you have gone?

Ms Dowden—We have 10 health workers. We work on a flexible roster situation. We have probably the best number of health workers in East Arnhem. At any one time we have 10 health workers who are working at the clinic. They all have an interest in community

health education. At the moment we are looking at ways of structuring that into the clinic so that the education happens perhaps two days a week or maybe half a day a week but the whole thinking is to get out into the communities.

Mrs ELSON—Are these younger or older Aboriginal women in the community?

Ms Dowden—We have a mixture. We have some young women and some older women. On health worker education I think what we notice is that when people finish at Batchelor they are very raw. When they come and work in the clinic that is when the real mentoring happens and it is the older health workers who are able to really teach those younger health workers.

Mrs ELSON—Thank you.

Ms ELLIS—You made mention of the store. This is of enormous interest to the committee. You said that the letter—just tell us what you can—going to the store would cause a few frictions. Is the letter going from the community council?

Ms Dowden—Yes.

Ms ELLIS—It is going to the store management?

Ms Dowden—Yes.

Ms ELLIS—Is the store run by members of the community or is it run by a hired manager from elsewhere?

Ms Dowden—The store is run by a board of management.

Ms ELLIS—Of the community?

Ms Dowden—Yes. They are paid board members.

Ms ELLIS—Does the store profit get ploughed back into the community and is it spent at the decision of the community council?

Ms Dowden—Dividends go back to the council but they are divided up to clans.

Ms ELLIS—Within the community?

Ms Dowden—Within the community.

Mr Gallacher—Galiwinku is also an ALPA store. The Arnhem Land Progress Association is an organisation that runs a number of community stores throughout the Northern Territory. AMSANT has been doing work with them as an overall group, talking to them about healthy food and so on. If you like, it is like a franchise. Each individual store is then run by someone separate.

Ms ELLIS—Is the unhappiness of the letter going to be because they are going to interpret it as a threat to their profit-making potential? Is it as basic as that?

Ms Dowden—I think it is profit. We have done education with the stores last year around the area of anaemia and it is just blocks all the time. It is lots of 'Yes, but'. What we are also going to do with that letter that is going from council to them is send a copy to the Heart Foundation. The director will then send a congratulatory letter to council and then send copies of that to the store.

We are hoping that it is not going to be received in a really negative way but this whole store thing for us has been over two years. We have tried gentle negotiations. We have tried lots of strategies. These resolutions that have come through council are probably the strongest.

Ms ELLIS—And you have got council on side? That is good.

Ms Dowden—Yes.

CHAIR—Jill is keen to ask Rob Curry a couple of questions. Then I am going to start at Bill Barclay because Bill has got to leave us a bit before 11.

Ms HALL—Rob, you believe that there should be more allied health professionals out in the communities. There is a shortage of allied health professionals even in the cities. I know in my own electorate that we do not have any trouble filling positions generally but we do have shortages of physios, speech therapists and occupational therapists. How would you see that you would be able to fill those positions?

Mr Curry—We could fill the positions. I just think there are no positions available. You may have shortages in the cities—in Newcastle?

Ms HALL—I think there are shortages in most places. There is an undersupply generally of allied health workers.

Mr Curry—I agree, but that undersupply is a gross circumstance in this part of the world.

Ms HALL—I agree with that too.

Mr Curry—That has ramifications we believe in terms of rates of mortality. We believe that there is avoidable death as a result in the longer term and lots of hospitalisation as a result of that lack of service.

Ms HALL—My question is what kind of a strategy would you see to attract people if those positions were available? If we went away and wrote the report and said there should definitely be more allied health professionals out in the communities, how would you see that we could achieve that?

Mr Curry—We have to go back to undergraduate sensitisation to the issues and some information about working in remote areas. We have to look at what the GPs have been doing. We have to look at rural incentives which currently apply to general practice but certainly not to other areas. We have to note too that the new postgraduate program in remote health, the first one of its kind, through Flinders University and run out of Alice Springs is going to be quite an assistance to people that are looking to work in remote areas and to get good skills for it.

Mr Maher—Some other things that we need to look at to attract people to the positions include support from management for having locums to fill in for people when they go away on training and the provision of training, whether that is going to another course or swapping out of their position for a month to go to a tertiary hospital to update their skills. One of the problems is that you are working in a very varied case load and it is very hard to maintain your skills across all that case load. Some of those support issues are very important.

Ms HALL—My next question is to James Gallacher. Given your opening comments, I was wondering if you have had a look at the possible directions that are detailed in our report on pages 15, 16 and 17. Would you like to give me your ideas on which approach you think would be better or whether there is a different approach still that we have not considered?

Mr Gallacher—I do not know if you were here when I mentioned that our executive secretary is coming this afternoon. Pat Anderson and John Liddle from Congress definitely want to talk more about that. I could talk to you briefly about it. We think option D is very interesting for us. We have begun a number of discussions about option D. We think it has got real potential for better service delivery and better outcomes in the Northern Territory. I might leave it as general as that because I know that Pat and John do want to address that.

Ms HALL—Thank you. I agree with everything that you had to say. Would a telephone interpreting service present some difficulties because of the nature of the communities being in such remote areas?

Mr Curry—For some communities it would, but not generally. In the last 10 years, Telstra have had a very effective system, at least in providing telephone services to the major communities. In many of the communities, there are public phones within the community. It is not a perfect service but it certainly would be an improvement on nothing.

Mr McMillan—On the telephone service very briefly, I have done a number of telephone interpreting jobs between Adelaide Hospital and here for Aboriginal people undergoing treatment in Adelaide Hospital. One of the most frustrating things has been that Adelaide Hospital did not have, on the occasions that I have been involved, a speaker phone. I have had to talk to the patient, the nurse, the doctor and the family member separately. I have had to fax drawings through to them so that we can discuss the issue. One person was in Adelaide Hospital for a tumour operation and thought they had a minor skin cancer to be removed from their nose. Their whole skull had to be opened up. Major things like that and very simple little things that we could put into the system—if we had an interpreting service—like speaker phones and some resource materials to be able to do that sort of service over the telephone would be most helpful.

Mrs Salter—I will very quickly add to this. I am a member of Telstra Consumer Council and one of the issues that we are raising, of course, is Aboriginal hearing loss. We are getting volume enhanced phones everywhere for a start. By the way, I did put in a submission under Dawn Lawrie's interpreter service about the double whammy of hearing loss and no interpreter service. That is all I have to say about it.

CHAIR—Thank you. I will come to Bill Barclay for a contribution. No doubt we will open up for questions; I am obviously getting a backlog of questions as I go. That is fine because I have seven people to go. I think we will get through that all right by elevenish.

Mr Barclay—I want to draw attention to one particular aspect in paragraph 2.42 in your discussion paper where I believe there is an indication of a misunderstanding on the part of the committee in regard to the funding of coordinated care trials. I believe this needs to be clarified. Funding is not directed through more specific grants. The innovative approach adopted by the department involved a pooled contribution equivalent to the national average of MBS-PBS. The territory contributes an amount equivalent to the historical cost of running the clinics that were included in the trial.

We consider the flexibility of these funding arrangements have been instrumental in the success of the trial to date. The suggestion that the funds were or should be directed through specific grants is an anathema to the board. We consider the flexible pooling arrangements not only transparent and fair but provide clear empowerment to set priorities and achieve results without the dead hand of traditional bureaucratic grant control. We believe this is absolutely critical in regard to future funding of organisations similar to our own.

We consider that the sections in the draft report on community control and funding issues inadequate in putting the case for more innovative solutions, including coordinated care. The paper indicates a limited understanding generally of the advantages of community control and, in particular, of the issue of the relationship between governance and management, a confusion, we believe, to have bedevilled community control from the outset. Those are the issues relating to funding.

The other issue that I would like to draw to the attention of the committee relates to an issue which is of immense importance to us right at this very moment—that is, the mental health situation and the distribution of the famous $39 million allocated in the budget for mental health initiatives. We are yet, and it is now November, to hear how that money is going to be distributed.

It appears to us that it is getting bogged down in the Commonwealth-state relationship. They do not seem able to sort out who is going to handle this money and how it is going to be distributed. Every day that the distribution of this money is delayed is another day to enable mental health to deteriorate further within Aboriginal communities. Somebody needs to get hold of this and sort it out rapidly.

We want to know where our share of that money is coming from, when it is coming and how we can spend it. We have already put mental health workers on our payroll and we want to know about that money so that we can continue to pay them. The mental health

situation in our communities is desperate. It must be attended to and we must get our hands on this money. We really are very concerned about that.

The last issue I want to bring to your attention relates to the one that was being discussed when we entered the room, and that is otitis media. The Menzies School of Health Research has spent over $2 million particularly on research on this in the Tiwi Islands over the last 10 years. There have been countless research projects and I would have to say, at this particular point, that there is nothing to show for it.

The situation with otitis media on the Tiwi Islands is as bad now as it was 10 years ago, if not worse. It appears to us that there has been an uncoordinated approach towards this research, and it is time that somebody took hold of it and developed a strategy along the same lines as has occurred in relation to the development of renal research. The success of the renal research and the ace inhibitor treatment is an object lesson, I believe, for all research organisations.

This matter will be discussed. The board has actually called a meeting of all interested parties involved in this area of otitis media on the Tiwi Islands. It is relevant to every other Aboriginal community. That meeting is actually being held tomorrow, and people from Menzies, the Territory Health Service and our own professionals will be involved in that meeting to try and come up with some new ideas as to how to deal with this problem.

We have nearly 100 per cent of our children suffering some form of hearing loss by the age of three months. It is unacceptable in this day and age, and something has to be done about it. We are not sure quite what, but we are sick of hearing the hoary old stories about how people have got to improve their hygiene. The hygiene in the Tiwi communities is no worse than it is in other communities and, yes, we have statistics which are grossly in excess of those which extend in other communities. We need to find out what the problem is. Those are the areas that I wanted to discuss.

CHAIR—All that was terrific and put with your characteristic forthrightness. It was much appreciated. That is what Harry Quick was alluding to earlier. That is exactly what we need.

Ms ELLIS—Absolutely.

CHAIR—On the subject of otitis media, do you know of a community where someone has actually grabbed it and shook it and done anything with it? This dead hand of bureaucracy is still sitting there for whatever reason. Is there any evidence anywhere that you know of?

Mr Barclay—No.

Mrs Salter—One of the great problems here is that the germ that is actually causing this is constantly evolving, twisting, revolving into about 10 kinds of influenza bugs that continue to evolve. This is particularly so with the living conditions: where you have got a lot of people living together, the transmission of these germs is very hard to control. They are developing into new forms all the time. This is one of the great problems. It is a

combination of the kind of disease that is evolving and the living conditions. Would you agree? You will probably be talking about this at great length, but this is the information I have from the Menzies.

Ms HALL—Would you like to expand on your comments about community control? How do you think the committee has missed the meaning of it and what would you like to see in the report, just to draw it out a little bit more, so that the discussion paper, as it is now, when it is translated into a report, will actually deliver what you want it to?

Mr Barclay—The major success of the Tiwi Health Board that has been demonstrated over the last 15 to 18 months may be further explained in the evaluation reports that are currently in preparation. A final evaluation of the trial will not be until 30 June next year. I believe the major success of the board and the demonstration of the effectiveness of community control have been where that control has been given totally to the people to decide their own priorities through their elected board and where they can ensure that those priorities are put in place through the normal management controls that any normal board exercises. I believe the funding for the board has to be transparent and their ability to control the expenditure has to be total. That is what has happened in relation to this board and it has proved to be, in my view in any case, immensely successful.

Perhaps Marius, who is a prominent member of the community, as chairman of the land council and also as a member of our board, would care to expand on that in terms of the way in which this board operates and how it has brought about a revolution in regard to health care in the Tiwi community.

Mr Puruntatameri—Yes, it certainly has. The community control now seems to be the issue that our community is heading towards because you get a lot of these non-indigenous people who come out to this community with a lot of different ideas in regard to the health and education of Aboriginal people. They instil their own ideas as to the running of health or education. They do not listen to Aboriginal people. I think that is where the turnover should be happening—in education and health, which are the two most important things for our people. So that is happening on the Tiwi Islands and it is working. You can employ as many professional people as you can in Aboriginal communities; that is another thing. But to work under Aboriginal control is a different matter altogether. I just want to reinforce that.

CHAIR—Thank you, Marius.

Mr Puruntatameri—Just to follow up Dr Peter Carroll's concern about a translating course, I attended one translating course which was held on Bathurst Island a few years back. I think this was in conjunction with people who were attending court proceedings. The outcome was that the judges were concerned that a lot of our people did not understand, as everyone is aware, the languages that are used.

Dr Carroll—Did you find the training helpful?

Mr Puruntatameri—I did; it was very helpful. We have a few translators on the Tiwi Islands.

Ms HALL—You would see the best model to be one where the Commonwealth directly funded the communities; is that correct? If so, if you looked at it on a nationwide basis, how would you split that up? Have you got any ideas for an overall model?

Mr Barclay—Do you mean split up the funding as between the state and the Commonwealth?

Ms HALL—Just generally speaking, would you see that it would be best to directly fund every community?

Mr Barclay—It is actually happening. In certain cases the Commonwealth is directly funding health services. Our own is receiving direct funding in a number of areas. Aged care is one. We see that as being a more efficient way of distributing funds than through the state, where I believe it does tend to get mired down. I do not know that my friends from the Territory Health Services will entirely agree with me here, but I believe that there are certain advantages in the Commonwealth taking a stronger initiative in regard to the crisis that exists in relation to Aboriginal health.

At the present time, I do not believe the states have the resources or the ability to deal with this crisis. I think that the Commonwealth is going to have to take a far stronger role in regard to the way in which these organisations are funded and the way in which they are allowed to get on with the job. I think that a lot of the money that goes through the states gets filtered off. You have a series of bureaucracies who have their bite of the cherry before it gets through to the organisations where the money is needed.

Ms HALL—Out of the models that are set out on pages 15, 16 and 17, do you have any preference? They are: support existing arrangements; states to assume responsibility; Commonwealth control; and a new approach.

Mr Barclay—Our board has discussed these issues over the last few months and it tends to favour direct funding from the Commonwealth but it realises that in some areas it is going to need to continue to rely on funding through the Territory. A mixture is what is required but we see opportunity for far greater emphasis to be placed on direct funding from the Commonwealth.

CHAIR—By way of a clarification of 2.42, the specific grants bill was referring to a geographic base, not a program base, in really supporting the principle of a coordinated care trial, to be fair to the discussion paper.

Mr QUICK—In 3.8 on page 20, we state that the committee also believes that funding should be based on a predetermined minimal level of staffing. Can you give us your ideas about how you see communities being given a predetermined minimal level of staffing so that, as Rob said, community A with 2,000 people has a predetermined minimal level, and we sort out the funding between the Territory or the states and the Commonwealth.

Mr Barclay—I would agree with that and the board would agree with that so long as it did not mean that somebody else was determining what the priorities were. That is the critical part of the whole exercise. You have to give that ability to whatever organisation you

are talking about to lay down its own priorities. That smacks to me of predetermined priority and I do not think that our board would go along with that. It is far more important in our view to look at the cash-out model. Go back to that cash-out model that people keep trying to avoid, particularly in the Commonwealth. The cash-out model works. We have proved that it works, and that is the only model that gives total control to the community concerned.

Mr Curry—We certainly would support the primacy of community control. We do not have an issue there. What we would be suggesting is that we need to validate what a minimum standard is—for example, of physiotherapy or speech therapy services—and that would be for the community controlled organisations to use for their planning purposes. We would need to be able to tell you what we feel works and what does not work and then the priorities are really up to the community controlled organisations to determine. So I support what you are saying.

Mr QUICK—For example, in the Northern Territory, because of the way in which the population is dispersed—and I think the term 'cashing up' is the right term rather than 'cashing out'—what do we do if someone says, 'We need 27 physiotherapists and 16 speech therapists in the Northern Territory to service indigenous communities'? For example, the Tiwis might say, 'We're going to set out our own priorities,' and the people on Elcho Island might say, 'We're going to determine our own priorities.' How do we justify training and having available this pool of resources for someone to say, 'We'll have two of these, three of those and six of these'?

Mr Curry—We expect that in an evolving situation as more moneys are available we would certainly have to allow for communities to determine their own priorities. All we would try to do is establish that minimum standard. Our standard which we are trying to set would be to have the capacity for monthly service of physiotherapists. From other work, we believe that is an appropriate level that would support client services and support your staff in terms of age and disability issues. This sort of model would take a long time to establish and your priorities would need to come first on that. Renal disease might be your essential priority, or mental health, and we would not presume to override that.

Mr Barclay—I think that is it: in the end the market has to determine the situation with regard to training or whatever else. It is the board that decides what services it is going to buy. Whether it decides to buy one or two units of physiotherapy, that is the board's decision. If it is going to buy four units of renal, then that is the decision. Very soon, the people who are providing those services out there in Darwin or wherever else are going to respond to that need. We find it already. We put it out to tender. We say, 'We want radiology services. Who is going to give us the best deal?' We buy whatever radiology services we want from whoever is there providing those services. It is the market that determines it.

Mr Curry—We still believe we can come to you with a recommendation about what is an appropriate level of service.

Mr Barclay—Absolutely. There is no prohibition on you coming with a recommendation, as long as the board makes the decision as to what it is going to buy.

Mr Curry—Absolutely.

Mr Puruntatameri—There are different needs, as you know, in different communities. As the need arises, we deal with it.

Mr Curry—Certainly.

Mr QUICK—We are talking about training of workers. You put your tender out and Queensland says, 'We can train them.' What happens to the training institutions in the Northern Territory? My concern is that there are training institutions here—we have got Batchelor College, TAFE and a whole lot of other things. So do we get to the market economy in the provision of health services? Is that the way to go because the current system is so hopelessly and bureaucratically locked up and fragmented? By cashing up and giving the community control, is this market economy for physiotherapists in training and Aboriginal health workers really going to be flushed out and sorted out because the bureaucrats cannot do it, state and Commonwealth people cannot do it?

Mr Barclay—It is about time. We have been looking for alternative sources to getting our people trained ever since we started work last year. We are not satisfied with what is on the ground. We are demanding better service from those people who are providing the training. If Batchelor cannot do it, too bad. At the moment they are going out and selling their services and going back and getting their $8,000 for a diploma student, or whatever else, most of whom are people who are not capable of doing the job. In other words, they are overselling their services at the moment. We are not satisfied with that. We are going to make sure that we get better service with regard to the training of our people. If Batchelor miss out and some other organisation gets it, so be it.

CHAIR—Harry, do you have all you need there?

Mr QUICK—Yes. I would like to read that in the cool, calm light of day.

Ms HALL—I have a quick question. Is there any training for allied health professionals in the Northern Territory?

Mr Curry—No. Not in Tasmania, as far as I know, and not in the Northern Territory.

Mr Maher—Flinders University is moving to set up a speech pathology school, a dietitians course and, I think, an IT course up here. That will be linking with that university in South Australia. Unfortunately, given our population, we just do not have the capacity to set up a number of schools as in other states.

Mr Curry—I would like to raise one question in relation to community control, and I am interested in Jamie's point of view here too. It seems that a number of communities are not in a position to take up full community control due to resource issues and other issues. So if we are talking about community control, which we clearly support, we need to look over a time frame so that communities are resourced to take up full control of health services. Jamie, do you have a comment, or Marius?

Mr Gallacher—AMSANT's view on that goes something like this. Community control is an objective we are all working towards. We recognise that all communities are on various parts of that road that they are travelling down towards full community control. The important thing about community control is that the community has the capacity to do it. It is no good just suddenly hurling a whole bunch of money into a community and saying, 'You have community control now. Off you go and do what you like,' when people do not necessarily have the skills in the community to do that. So one of the things that AMSANT talks a lot about is community capacity and community capacity building. It is a very important part of community control.

Ms Jones—I would like to ask Bill a question on research. I note your concerns about the otitis media research by Menzies, but I am interested in your memorandum of understanding with the Tiwi Health Board and the Menzies School of Health and Research. If the concerns are so great, what is happening, how effective is that MOU, in trying to resolve some of those research issues?

Mr Barclay—It is really perfectly simple. Menzies continues to propose new projects and the Tiwi Health Board continues to dispose of those projects. In the next month or two, another three Menzies projects related to ear research will be considered by the board, and the board may accept one, two or maybe all three. On the other hand, the board may decide to reject all three on the grounds that they have had enough. There is not only researcher burnout and clinical worker burnout in the ear area but also those people who are being researched are starting to get burnt out, particularly on the Tiwi Islands. They are sick of it. To be quite honest, without real results coming out of, they are beginning to ask the board: what on earth is the point of this; where are we going? Allegedly, we know the answers. Let Marius tell you.

Mr Puruntatameri—I think, as Bill mentioned before, there has to be a proper strategy set up to do these things and also better coordination.

Mr Barclay—Between research and the clinical side.

Ms Jones—And it also raises other issues like compliance.

Mr Barclay—Absolutely. Compliance is going to be become an even bigger problem in the future because the same people are being researched over and over, and they are literally sick of it. People complain about people not complying with the treatment regimes. People just cannot go on and on, particularly where extraordinarily strong antibiotics are involved. It is just going on and on. To deal with this problem, people are being asked year after year to take stronger and stronger antibiotics.

Mrs Salter—Yes, this is the feedback.

Mr Barclay—One of the projects before us at the moment is simply doubling the level of antibiotic treatment for a group of our people. What for? To see if it works. Is that any way to conduct research? I am not a researcher; I am a layman in this area, but to me it smacks of out-of-control research.

Mrs Salter—It is very frightening.

Mr SCHULTZ—I have a brief observation, Mr Chairman—and I am probably playing devil's advocate to some extent here. There appears to me, in my brief period on this committee, to be an absolute lack of coordination of health care right across the communities and certainly an ignorance of or a parochial view about some of the successful reports, resources, research and models that are occurring. The Tiwi Health Board obviously has a very successful model working there. When you hear about the work that Michelle has been doing in her area, one wonders why we do not have this exchange of information in the best interests of the indigenous people as a whole, rather than be locked in to a situation where, leaving aside the lack of financial resources, which is a big problem and which this committee is well aware of—and we have a very strong view where we believe the money should go from the Commonwealth—there seems to be a deficiency in the system in that we do not seem to be exchanging all of the good news with one another that may help other communities get up and running on a particular problem that they have. I would like some comment on that.

Mrs Rae—I would just like to respond to that last comment about the lack of sharing of information. I think in relation to, say, the coordinated care trials, one of the things we would all note as a result of that is that, while the coordinated care trials have been innovative and have led to very good results, we are very tied up in legalise, in terms of what sort of information can be released, until the final evaluation report is done. So, as a matter of explanation, there is an intellectual ownership held by the Commonwealth in relation to a lot of this. It is all tied up in the trials. This sort of thing cannot be published. We talk at meetings like this and at other things, but there is a reason to not get involved in the coordinated care trial again, shall we say, because of the legalese and the time consuming nature that could be put to better purposes.

Ms Dowden—There have been some quite useful forums to exchange information. There is a chronic disease network that has been commenced in the last couple of years in the Territory. That is quite a good forum for people to get and share stories.

The whole issue of isolation and travel makes it quite difficult to actually have face-to-face meetings. I feel fortunate to have been supported by the council and the clinic to come into this meeting today. We are 450 kilometres away on a bumpy Metro aeroplane. It is difficult in the Territory to actually get to see people. Perhaps it is a misconception, but the Tiwis are closest to Darwin, and the bad side of the research is probably their proximity to Darwin, which is not perhaps a good thing. They are 10 minutes in a plane.

Mr SCHULTZ—The technology is obviously a problem, with the issue of Internet and email and all of the things that we take for granted in the metropolitan area and the densely populated areas of Australia. Is there an absolute lack of that sort of resource?

We were talking to Professor Thomson the other day. He has some terrific stuff that people can access through the Internet. When I raised the issue of the fact that not everybody has access to that sort of technology he made the point that you could put it on to a CD-ROM and send it. As long as they have computers, they could still have access to it. I

suppose I am raising another issue here but, in terms of the communication program, we need to upgrade the communication facilities.

Ms Dowden—That IT stuff is quick for people in urban areas, and people have managed to keep up in urban areas. If you are looking at remote areas, it is still available but it comes a lot quicker and you have to keep up a lot quicker. There is not always the support for IT stuff. We are always making mistakes because we are not the best informed on IT stuff.

CHAIR—We have some evidence on some of the various programs that health services use.

Mr JENKINS—We have often had put to us that there is not a one size fits all solution. We have been very impressed with the results from the Tiwi coordinated trial, the Tiwi for Life Program and things like that. Others have emphasised—and I think that was the point of Jamie's contribution—that a number of the communities require some sort of assistance to get to that right capacity. I am not sure of what form of assistance that requires. I think it is a bit more than having access to the information. I do not know how detailed AMSANT's community capacity building program is.

CHAIR—I support that. To us, that is an absolutely key question. It has been coming up regularly for the last three days, particularly in the last two days. Over the next few weeks, we are going to be constantly testing the balance between, if you like, paternalism and the degree of the community taking control and having ownership.

Mr Gallacher—In terms of what we do in capacity building—which I will give an example of in a moment—one of the important things that the committee needs to know about AMSANT's way of dealing is that we say we negotiate with communities. We do not consult communities. 'Consultation' has been a very big word for a long time but to us it implies a one-way thing. We negotiate on an equal basis with communities so we are partners in terms of the capacity building that we do. We negotiate on an equal basis.

I will give you an example. This is an area where people do deserve recommendation, particularly in THS; we have been able to cooperate very well with THS and the Commonwealth. At a community called Robinson River, which has a population of just over 454 people, we are about to begin to establish their own community controlled medical service—as opposed to the THS clinic, which is a clinic in the community which is open once a fortnight for a day and has a visit from a doctor once every six to eight weeks. The way we have done capacity building with them is we meet with them and we talk about the issues of what the community is going to need to do in order to run their own health service. They have begun now. They have got the initial meetings of their health group together. That is a group of people who are interested in health issues. We talk to them. We are in the process of looking at tendering out a development package for the capacity building of that health committee.

CHAIR—Thank you. I invite Dr Alan Walker, who I understand is a retired NT health paediatrician, to come to the microphone.

Dr Walker—I am indeed a retired paediatrician, having worked here since 1967, and I believe a friend of the Tiwi people. I have visited the Tiwi islands for well over 30 years. I really just want to make a comment about research and the Tiwi people. I am not a member of the Menzies School of Health and Research but I have great admiration for what they do. I think the tenor of what Mr Barclay has said is unfortunate. I think that particularly applies to the ear program.

One of the facts of research is that there are many areas in which very little progress is made over many decades. That applies to health problems in all communities. If you think that research is going to provide an answer like that in a finite period of time, then you are wrong. If the Tiwi people are going to turn their backs on research in ear disease, that will be their decision and that will be very sad. I am familiar with the antibiotic trials that are undertaken there and I believe they are quite reasonable. The doses of antibiotics are not high. The antibiotics are not powerful in any harmful sense. I think doubling the dose in a future trial, if the Tiwi people agree, is perfectly reasonable.

The alternative is to accept the situation and wait until the levels of education, housing and the economy improve. That will undoubtedly bring with it a decrease in middle ear disease. The prevalence of middle ear disease in the Tiwi people is the same now as it was in Glasgow in the 1930s. Its disappearance, virtually, from Glasgow is due to improvement in housing, education and the general level of social standing, and better treatment. It took a number of generations to do that. I would plead with Marius, a very old friend of mine, to consider the difficulties in research. I know the Tiwi people have been researched ad infinitum.

I would like to point out the fact—and I think Marius would know this—that the mortality rates amongst Tiwi children have been reduced I would think somewhere near fortyfold. That is in part due to research. So research on the Tiwi people has not entirely been unproductive, although I recognise that there are many areas, including ear disease, where little or no progress has been made.

CHAIR—Dr Walker, thank you very much for that. That is very much appreciated.

Mr Barclay—I would like to reply to that, Mr Chairman. I protest most strongly. I did not criticise research per se on the Tiwi Islands. To the contrary, the Tiwi people are adamantly in favour of particularly the research that has been carried out by Dr Wendy Hoy in the renal area. They have cooperated mightily in that area and the results speak for themselves. It does not for one moment detract from the fact that they have every right to and they are protesting, they are concerned about the level of research, and I think that Menzies and every other research organisation need to take that into account in regard to their future planning.

As I said, there have been 10 years of research, a huge expenditure of money and, at this stage, very little to show for it in regard to ear research. That is the particular area that we are concerned about and that we are drawing attention to as has been discussed here earlier today. The level of otitis media is not peculiar to the Tiwi Islanders but certainly the high level of incidences is something which is of huge concern to them.

So I take on board your comments, Dr Walker. I think that a lot of what you said was true in that area but, at the same time, I think that we have to note that the people on the islands themselves are concerned about that level of research that is not bearing any fruit, or has not borne any fruit.

Mr QUICK—Just in case Marius is not here after we resume from coffee, following on from the community control thing and what Jamie said, I would like to ask Marius whether the land councils have a role in this transition from total dominance to absolute community control as operational in the Tiwis. I am not too sure whether Marius is going to be here after coffee, so I would like to put that on the record.

CHAIR—Are you staying with us? I know Bill has to leave a bit before 11 o'clock. Are you going to stay with us, Marius?

Mr Puruntatameri—No, I have got to go.

Mr JENKINS—While Marius is answering Harry's question, I am also interested if Marius could share with us what capacities he thinks are within his community that have enabled his people to be able to deal with things that are very complex, about whether they should tick off on a research program and things like that. I think that the committee has come to a realisation that, whilst we generally support community control, we have to have a better understanding of what that actually entails.

Mr Puruntatameri—I have been meaning to respond to your answer to Jamie in regard to capacity building. I believe we, the Tiwi people, have taken 20 years, and our capacity building has been mainly through the developments of people that have an interest in our island. We have had a lot of learning experiences and most of them were through mistakes. I think you would agree that each mistake that we make has made the Tiwi people stronger in regard to controlling our land. So that is the overall view of where we stand now. It is a fact that we have had a lot of negotiations with a lot of non-indigenous people who are interested in building developments on our land. I think where we are heading now is that the leaders have come together, the land council leaders and the health board members have come together. I might add that the same members who are on the health board are also on the land council so you can understand why we have got to where we are now. That is basically where we are and that is our capacity building, if you like to put it that way.

Mr Barclay—Specifically in relation to that—the question of how they deal with research proposals—the board has a research subcommittee which comprises five health workers and the resident medical officer who acts as convenor of that committee, and those five health workers examine the proposals that Menzies puts forward on a monthly basis. There might be one, two or three different proposals every month that come forward. That is the level of research conducted on that island. They may defer it until they get more information or they ask for further information from Menzies and Menzies have to come up with it. Then they consider it again and, if they feel that it meets their requirements, they recommend to the board that the board approve that research. So it bypasses the existing Aboriginal ethics subcommittee. The Northern Territory ethics committee has an Aboriginal subcommittee. The work of the research subcommittee of the board substitutes for the work of that Aboriginal committee.

Mr Puruntatameri—If I may add something, Mr Chairman. I forgot to add that, on our way to our capacity building, a lot of genuine, non-indigenous people have helped us through.

CHAIR—Thank you for that.

Mrs Salter—One very quick question: I understand that a similar process is being set up in the East Katherine area. Are you in communication with them or have you advised them? How did this one arise in the East Katherine area—a similar, autonomous one?

Mr Barclay—I do not know of anything at East Katherine. Do you mean Katherine West?

Mrs Salter—Yes, sorry.

Mr Barclay—Yes, we are in fairly close communication with them but they have slightly different problems—problems with communication. They started after us.

Mrs Salter—Yes, I appreciate that. I just wondered how much communication there is.

Mr Barclay—But there is communication. Our board executives meet—they met last month and they are paying a visit to the Tiwi Islands in January or February to see what we are doing.

CHAIR—Louise, did you want to say something?

Ms Brown—Yes, I just want to quickly make some comments about education and training for staff. My position specifically looks at the education and training needs of staff with the Tiwi Health Board. People are very committed to maintaining their professional development, improving their skills and having ongoing in-servicing. Some of the barriers to that are financial, of course. It is incredibly expensive to take training to the islands and it is very expensive for people to come in to attend training. So there are the financial limitations. There are also support issues for staff. If you are taking people away from the clinics, you need to provide relief staff so that the clinics maintain their output. That creates more financial difficulties. There are housing issues then of where to put relief staff. So the issues around education and training are very complex.

I also wanted to say briefly to Dr Peter Carroll that, on the issue of interpreting, Aboriginal health workers now have a new career structure and a national set of competency standards. Delivering an interpreting service is actually a core competency for health workers. So hopefully that area will be addressed officially now as a core competency.

Dr Carroll—Louise, thank you for that comment. I am very encouraged by that. You were speaking about training of health staff. Does that include training of health workers?

Ms Brown—Absolutely.

Dr Carroll—I am interested to know whether you might be able to relate to a comment that Bill made earlier. He expressed dissatisfaction with the level of training at Batchelor College for health workers. My question really is: do you think the fact that, when Batchelor teaches in English and you have got Tiwi health workers coming for whom English is a second language, it creates a significant problem in their training?

Ms Brown—I think that the reality is that those health workers are still going to need to communicate with other medical staff outside the clinic. So I think that it is a fact that English probably needs to be the major language that the training is delivered in.

Dr Carroll—I am not questioning that. In the seminar that I held several years ago with Batchelor health education staff I raised this problem. Some of the staff were not even prepared to admit that it was a problem. My perception from working with Aboriginal people from other areas is that, when they speak English as second language, their semantic concepts develop in their native language. When they go to an education institution that trains only in English, they have got to operate in two semantic worlds. Some bilingual people are able to do that very well, but Aboriginal people from other areas that I have worked with have had great difficulty. My point is that if the trainers are not aware of this problem their students have that is a big difficulty. I suspect that this is part of the problem that Bill is alluding to—that he feels they are not getting adequate training from Batchelor.

Ms Jones—I would like to respond to that as well. Territory Health Service in the Alice Springs Hospital employs Aboriginal liaison officers but they are interpreters-liaison officers. The essential criterion is that they must speak one of the major five languages. Most of their work is interpreting. It is a successful program and they are accredited through NAATI. As well as speaking one language they are encouraged to get accredited in another of the major languages.

CHAIR—What about in Darwin?

Ms Jones—No.

CHAIR—I am aware that the Tiwi people need to leave us fairly soon. I am also aware it is time to break but what I do not want to lose at the moment is any particular focus on the Tiwi situation. Is there any comment from Bill, Marius, Louise or from anybody else just in the next few minutes? As there is not we will take a break. Thank you everybody.

Proceedings suspended from 10.42 a.m. to 11.00 a.m.

CHAIR—I invite Mrs Rae from Territory Health Services to make a few comments, and then we will have a general chat around the issues. There is the issue of the Commonwealth and the territory—the old perennial around the constitution and how we all co-exist and the framework agreements and those sorts of things.

Mrs Rae—Yes, that is what I want to focus on. I think Jamie actually started off the day by talking about the framework agreement and the fact that the Aboriginal Health Forum has been established in the territory. I think it is fair to say that it is early days, but what we have is an opportunity for far more cooperation and collaboration than we have had before. You have to be realistic about what history has been like in this area. Generally, we have been a loose conglomeration of warring tribes, as Sir Humphrey would have had it. Everybody in the health field is being seen as the opposition. I think that the framework agreement and the establishment of the forum really gives us an opportunity to move forward in a far more cooperative way than we have before with everybody realising they are in the same business. While I accept Jamie's comment about AMSANT missing out on some of the mental health consultations, that is going to happen but we are probably going to get better at it at the end of the day.

What I would like to move on to is that Territory Health Services is trying to move forward in a positive way in recognition of what some of the health problems are here. Some people in this room may have heard about strategy 21, which is the new corporate plan. On the one hand, you could say that it is some more bureaucratic babble, if you like, but I think it is important to recognise that its real intention is for it to be more than that. In fact, it actually embraces health promotion in its broadest concept. If you look at the goals within the Territory Health Services strategy 21, they include things like strengthening community capacity. That has been dwelt on quite extensively here today, and it includes looking at other service providers.

In other words, for many years THS, in its various incarnations, saw itself as the only service provider of any note. That is an attitude that is changing. Other people are to be definitely encouraged to participate in this way in the building of a work force—both an indigenous and a non-indigenous work force, particularly the Aboriginal work force—that can work in remote Aboriginal health. The last part is looking at where we can establish better intersectoral partnerships. That goes not only for the traditional primary care service providers but for stores. It is obviously an area of interest in the whole area of environmental health in looking at partnerships with town councils and how we can work with them to get some of those basic council style services actually functioning better. As I say, the approach that is now very institutionalised is one of health promotion in its broadest sense. I would like to think that that would be well recognised.

CHAIR—Thank you.

Mrs Rae—I would be open to any questions.

Mr QUICK—I would like to see a copy of strategy 21, to have a look at it.

Ms Jones—Yes.

Mr QUICK—On the issue of stores and nutrition, we heard today from Michelle about how hopeless the situation is—not necessarily Michelle's situation. We have been around and seen so many stores, and some are Christmas clubs for the local football team. We are talking about freight equalisation and freight subsidies and the like. Is the Territory going to get to the stage where we have a Northern Territory registration of store owners so we do not have the villains—the people who would not rate a police check on their credibility? Are we going to have town clerks who are town clerks and not villains ripping off communities? In my mind, the buck stops with the territory. You can have strategy 57 but still have people wandering from community to community taking hundreds of thousands of dollars in their back pocket and then going to another community and changing from store owner to town clerk.

I want to see, in the strategy sanctions, punitive measures and registration, so that if we go to store A in Ngukurr, a lettuce is basically only 20 per cent more than it is in Sydney, and if you go to the Tiwi Islands it is still 5c or 6c either way of what is happening in Ngukurr. We should have some actual, credible, achievable things, either in legislation that the territory can implement—it has the power—or you could coerce and sanction agencies so that there are no gaps.

Mrs Rae—I hope you have actually seen the work of Territory Health Services Food and Nutrition Unit, which did a very major investigation into food supply issues in the remote areas of the Northern Territory. This was something that was jointly funded through the Commonwealth and Northern Territory governments. It resulted in a food and nutrition policy. In fact, the push on issues to do with remote stores was what drove the recent overall food price inquiry in the Northern Territory.

On your point about legislation, the reality is that, with equality, equity and antidiscrimination these days, if this were to be done in remote communities, surely it would have to be done for the managers of Coles and Woolworths stores as well. There are issues like that to be addressed. It is not simple—and I am not trying to duck out of this. I would like to see public health legislation that in fact required quality and quantity of relevance to the population.

The stores are actually owned by the communities, in most instances. They are not owned by other people. One of the most recent pieces of work has been a joint project with the Northern Land Council, the Central Land Council and Territory Health Services to develop, if you like, selection criteria and model contracts that individual communities can use to employ a store manager so that there is a requirement for them to have some basic skills, to participate in ongoing training and to perform against pre-set measures which include the quality of the food.

Mr QUICK—As an example, we heard yesterday when we were in Alice Springs that there was an advertisement for a town clerk and there were six applications. When they stated that they had to do a police check, six people withdrew. We hear all these stories. I have visited just about every Aboriginal community in the Northern Territory in the last 12 months and the stores are charging obscene prices. Michelle has already mentioned—and we have seen evidence of it—that rubbish is being sold to people. The Northern Territory

government is being forced to waste tens of thousands of dollars on health issues that can be prevented.

Bugger the social and political correctness about your not being able to do this and the human rights people jumping up and down. If indigenous people are suffering because of inactivity, I think the Northern Territory government have the power to say, 'We are going to do this whether you like it or not,' and there should be sanctions. With regard to the framework agreements, Bill mentioned the $59 million. There ought to be sanctions against the federal government to say, 'Give us a time frame for this money, and add $10,000 a day after the cut-off date if you do not give us that money.' Sanctions go both ways.

Mrs Rae—They do indeed, and I do not disagree with anything that you have said. To be fair, sometimes the obscene prices are blown out of proportion. I strongly recommend that we get you a copy of the most recent survey that was done. There are individual food items that will be sold at obscene prices.

Mr QUICK—As part of an inquiry into the Reeves report, I visited just about every Aboriginal community—and so did Barry Wakelin—from March until August. We all made an effort to go into the stores and do a price watch, as I do in my electorate, to judge the prices—not only store against store but store against the prices in my electorate. The Territory health department is picking up the money because people are being evacuated and flown into Alice Springs and Darwin when there could be strategies in nutrition put in place—and Michelle is busily working her whatsit off to implement the thing—but the elders and the land councils are saying, 'Here is a nice big goose laying a golden egg so we can have the best footy team in the Northern Territory, but our kids are suffering long term, and there is youth suicide, diabetes and renal failure.' Either you guys are in the health thing or you are not. We say that one option is that we exclude the THS, and you have nothing to do with it.

Mrs Rae—I take exception to what you are saying. It is quite clear to me that you have not had access to the documentation on what is going on in food and nutrition, the work that has been done and some of the results that have come about from it. The other thing to realise is that the store in a community is one part of the food system. To some extent it is an end point; they are an end user. There is the whole food manufacturing and production industry, and there is food transport. I will give you an example. One of the mysteries of my life—and my background is in nutrition—is how Australia is able to put broccoli on ice into the Netherlands week after week. We get compost arriving in stores in the Northern Territory. That is how it arrives.

To be fair, it is not all at the hands of the local store manager. It is not all at the hands of buying more footballs and having a better basketball court. That is part of it, but it is not the whole issue. The other thing is that it is out of sight, out of mind. You do not get consumer complaints from communities, but try and put the same things in places in Darwin or Sydney and people would act as good consumers and complain. So there are a lot of issues in this. It is not a simple story.

The other point to make is that one of the things that keeps the prices down and keeps everybody reasonable, if not honest, is competition. They are monopolistic environments.

There is only ever one transport; there is only ever one truck that drives from A to B. There is only one store at those places. There is no competition in the model, and that is one of the difficulties. It may well be reasonable to think of putting punitive measures into public health legislation, requiring store managers to provide foods. This has been considered, and is still under consideration in public health legislation at the moment, but has by no means been agreed upon.

Mr SCHULTZ—In one instance we were advised that, when the indigenous people wanted to cash their cheques, in order for them to do so they had to compulsorily spend a certain amount of their cheque money at a store before they could cash in the paper. That would appear to me to be immoral in the extreme and, more importantly, sends a message to me that they would be forced to purchase some stores that have no nutritional value to them at all.

In other words, they may not want to purchase but they are forced to purchase because they are required to spend about 40 per cent of the cheque. I forget the figure; Harry might be able to tell me. That is the obscene situation that we have in many of these stores, leaving aside the inflated prices. So that is an issue. The profit driven attitude of store owners at the expense of the indigenous people is absolutely deplorable when you hear of those sorts of forced impediments on people just wanting to cash their cheques.

CHAIR—Thanks, Alby. Before you respond to that, I will just ask Michelle for her contribution on it.

Ms Dowden—I do not want to harp on about education or about stores, but in people's living memory on Elcho Island takeaways have been there for the last 10 years. It is quite easy in some ways to do education around the area of nutrition, because you can get people to think about what food they were eating 10 years ago and how much exercise they were doing 10 years ago and what people looked like 10 years ago. That is a real positive in the work that we are doing: we feel that we can actually make some changes because the memory of good health is still there.

Maybe legislation around the area of the amount of good food is the way to go, because there is certainly proportionally more fried, fatty food than there is good food in takeaways. I think that is maybe what we are not talking about at the moment—the difference between stores and takeaways. There has certainly been an increase in the number of takeaways on Elcho. I worked at Port Keats quite a while ago, and there were perhaps two takeaways there at that time. I do not know how many there are now; I do not know how many there are at Tiwi. We all know that in urban society the availability of food is certainly much greater than it was 10 years ago. You used to have to finish your shopping by 12 o'clock on a Saturday. Now you can basically go and get whatever you want at any time of the day. It is getting like that in communities as well. Takeaways are open longer, and they are selling fried, fatty food for most of that time. So that does impact on people's health.

School takeaways are also included. We are always pushing shit uphill just trying to get basic things. Down south in school canteens they have had healthy food policies forever. You would not be able to buy lollies, pies and pasties, but you have school canteens in the Territory that are still selling crap because they say that, if they do not sell that, the kids will

go to the other takeaways at lunchtime and buy that food. That is just a small example. There are lots of examples of decisions like that that are made in communities but are not made for the rest of Australia.

Last year we worked strongly with one of the takeaways to stop selling single cigarette sticks. Single sticks were being sold for 50¢ each. That has stopped now because we said that it was not okay from a health point of view. Smoking is another area that needs a lot of work in communities. So I think that the differences are enormous between remote Aboriginal communities and the mainstream at those simple levels that you take for granted in big cities.

CHAIR—Thank you, Michelle. I think Mr Lindner will probably talk about lifestyle as well. We heard yesterday about a $1 million budget in a given store: $200,000 goes in smokes, and $200,000 goes in cool drinks and soft drinks. I think someone said that $4 a day per individual in that community goes out to buy food, what might be regarded as not nutritious food. So they are some of the issues. Tuckshops or canteens—which is what we used to call them—and proper diet and those sorts of issues have been there for a while.

One thing that I would like to introduce, and I was reminded of it in a conversation that I had in the break about sports, is the contribution that sports people make to the debate—Aboriginal people's great interest in and love of sport and how we utilise that. One area that I would like to talk about by way of a question to you is the issue of Territory health relationships, the working together of the Aboriginal medical services—community controlled services. It is fair to say that there was perhaps the warring tribe phenomenon that you referred to earlier on. It seems that, over time, there is less of a warring tribe phenomenon and perhaps even collaboration under framework agreements, et cetera. We have touched on that.

It might be useful to look at this in a contemporary Territory sense, because I can relate all of these issues to my own electorate in South Australia, and I can relate them to many other areas of Australia that we have been to. So whilst we are focusing on the Territory now, it is very much a national issue. Could you give us a brief oversight of the practical collaborative work with the Aboriginal medical services, the community controlled services, and looking to the future—liaison officers, for example. Clearly, the Territory provides the majority of the services to Aboriginal people in a whole lot of areas. What is the vision? I have not read *Strategy 21*, but I presume it is in there. Can you give us two or three snapshots of where it is going, particularly with the community controlled services. Can you give us your definition of what community control is?

Mrs Rae—I think the first thing to think about is the different types of community controlled organisations. AMSANT represents certain groups. Over time, this has evolved as organisations get their income from one source that is different from THS. Over a number of years, THS has had another form of community control. They started off as grant service agreements, whereby individual communities could take the funding that THS normally expended and manage that themselves. That has ranged from relatively small communities who are able to pay the salaries of the staff, and very little more, to quite sophisticated sorts of health services that have been run at community level, that have had a high level of community input into decision making and planning.

CHAIR—Like Tiwi, for example.

Mrs Rae—Yes. I refer to the Nguiu health service that was run by the Nguiu town council and previously by the Catholic missions, Daly River and Galiwinku. There is a range of those. In the small communities with only 100 to 200 people, the best they can manage might be to pay the staff every week. So that varies a bit. Then there are the different arrangements whereby there is joint Commonwealth and Territory funding going into something like the coordinated care trials, the essence of which, of course, is to get the MBS and PBS funding up to a national per capita level. That has made a huge difference to the amount of resources that have been available to deliver a health service. In fact, in both the Tiwi and Katherine West, it has pretty well doubled the resources that Territory Health is able to put into any individual community.

The actuality of community control does have many faces, if you like. There have been periods when individual communities have looked at taking over a service themselves. They have gone into it, investigated it and thought about it and, at the end of the day, they have decided, 'Well, what happens if somebody goes off sick? We can't replace them, but we can insist you do. Therefore, we'll decide our providers should be THS.' That is community control, too. Of course, that has often been no more community control than deciding to keep a THS service rather than do something individually.

There are a number of communities that have health boards and health committees. These are getting together more and more. There is a group around the Cobourg/Warruwi/Minjilang area that have formed a health committee that meet regularly and provide advice to THS about the nature of services in that area and about the frequency of visiting or mobile services that are required at different times of the year. They also undertake to advise on population movements as the seasons change. That is another form of community control or influence, if you like. The Maningrida Health Board has been properly established and incorporated. There is very minimal OATSIH funding in their model which allows us to work with the Maningrida Health Board—

CHAIR—Is there a doctor focus or accommodation focus in Maningrida?

Mrs Rae—No. The Commonwealth is also providing funding for a new health centre and an aged care facility but there are GPs under the national rural work force agency arrangements. At the moment all the other staff are THS funded. The idea is that over the next year the health board has a vision for them at the end of the next year to be able to start to play a big role in managing the health services and making decisions about where they might go from there. These things are slow to get going.

The Top End planning study is similar to the one that was done in Central Australia by Ben Bartlett, whereby he came up with the concept of zones. The same thing is being done in the Top End. The zones that are being proposed are pretty well aligned to what anybody would could come up with. There is nothing that anybody wishes to argue about. They do really reflect some cultural movement, similarities, language, traditional ways that people move around a geographic area. They do not fit in totally well with statistical boundaries by ABS or with local government, but they probably fit in well with human services as we would understand them in the Top End. From that point of view, one of our visions is to

look at how we can move to making those zones a reality in some way. In the Darwin rural area, the Tiwi have already been identified as a zone and are off on their own. There are three other zones in that area. We are now looking at working with people in the areas, with the health committees that already exist.

CHAIR—How would that be different from five years ago?

Mrs Rae—Everything was absolutely run by THS. There were local Aboriginal forum meetings where people came in and gave advice as a group from different communities.

CHAIR—That is a fairly significant change.

Mrs Rae—Within two years, instead of having this big bureaucratic management, we will come down to zone management, which will allow us to deal better with some of the things that Peter Carroll raised about language. If you have got staff working in and focused on an area rather than trying to go to 20 different places at once, there is the opportunity to start to work with languages.

CHAIR—But you do not have a liaison service yet in Darwin?

Mrs Rae—There are Aboriginal liaison officers in Royal Darwin Hospital but it is not done in the same way that it works in Alice Springs Hospital.

CHAIR—In terms of the preventative end, primary health and acute care, the big cost is in the hospitals—whether you are in Alice Springs or you have got these big areas and you come to the hospital, that is where your big dollars are. What is your strategy and how do you see that strategy developing in terms of acute care? People will differ with what I am about to say, but with respect to the definition of preventative or primary care, clinic care, a lot of the stuff that Michelle is talking about is out there in the community before it even gets to the doctor or nurse. We appear not to be doing particularly well there. The more investment there, the better off we will be in hard, economic rationalist terms. Hopefully at least there will be some better balance at the acute end. What is the thinking in a strategic sense?

Mrs Rae—I will use the example of chronic diseases and there has been developed within THS a chronic disease strategy which focuses on five chronic diseases: cardiovascular disease, diabetes, hypertension, chronic obstructive airways disease and renal disease, all of which have in essence common antecedents and common, if you like, approaches to prevention and management. The key issues of this are the prevention and promotion at the earliest possible stage, but based on evidence, early detection of risk factors, not detection of diseases, and best practice management of any of the risk factor conditions or disease conditions. The idea is that you put a lot more resources into the private care end of the system and, hopefully in a decade, reduce your expenditure.

CHAIR—You are certainly not seeing it yet.

Mrs Rae—No, that is right. It is shifting resources. It is based on a resource allocation model that is shown to be robust, but it does mean making investment in certain areas. But

most importantly, we are taking a best buys approach. In other words, using evidence to see what is actually going to work and what is actually going to get you the health gains that not only we want, but people in the community want to see. Two clear things, I would say, that people want to see are less renal disease because it is so visible and diabetics having fewer amputations. There are well documented, proven strategies for good medical practice and good nursing health worker care that allow you to actually do those two things.

CHAIR—Okay, we have got three MPs lining up. I have got Jill, Harry and Annette, and also Jamie. I will go to Jill first.

Ms HALL—Cheryl, you just reminded me of something when you were answering a question and you mentioned language. Dr Carroll earlier this morning also mentioned interpreting services within the health service. Thinking about infrastructure, when we have got the Army that comes out to the communities, maybe there should be some sort of a commitment to providing interpreter services. It is my understanding that there is already that sort of service provided when the Army is serving in other areas where there are non-English speaking people. Dr Carroll might like to give some thought to that while it is on my mind.

Dr Carroll—I was just about to pick up a few local examples that might help the committee and maybe Michelle can make a comment. My understanding is that the Army has provided significant infrastructure support in several communities in the last year or so. One has been the Galiwinku community where there has been a major housing program, another has been communities in the west Katherine area into the Victoria River district. The question of the Army language resources came up and it has been very obvious on our TV screens with East Timor that you have seen numerous Australian military personnel able to provide interpreting services. I ask the question: why cannot the immigration interpreter service include Aboriginal languages? I guess Jill is asking the question: why cannot the army language service extend to Aboriginal languages? You might get a reaction from the Defence Force that they might not like to be perceived as wanting to know the language of Australia's indigenous people because the Defence Force is on about defending Australia from attacks. There is a significant practical problem there.

I think what it highlights is that different parts of the Australian bureaucracy have dealt with the question of language, interfacing with Australia's overseas contacts. What I am saying, and what in a sense you are supporting, is that within the Northern Territory and also within parts of Western Australia, Queensland and South Australia, Aboriginal languages are a living reality and Aboriginal people in those communities generally do not have a good command of English. Their leaders will and a growing proportion are getting a better knowledge of English, but significant numbers do not have a good command of English. The Australian community as a whole, not just the bureaucracies, have great difficulty interrelating with people in those communities.

Ms HALL—Thank you very much. Firstly, Cheryl, I want to go back to another presentation this morning. I think it was Rob, who has gone, but I know Patrick is still here so I do not feel at all reticent about bringing this up. With respect to allied health professionals, how do you go about filling those positions in the Northern Territory currently?

Mrs Rae—Not easily, I have to say. It is always problematic because there is generally a call on those numbers everywhere. I have certainly seen some of the work that Rob has done in trying to do some pretty imaginative recruiting. One of the things we did was that, with all of those allied health professional groups in the public health groups, we tried to encourage students to come up and have a student practical experience during their education. The biggest difficulty with this is that we have not had the resources that have been available to the medical profession. They are just not available for dietetics, physiotherapy or speech therapy. In the areas where people have actively focused and said this is important the pay-offs have been very good actually.

I know that about a quarter of the nutritionists who work in the Northern Territory at the moment came here as students. It is just not easy to keep on doing it though, and in some of the small areas where there is little funding available for some of the positions it is harder. That is one of the biggest things. I think if people in their student years can see the options of what there is available to do as a professional when you have graduated then some of them are going to be attracted to this area and others are not. At the moment, so many students do not even have the ability to see that working in a primary health care environment with another culture is an option.

Ms HALL—Over the years there has been a certain amount of tension between the state, the Commonwealth and community delivered health services. Has that improved at all in recent times? What strategies are in place to see that that continues to improve so that the people who need the services get the services and it is not caught up in the bureaucratic power struggles that take place?

Mrs Rae—To answer your first question, yes, there have been tensions and, yes, I think that things have improved. I think we are better to try to think into the future and make sure they get better rather than dwelling on why some of those things might have been in the past. I think the framework agreement and the NT Aboriginal Health Forum is really a very important opportunity for bringing people together. The framework agreement itself, if you like, was put together by a conglomeration of warring tribes. It is probably better now that there is a bit more harmony and people are willing to work together to look at that in the context of looking forward and looking collaboratively and cooperatively rather than leaving it as it is. That is something that I am sure will actually happen over time.

The second thing is that in the last couple of years there has been established a CRC for Aboriginal and tropical health. That has actually then created yet another environment in which the core partners are the Aboriginal medical services and THS and the Northern Territory University in addition to Menzies school and Flinders University in South Australia. That creates another forum for people to work together in a different way. CRC has to have its own life and its own agenda and you will hear about that this afternoon. That just creates another opportunity for people to come together.

I refer to the sorts of things that Jamie mentioned this morning about the greater willingness of people to negotiate and say that the object here is to get services to people who do not have any services. Let us deal with that issue instead of hanging on to sectoral interests. I think that is quite important. I think the progress that is being made on the Robinson River issue is an example of people keeping the goal in mind rather than trying to

put up little fences around themselves. I think that is happening more and it is not perfect yet, to be fair, but it is certainly getting better.

Ms HALL—I have one more question I would like to ask you. I wondered if anyone else would like to comment on that question.

Mr Gallacher—I have some comments, but if you want to ask the other question first—

Ms HALL—No, I am happy for you to go ahead now.

Mr Gallacher—I was remiss before, and I was reminded by Trish Jones, in that I should have used the opportunity earlier to comment on this when we were talking about capacity building. One of the things I did want to talk about was that AMSANT hosts each year what we call an Aboriginal health summit. This document I have here—which I will make available to the committee—is from the last health summit, which was in August this year. It is where we get community people together to look at and develop health policy from the ground up. So it is not health policy that is imposed; it is people's ideas of what health is.

One of the resolutions from the summit, under the section on policy development and planning, was that the Banatjari Aboriginal Health Summit expressed concern that the Territory Health Services plan for the development of health services in the Northern Territory, *Strategy 21*, was developed without any meaningful consultation with the Aboriginal community or the community controlled health sector. We acknowledge, and we have said today, that the level of cooperation is much better, but the production of those big overarching health statements that state governments make—and, for that matter, federal governments—are only going to be meaningful to the Aboriginal community if they are developed in negotiation, in consultation, with them.

Mrs Rae—I would like to respond to that particular comment. AMSANT, along with many other non-government organisations, was asked to be involved in this. AMSANT very specifically declined to be involved in that consultation because they felt there was a conflict of interest. So they were not involved and that was AMSANT's choice.

Mr Gallacher—Certainly, but I am not saying this from AMSANT's point of view. What I am talking about is that it was 250 to 300 people gathered together from a broad range of Aboriginal communities in the Top End and the centre who said this. It is not AMSANT saying this; it is this meeting of people saying, 'We were not consulted about the development of this policy.'

Ms HALL—So do you feel that there still is not enough consultation, that it really is being forced on the communities without their consultation and that this power relationship and the struggles between the various levels are still playing a very important role in the delivery of services to those people who need it?

Mr Gallacher—Things are happening on two levels. There is an increased level of cooperation at the higher levels of the bureaucracy and with the management of the community controlled health sector—there is no doubt about that. But there are difficulties still at the level that is closer to the ground. That is what we need to work on, and

AMSANT acknowledges as well that we need to work on that. What we want to do is acknowledge that cooperation is better now than it has been. We also want to say not only that it needs more work and it is early days yet, but that there are still some significant struggles to go through with it. The one that I raised with Cheryl over *Strategy 21* is the classic example. I agree with her totally that AMSANT as an organisation did not want to be involved in the negotiations. But when it came to discussing *Strategy 21* amongst a really good representative group of people gathered together to talk about health, one of their major concerns was that they were not negotiated with about it.

Mr QUICK—Following on from that, in our document, at page 23—

Ms HALL—I have not finished my questions. On pages 15, 16 and 17 there are three approaches detailed. Could you tell me which sort of approach you would favour?

Mrs Rae—I think we are looking for new approaches here; we are not looking to retain the status quo at all. We have had experience of states' responsibility, the Commonwealth's responsibility, and we are looking for something more futuristic and with a bit more vision in it, quite frankly, than just going one way or the other. The reality is, though, that the states are always going to be around, the Commonwealth is always going to be around and the communities will be around. If we do not come up with something that involves all parties in making some decisions and moving forward, then somebody is going to lose out somewhere. To me, that would be a concern about going very rigidly in one way or any other way. Clearly, the status quo does not work either. So we do have to look for new approaches and for everybody to be more flexible about how they view who can do what.

To go back to some of the things that Bill was talking about this morning and the talk about cash out or cash up, the point was that the Territory and Commonwealth money provided a flexible funding pool and high level outcomes were agreed upon, but then it was the job of the Health Board and of the people they employed to do the job to actually get the right services, to get what was agreed. Nobody disagrees on what needs to happen and what are the big problems; it is how you go about it. They are the things that Bill and Marius talk about, in the same way as the Katherine West Health Board do. That flexible funding pool gives people a lot of room to move and to try and get things right, and it is not caught up in the public service rules of employing people or the financial accounting methods of government. They have that flexibility to respond to need and to say, 'This isn't working. Let's try another thing here.' That is the flexibility. It is not just having the money at your disposal but the ability to really try and make that money work.

Mr QUICK—Following on from that, and it ties in with 3.8, 3.9, 3.10—

Mrs Rae—What page?

Mr QUICK—Page 20 of our document. What is *Strategy 21* doing to ensure that funding is based on a predetermined minimal level of staffing? Paragraph 3.9 is about Docker River with one nurse operating 24 hours a day and obviously suffering from burnout and the like. There is that little part of the question. A larger part is: how is the Territory Health Services managing to convince other Territory departments and Commonwealth departments to ensure in framework agreements, or however you operate, that places like

Docker River have decent roads and adequate airport infrastructure to enable the provision of reasonable health services? It is not just Health, it is a whole lot of other agencies. From my understanding and visits to this place, the left arm does not know what the right arm is doing, let alone what the head is doing.

So, apart from liaison with AMSANT and community development, how are you liaising with other organisations and departments, Territory and Commonwealth, to make sure that the poor old nurse out at Docker River does not burn out, that she has another nurse there? You could do that quite simply tomorrow by saying you will reallocate some resources. But the road is hopeless and the Flying Doctor Service cannot land there at night. Is that your responsibility or is that Transport's?

Mrs Rae—No, it is very much Health's responsibility to be aware of those things and advocate for them. I can give you some examples, perhaps not in the area of transport but in relation to education. You will be aware of the Bob Collins report. For the last year, I suppose, in the Territory Health Services we have had a joint regional director of health and education in Alice Springs—you would have heard about this yesterday, I am sure—because there is a big overlap of issues here. There is a very successful interdepartmental task force that has been looking at environmental health. This has involved the departments of housing and local government, the Office of Aboriginal Development, Territory Health and ATSIC, and that has all been linked together to work with the ATSIC HIPP program and NAHS. What we want to do is get an appropriate standard of service and a standard of equipment and of building houses that is going to be accepted by the industry and then implemented at governmental level.

That has been very successful, and as a result we have been able to assess housing maintenance needs. This has led to the money being pooled within the Indigenous Housing Authority, which now has a formal way of managing indigenous housing maintenance in remote communities. This is already making some huge differences. If I can talk about one community—

Mr QUICK—Yes, but housing is easy. Roads and airports are bloody difficult because you are going to need tens of millions of dollars. What sorts of strategies are in place? Is there a list of 10 communities that are going to be prioritised? There must be a list somewhere, because the Army went out to community A, community B and community C in the Territory or in the states—Western Australia, Oak Valley in South Australia or wherever. The Army went and did it because the states and the Territory were hopeless. Can someone tell me, whether it is you or the Territory department, when Docker River is going to get some services?

Mrs Rae—I can actually tell you that. This has all been done through ATSIC under the NAHS HIPP program. All of those needs, be they airstrips, water reticulation, water supply, roads or whatever, have been assessed on the basis of need, and all of the needs for all of the communities have been assessed as to their priorities.

Mr QUICK—Can you give the committee a list?

Mrs Rae—That list is indeed available. The project managers will be able to provide you with that list. As a result of that list, they look at what projects might be priorities for the NAHS HIPP funding through ATSIC and then the Territory transport, works, housing, power or water departments use that same priority list so that everybody is not doing different things. There is in fact a very cohesive approach to managing, to making sure that the things at the top of the list get done first up.

Mr QUICK—You probably will not have it now, but can you provide this information to the committee: what changes in percentage terms in the Territory health budget have flowed away from hospital extensions and hospital hardware to things like Michelle is doing, preventative health?

Mrs Rae—I can actually tell you that. In about 1995, I think, something like one to two per cent of our health budget was able to be clearly identified as being part of primary prevention programs. That was very largely accounted for by specific health promotion officers for some of their operational funding. You can actually see that close to 10 per cent of the health budget is now very directly tied up in primary prevention type activities.

It is not enough. It needs to be more, and we are gradually finding ways to do it. I think in the last few years there has been quite a big shift of resources. This was initially achieved by making everybody give up one per cent of their budget and then putting all that into one bucket and redistributing it on the basis that it has to be used in primary prevention type activities. That has now become recurrent funding.

Mr QUICK—If we recommended option B, where the states and territories assume responsibility, would you have the capacity to implement whatever the indigenous population needed? Part 2.61 of the discussion paper states:

. . . the Commonwealth could pass all responsibility for direct funding of services to the States and Territories . . .

Would *Strategy 21* enable you to do that?

Mrs Rae—Yes.

Mr QUICK—How much in additional resources would you need?

Mrs Rae—I do not have those figures at hand, but there are certainly a lot of negotiations going on at the moment looking at various funding formulas. The biggest deficiency, I have to say, is what we call the missing $40 million—that is, the MBS and PBS money that does not come into the Northern Territory at the moment. As a result, we spend our financial assistance grants for health on things that in other states can be funded by the MBS and the PBS. That is the deficiency, if you like. And that actually works out because, if you look at the money coming into the Tiwi Health Board, that is about $40 million, as I understand it. That data is available more specifically should you require it.

CHAIR—Thank you very much.

Ms ELLIS—I have a couple of quick questions, Cheryl, quite diverse from what we have been talking about. As you know, this is a national inquiry, so we are looking at all aspects right around the country. In a recommendation to overcome the difficulty where people who do not live in the Northern Territory but who live closer to Darwin than Perth or Brisbane, what would we need to do to get them access to services here in a medical emergency? Currently, I understand they cannot receive this because of that thing called a border?

Mrs Rae—But they do.

Ms ELLIS—I will base the question on the fact that we have been told in other places, on record, that it is not at all unknown for medivacs not to be able to enter Darwin hospital?

Mrs Rae—I am surprised because—

Ms ELLIS—We have had it given as evidence.

Mrs Rae—Okay, there may have been some instances. Darwin hospital, like every other hospital, does have its moments when it is full.

Ms ELLIS—Yes, as does every hospital. It was not put to us in that vein.

Mrs Rae—No, okay.

Ms ELLIS—Because of a thing called a border.

Mrs Rae—In general, I would say that we actually get pretty unconcerned about borders. I give the example of the top end of South Australia, the whole Pit lands area, where expediency is the name of the game and whether someone lives in South Australia does not really apply. In the same way, quite often people might go over to an Airmed plane, or an RFDS plane might leave Alice Springs to pick up somebody at Alparrulam, which is at Lake Nash near the Queensland border. In fact, we take it on to Camooweal and Mount Isa hospital because it would be a lot closer than trying to get them back into the Territory somewhere. Sometimes it is obviously better for somebody in that area to get a flying doctor plane out of Mount Isa than it is from Alice Springs. It depends on the tasking of aircraft.

Ms ELLIS—Would THS be able to give us figures on the number of admissions through the circumstances of which I am speaking that come from other states?

Mrs Rae—Absolutely, yes.

Ms ELLIS—Could we get that from you, please, because I think that may be contrary to what we have been given in evidence in other places.

Mrs Rae—No, the information is certainly available there. In fact, I know in some areas of the Kimberley, traditional land movement is for people to come up towards Darwin rather than go south. So their preference, if they are able to elect, would be to come up this way because they have got family supports in the area.

Ms ELLIS—Okay. I have another question which is completely different. You said a few minutes ago that you consider that part of the health decision making process also involves the infrastructure like airports and roads and so on. To throw you a hypothetical which is based on a bit of reality, in Maningrida, we understand that, after the wet in most cases, in most years part, if not all, of the road disappears?

Mrs Rae—It does in Darwin, too.

Ms ELLIS—Yes. As a result, the only reliable way of getting stores into that place is by barge, but there is only one operator and he can write his own barge cheque in terms of cost. If that is all correct, what would your recommendation be—to have freight equalisation for the barge, to get the money into building a road or repairing a road at less cost each year?

Mrs Rae—That is true, Maningrida gets everything in by barge. It does not matter what it is. It is only private vehicles and private goods that are usually brought in by road.

Ms ELLIS—Is it true there is only one operator?

Mrs Rae—There is only one barge operator at the moment. It is V.B. Perkins. Again, it is an economy of scale—the size of the market, as much as anything else. One would hope, with the amount of supplies that have to be transported to Timor, that maybe some other barge operators will come up and provide a bit of competition.

Ms ELLIS—It was put to us in very strong terms that, when that road is out, barge costs go up quite dramatically straightaway?

Mrs Rae—But not much goes in by road anyway.

Ms ELLIS—But that is what they have told us.

Mrs Rae—Most of the road, you see, is through Aboriginal land. It is only private transport that is allowed over those roads. You cannot get a permit to do any commercial trafficking.

Ms ELLIS—Again, it is conflicting evidence.

Mrs Rae—No, private individuals can get a permit to drive to Maningrida, but there are no commercial trucks.

Mr McMillan—I have got no axe to grind for the barge company, but barge freight rates are set. There is a barge freight rate schedule. They are set and determined and if they change, a new schedule is printed.

Ms ELLIS—Set by who, Stuart?

Mr McMillan—It is set by the barge company, but those rates do not change regularly at all, and that schedule is publicly available. The committee would be able to access that schedule. It is pretty unusual for barge rates to change more often than once a year.

Dr Carroll—Just to comment on the road, what Cheryl says is right. It is across Aboriginal land and the average person does not get a permit to go on it. But having driven on that road a number of times in recent years, I have frequently passed heavy vehicles going towards Maningrida. Some of them have got building materials on them; some of them may just be local people taking a truckload of supplies out. The road is certainly used but not to any extent compared to the barge traffic. Everything goes in by barge. The road is used; there are people who use it.

Dr Walker—Harking back to the question of the border, with regard to admissions from Western Australia principally, but also South Australia in the south, the Territory hospitals have always accepted admissions as a matter of policy. There will, on occasions, be a considerable shortage of appropriate beds here, and that is usually discussed with the referring person in the Kimberley or South Australia. I think Cheryl did actually say that but, certainly, the policy is to accept admissions from areas close to here, unless it is decided that the treatment is so sophisticated as to need to go to Adelaide or Perth.

Ms ELLIS—Thank you very much. This gives us an opportunity while we have got the Territory Health Services here to ask you to either agree or refute information given to us in other places. That is why I am asking these questions.

Mrs Rae—We will get you the information anyway; that is okay.

Mr SCHULTZ—Cheryl, just on the issue of the shift in preventative health strategy funding, if I remember rightly, you said in 1995 it was one per cent of your total budget?

Mrs Rae—Yes, one to two per cent, somewhere around that.

Mr SCHULTZ—And in 1999, 10 per cent of your budget. Is that a nine per cent increase in real terms or is it in addition to the CPI increase that has been absorbed—the cost of living and the increased cost of wages that has been absorbed? In other words, what is the actual physical increase in that area of funding? Is it an actual 10 per cent, taking those things into consideration?

Mrs Rae—You are asking me whether it is a cost shifting exercise. No, it is not a cost shifting exercise. There are some real things about it. A good example of what has gone on throughout the Northern Territory is that we have got a fairly big growth promotion program going on, and that has involved the hiring of an additional nutritionist, child health specialists, nurses and community paediatricians. Certainly, some of the data in Central Australia is very encouraging. The GAA have got a promotional program with the results and they are starting to come through in the Top End of the Territory as well. That is a good example of some real funding increases or of funding being taken out of one area and specifically placed in something like that.

Mrs Salter—I would like to add to that and I do not know whether this has been mentioned—I would not have heard it if it was. I would like to point out that the Territory has a wonderful record of immunisation. It has had awards for it. But this is a double-edged sword because, obviously, the Aboriginal communities are well covered by immunisation programs. I am just wondering how much information is understood by the mothers because

of the language difficulty and differences. How much do they understand about what is being offered in the way of an immunisation, MMR and things like that? Not that I am decrying this, because I think it is a wonderful record of immunisation. It is acknowledged throughout Australia as having one of the highest overall immunisation programs in Australia and it has been so awarded.

Ms Dowden—I would like to make a comment about the immunisation rate. It is the highest, and in some communities it is up to 90 per cent. It has been up to 90 per cent at Elcho Island. The immunisation rate at Elcho is falling off at the moment, and that is because we have decided to do more education in the community about anaemia. Anaemia in children and malnutrition is probably up around 80 per cent. The reason that the immunisation rate has been 90 per cent is because health workers go out, toot the horn outside houses and drag mothers and children in and bring them to the clinic for immunisation. Parents and families do not necessarily have an understanding of what that means. At the moment—Alan Walker might like to comment a bit on this—we struggle with the fact that we want to inform people more about health and nutrition and what immunisation means. We are looking at people making informed choices about the care that their children are getting. This may mean that our immunisation rate will drop off, which may mean that we come under flak for not having an immunisation rate as great as we have had. The health workers were absolutely incredulous that their immunisation rate was greater than that of the rest of Australia, but then we talked about what happened in Palmerston, what happened in Broadmeadows and what happened in other low socioeconomic areas of Australia, and community health cars do not go around and toot the horn outside houses and drag mothers and babies in.

They are some of the issues in Aboriginal health that perhaps have not been talked about at length in the document. There is still a paternalistic notion to make statistics look good. I was encouraged at the public health conference to hear David Werner talk about similar statistics in developing countries where immunisation rates are as high as in Aboriginal communities but malnutrition and anaemia rates are really high. That is analogous to our communities. I would be interested to hear what Alan Walker has to say about that.

Dr Walker—I am sure the Aboriginal parents do not understand the reason for immunisation in most cases, just as most parents in our community do not understand it either. The fact is that most of the diseases we immunise against these days disappeared 30 years or 40 years ago. Whooping cough is still around, of course, but poliomyelitis has not been seen in Australia for 30 years or 40 years. Diphtheria is the same, and tetanus is rare. We immunise people because it is accepted as being a good thing. I do not think people understand that any more than the Aboriginal people do. There is no doubt that one of the great differences between the health of Aboriginal people and the health of children in Africa is the fact that immunisable diseases do not exist here. In Indonesia, tetanus and polio are rife. If you want to see the advantages of immunisation, just go and have a look at what is happening in Indonesia. I would hope that immunisation will continue, because there is certainly a risk that if it falls off those diseases will reappear. But we have to accept it at the moment as an article of faith. There is no doubt that Aboriginal children have a high immunisation rate because it is forced upon them, for want of a better word. Let me say also that in France, if you do not have your children immunised, you do not get any child endowment.

Dr Carroll—Could I pick up a minor point? From the patient's point of view about injections, the Kunwinjku people call the needle a djalakiradj, which is a fishing spear. I suspect amongst the children there is some resistance to the thing. The achievement of the medical service to get 90 per cent is very well done. It is an interesting perception from the patient's point of view that getting a jab with a needle is like getting a fishing spear put in you.

CHAIR—Cheryl, did you want to respond to any of that, because Harry Quick wants to go on.

Mrs Rae—No, I think that is fine.

Mr QUICK—We were talking over coffee about the need for sanctions to work both ways. In the issue of mental health Bill brought up a point about the Commonwealth dragging the chain. If we are going to have a framework agreement like you do with construction of this place, if you do not get it on time there is a sanction there where the Commonwealth or the Territory is denied money or asked to provide additional money. What would your views be on that? As Bill said, they are already spending the money hiring the people, and I have no doubt that you have as the Territory Health Service as well. If we have the bag of money and we are tardy, we ought to be putting, as part of our recommendations, that there is a time frame that is met, and if it is not met there should be some sanctions.

Mrs Rae—Without wanting to be facetious, I do not know that the Northern Territory or the Commonwealth Treasury would agree with any of this. They are the people—

Mr QUICK—The people where Michelle is are saying that on the Tiwis the suicide rate is going through the roof and there are no bums on seats. The Treasury guys in Darwin and Canberra are on $150,000 a year and they do not care.

Mrs Rae—My only comment about that is to ask whether sanctions are the way to go. Shouldn't the agreement agree to just do things right, do things in a timely fashion, and we should not have to worry about those sorts of things? It assumes the worst case scenario and it assumes we are going to be confrontationist in our negotiations. I think that is not healthy.

Mr QUICK—Aren't framework agreements basically the lowest common denominator? We heard evidence yesterday in Alice Springs that the standard of training of Aboriginal health workers is probably the best in Australia but, when we sat around and developed the national approach, people thought, 'The Northern Territory high jump bar is too high. We will lower it and we will all agree on the lowest common denominator.' To my mind, that is ridiculous. If you are providing the best service, we need to drag the other states and territories kicking to meet your standard.

Mrs Rae—Yes, I think that is a fair comment too. To be fair, I have not given consideration to the subject of sanctions and things like that. I do not know that I can actually elaborate on any response.

Mr QUICK—Can I have your views on the lowering of the standard for Aboriginal health workers? Why can't we meet the Northern Territory standards?

Mrs Rae—I do not know why other states cannot meet Northern Territory standards. The Northern Territory has difficulty. It goes back to the basic education issues. There are not nearly as many people who are able to meet the entrance requirements to get into the Batchelor College program as we would like to see. As a result, there are two levels of training, as you would appreciate from Alice Springs yesterday. One is run by the Central Australian Congress and Danila Dilba here in the Top End, which was the forerunner of basic skills programs and the forerunner of the Batchelor College style programs. Literacy, numeracy and basic education is certainly the most limiting factor to all of that.

But I do not think standards should be lowered. If you are going to provide quality care and you are actually going to make any dent in this huge burden of disease that Aboriginal people live with day after day, then we have to have good quality people who make good observations, are able to refer on, able to make an assessment and treat, and it is really very important to maintain standards. In fact, in the Northern Territory the Aboriginal health worker career structure, which is essentially part of our Aboriginal employment and career development strategy, means that the standards and putting the time, money and effort into allowing all of those individuals access to the training they need to get up to those levels are absolutely vitally important. We have been working on this for the last couple of years and we continue to work on it. This is not something we will ever let go.

It is not an industrial issue—in other words, meeting an award—it is an issue about the quality of service you provide. You cannot provide a good quality of service to indigenous people if there are not indigenous work force members. You have to put it into that context. So if you are going to go down that road, then you do have standards and you do maintain them and you do invest in maintaining them. That is my view. We should not be lowering any national standard at all. We should be making sure that we continue to reach out and go forward.

CHAIR—Can I just stop you there. I want to come back to Aboriginal health workers because I think it is important. I want to give you a spell, and I want to move on because two people have not had an opportunity to speak. Firstly, Ms Austin, would you like to make a statement?

Ms Austin—I am a sportswoman and businesswoman from Darwin. I do not have any role in any health organisation but, as you can see, I am of Aboriginal and Torres Strait Islander descent. I find this inquiry very interesting and appreciate that there are a lot of programs, organisations and a lot of other avenues to hopefully help improve Aboriginal health.

I spoke to Barry before and it seems to me that a lot of this is based on remote Aboriginal communities, not urban Aboriginal people. I can appreciate that because we have more access to medical facilities, hospitals, et cetera, in urban areas. One of the things I would like to speak about is that, when we talk about community stores and we talk about access to fruits and vegetables and proper dietary foods, we also have to appreciate that we do not get paternalistic. People do have a freedom of choice, liberties, whether they are

black or white. Their lifestyle is a lot different from ours. We also need to get them to become self-developed and encourage them to grow a lot of the fruits and vegetables in their communities.

One of the subjects I also spoke to Barry about was sport. I think sport plays a very important role in health. Sure, education is number one. Through education they learn to read and write, and they learn a lot about what goes on in the outside world, apart from their communities. But sport is a great thing. Sport teaches them about physical exercise, about diet, about socialising with other people. It teaches them about different lifestyles. It gives them ambition to improve themselves—self-esteem. You just have to look at the number of national and international sports people of Australia—many of them are indigenous. I keep coming back to the most important issue that we seem to be skirting around or evading or avoiding, which is the alcohol and other substance misuse. The discussion paper states:

Even when considered at the State, regional or local level the majority of people saw alcohol as the most common health problem.

I just want to know if this subject has been addressed in all your travels. We need to get the local people, the community people, involved. It is all well and good to have all these programs and to get funding from here and there, but we need to get right down to the grassroots level and show the people themselves what they can offer to their own communities. We need to get more of the Aboriginal leaders involved as well. I do not know if Jamie's organisation covers all of that, whether that comes into any of your forums, but to me that seems to be a very major problem, not only in the communities but in urban Darwin. You have probably seen it yourself. You wander around and there are groups everywhere.

You talk about taking the cheques into the community stores. Let's be realistic: a lot of those cheques are being spent on alcohol. The little children who are following the adults around who are buying this alcohol do not know any other way of life. They think that is life—growing up in that environment. So we need to touch on that.

That is the most important part of all this health issue. We need to address that. We need to get the local Aboriginal people, the community, involved and find a way to cut it down a bit and educate our little children that alcohol is not life. Growing up like that is not life. I do not know how I would go about it, but I just wanted to make that point. We have not touched on that subject. That is important for Aboriginal health, regardless of whether they are out in communities or in urban parts of Australia.

Mr SCHULTZ—In relation to growing your own food, I think you are absolutely right. I mentioned to a couple of committee members some time ago about being absolutely amazed that somebody has not pointed out to the communities that they can grow fresh vegetables through hydroponics at a very low cost to set up in any of the communities. Most of the communities have water. I am absolutely amazed that somebody has not taken that up. The point you are making with regard to growing food is excellent. I am sure the committee has taken that on board.

Mr Lindner—I am here in a private capacity. I apologise for my original submission being a hotchpotch sort of a thing with not much communication between the biro and the

brain at times. I knew what I wanted to say. I have given you a response to your discussion paper, and that is to say that the discussion paper is wrong and I am right. I will go into that.

A basic thing has come out in mentioning growing food and that sort of thing in communities. I have been around for 35 years, married into Aboriginal families and so on. Probably for the first 20 years I was trying to convince people they should eat lamb and peas on Sunday and lift their game. In the last 15 years I have picked up another view. I was inspired a bit by Peter Wellings, who worked in parks, who probably knew more about Aboriginal people in the first fortnight he was employed in parks than I did in the first 15 years simply because he was not imposing his views. He had an academic and personal interest in the Aboriginal lifestyle.

I have lived 20 years out of government employment. I worked on stations and then with the Conservation Commission until 1979. Since then I have picked up jobs available out in Kakadu working for Gagudju Association supplying buffalo, which is a traditional meat, if not an indigenous meat, geese and so on to people who wanted me to give it to them who could not get their own. I supplied it as well to the people who would have pinched it off the other people if I had not given it to everybody. You are very exposed to people and their real attitude—their day-to-day attitude towards bush tucker, supermarket food, take-away food and so on and the general behaviour of people. I am not shy of being called racist or whatever in identifying differences between people. I do not see that there has to be a derogatory attitude in any way. In fact, I have followed the Peter Wellings role and become obsessed with the qualities of the people I live with.

They do not like planting things and growing them. I know this historically. I have had contact with Uniting Church missions, Croker Island and so on. I knew Rupert Kentish well. He used to tell me at length what used to happen in the good old days on the missions.

They used to bring in Fiji missionaries and people like that and put them on the mission stations around the Top End. There were probably other people, Tongans, I do not know. They were religious. They came from garden cultures and they grew magnificent gardens. The gardens thrived while they were there and the moment they left they fell into disrepair. In my own home life I tried to set up banana trees and whatever around the place.

Basically the people are naturally obsessed with hunter gathering. In Kakadu that is a very rewarding pursuit because it is very rich country. The flood plains are second to none, including cultivated efforts of modern man. The flood plains of Kakadu hold up by comparison. You have your Eleocharis bulbs. Peter Carroll was well aware of that. There are dozens and dozens of foods available in Kakadu and in Arnhem Land which are not subsistence foods but palatable, tasty foods which people go for. I find that people I deal with who have been hunter gatherers have behavioural differences which impose now many of the problems which give rise to this conference.

This conference so far has largely been about medical matters and not about health matters—the repair work needed. The people are very ill because they come into contact with a different lifestyle and they have gone for it. It is good to know that from 1996 to the present, health preventive care expenditure has gone from one per cent to 10 per cent or

something like that. The interesting thing was that I have lived with a lot of very ill people, I have delivered meat to about 300 people over the last 20 years continuously for that period, I have seen a lot of people die. Some people have died of undetected tuberculosis, pneumonia and so on. A lot of people are dying from heart disease and some are dying from cancer. There is a lot of cancer, lung cancer and so on. A lot of people are dying now from heart disease, alcohol related liver disease, hypertension diseases, renal failure and so on. It seems to be getting worse.

Diabetes is a shocking disease. I took a companion through three years almost non-stop in Darwin Hospital with eye damage from diabetes. Of course, as many of you would know, nothing impacts more on a disease—whether it is cancer or diabetes—than losing someone very close to you. It is a shocking thing after three years of futile treatment. She had been diagnosed eight years before I started living with her and was given virtually no treatment for diabetes. She had very advanced damage. She was a bush woman from bush culture. Along the line her husband, who died some years ago, was a very senior owner of Ranger mine. Her culture went from an absolute bush culture of walking to driving around in a vehicle. That is the basis of my concern over health, as explained in the original submission and again, in my response to your discussion paper. That is the direct and, to me, irrefutable correlation between not walking and the diseases that are now the major concern of your medical strategies that have been so far the preoccupation of the conference.

Taking her through laser treatment to the back of both eyes for diabetes damage, I had the pleasure of meeting a Dr Jaross, one of the most dedicated doctors I have ever known. He was working extreme hours on the lens replacement and diabetes necessitated laser treatment. He was enlisting the help of a Maningrida lady to counsel Aboriginal patients with diabetes in relation to diet. She used to come around with a photo album of bush tucker. She would trot out these pictures of what people should be eating. In the normal perverse way, I got hold of Dr Jaross and pointed out a few home truths to him—that people, in pursuing bush tucker, go for fat animals. Their preoccupation up here is with fat meat. Surely Peter Carroll, for one, would appreciate this. I supply geese to people in the Kakadu area. They go to the Oenpelli. I hunt them along with the eldest in the family and so on. I only hunt them when they are flying and fat—very fat.

The lady I lived with for seven years had rheumatic fever heart damage. She was told directly not to eat marine green turtle and dugong, both animals illustrated in the health worker aids bush tucker recommended diet book that Dr Jaross was following. He was very concerned when I told him that, for example, you could blow a wallaby over or pick it up dead on the road somewhere—people here, if there is a wallaby dead on the road and you drove past, expect you to pick it up and deliver it to them—but if it is not fat, they do not want it.

The problems of hypertension, heart disease and diabetes would not occur if people who ate white sugar, white bread and fatty take-away food were walking and not using Toyotas. I do not eat white bread, but I still manage to be pretty healthy. I would not be alive if I was an Aboriginal. I do not think the genotype could handle my overweight. I have seen too many people die in their 40s, relatively fit compared with me in outside profile. But I think there is a major problem with people who stop walking.

Further than that, when they are employed now by parks—and there is massive employment down in Kakadu; the mine has a liaison section which is constantly trying to recruit people to work—the tendency is for it to be almost apologetic employment, to mechanise it as much as possible. The CDEP program as applied to people I call the car driver education program. It seems to be about a maximum amount of vehicle use for a minimum amount of work on the ground. When you do work, you work with chainsaws, lifting gear, ride-on mowers—you name it.

One of the first indicators I had of the role of walking was—I will mention a name, it will probably go against a lot of people's grain that I am mentioning a name—Jane Christopherson in town here, a very well-known identity, a very respected woman, and a person I owe a lot to. She was diagnosed with diabetes I think about 30 years ago. They got rid of their ride-on mower and she pushed the smallest possible mower that could do the job over a five-acre block, and similar sorts of strategies they imposed on themselves. She is now well into her 70s and she has none of the burdens of typical Aboriginal diabetes untreated and not catered for by diet. Obviously, she has a very stringent diet. I cannot push dieting because I have thought about it for 55 years and now I am just about giving up on it. But I do know walking is something that the Menzies school should be looking at. If we adopt the name 'Toyota disease' for it, maybe Toyota will give us a few million dollars to investigate it, I don't know. But I think it is the crux of the problems now.

CHAIR—Dave, thank you very much. You have given my pot away. My wife is sitting down there. She has been trying to get me to walk for the last 10 years, and I have not started yet, but I'm gone, I'm history. You have given her the secret.

Ms Dowden—I would have hoped that I might get a bit of help from a nutritionist over the way. For the record, it is important to point out that the fat in wallaby and kangaroo is probably a different type of fat. It is the leanest meat, and it is the best meat for indigenous people and ourselves to be eating. I would like to refute a lot about the white bread, sugar notion. Maybe a nutritionist could help me out on that.

Mr Lindner—I am not advocating it; I am just saying that the main problem lies elsewhere. There has been a huge change in the ecology of people, and it is related to people.

Ms Dowden—The other point about bush foods is that there are seasonal variations in food. The people on Galiwinku certainly talk about how they hunt different things at different times of the year. That gives them variety. So they are not eating dugong every day of the week, like they are eating white bread and sugar every day of the week. Nor are they eating turtle every day of the week, or weti, or magpie geese. So there is traditional food eating with variation. I felt I needed to say that for the record.

CHAIR—I would be of the view that that lifestyle has certainly changed for all of us, whatever our race or origin. Aboriginal people are probably caught up in that as much as anybody.

Mr Lindner—We have not had effective medicine for more than 100 years or maybe 30 years since antibiotics came in. There was a huge selection process resulting from the

neolithic age, or whatever race it was, from 5,000 years ago to 13,000 years ago in New Guinea where people became sedentary and grew crops. A lot of people died to produce genetic modification in the people who are adapted to sedentary lifestyles.

Mr McMillan—I am not going to say a lot because I came to participate in the discussion. I am interested in the discussion, particularly the aspects that you are going to talk about in relation to culture, so I will do that. There are a few points I would like to make. Most of my points centre on the issue of control, the issue that keeps coming up, the issue that you raised at the very beginning—the need for indigenous people to take responsibility for their health, the community capacity issues.

I want to stress how important it is, if we are going to give people control, to empower them to make informed decisions. We cannot empower people to make informed decisions without language and without a world view. The common phrase we have coined is 'cultural knowledge base'. We are going to talk about dietary things in the way that Michelle has been doing in some of the work at Galiwinku, using the people's cultural knowledge base and traditional understandings of good dietary practices and then explaining information that we now know—for example, wallaby and that sort of meat is the leanest type of meat—and to explain why those diets are good, but also building on the cultural knowledge base of the people.

I want to stress the importance, if we are on about control, of investing in that area. Cheryl has already talked about a shift in Territory Health Services funding. It is critical that there are those sorts of shifts that invest in the things that are going to create long-term results because people are able to make informed decisions.

There are some aspects in the report I would like to go to that relate to control. There is a discussion about cultural awareness at 3.3, 3.16 and 3.21. The issue of cultural awareness, cross-cultural training, is critical if health professionals are going to interact with Aboriginal people and enable Aboriginal people to make informed decisions, to understand something of the world view of the people, to understand something of the culture they are coming to work with.

As Cheryl said, we encourage students to come up here. We have many health professionals, doctors, on very short-term contracts. It is critical to make that investment in cross-cultural awareness, the cross-cultural training area. The proof of the pudding is in the eating in terms of its cost-effectiveness, not just the long-term empowerment of people. We have been running cross-cultural training in Eastern Arnhem Land for a long period of time now, initiated by Territory Health Services out of deaths in custody money originally. We run that program in our own right now. In the very early stages of that, after about three years of running that sort of program, we are able to evidence a decrease in the turnover of staff and an increase in communication within the hospital system out there where the admin people were talking to the health professional people and resolving some of their own problems in the area. Cultural awareness training does more than be cost-effective for Aboriginal people; it is cost-effective for the system in terms of improvements in the system.

I want to speak against the Army—3.46 in your report. Whilst I recognise that the Army goes in and does some great work, it flies in the face of what we are talking about in terms

of empowerment of people. It flies in the face of good community development practice. There is an illustration in a document that I will submit to the committee from our organisation. It talks about babies that kept on floating down the river and the people in the community that were pulling the babies out of the river. This is a true story, an Asian circumstance. People were pulling the babies out of the river and wondering what they should do. They built an orphanage, and they kept pulling babies out of the river and putting them in the orphanage. Eventually, somebody said, 'Let's go up the river and find out why these babies are being put in the river.' Paternal practices, practices of doing things for people and not empowering people to do things for themselves do not have any long-term results.

The report talks about breeding dependency at 4.63. It talks about, at 4.59, the deskilling of the community. What I have seen in the 17 or 18 years that I have been here working with Aboriginal people primarily in East Arnhem Land is a deskilling of a community. A community that used to build all their own houses now has contractors build them. A community that used to do all their own book-keeping now has white fellas do most of it. This is a community that were the mechanics, that ran their resource centres, that did so many things. Essentially, because of financial constraints and because of our desire to do things for people, we deskilled a community. And we must stop deskilling the community. We must stop doing things that are very short term in their solutions, in their results.

Feeding programs for kids is another example. They have been trialled on and off over so many years. Feeding programs just demotivate parents to worry about their kids. The program shows short-term results but the long-term results are no better in terms of malnutrition and those sorts of things in places where programs have been trialled in the past. We need to empower people to make the right sorts of decisions, responsible decisions for the care of their children.

Dr Walker quoted something that I thought was really brilliant when he was talking about the ear disease. He said that in 1930 the rates of that disease in Glasgow were the same as they are here. We have to recognise that we are talking about a very short time frame for all of these lifestyle diseases and things that have come upon people. There are people here that have got a very strong cultural knowledge base—and I am talking about people in the remote communities, I am not talking about the urban situation—but there is a whole mass of new information that our society really has only put together in a very short period of time, and we need to be able to present that information in language and conceptual ways so that people can build on their cultural knowledge base and take that new knowledge and make responsible decisions.

Can I commend to the committee, if you have not got it, the Health Complaints Commissioner's first report from the Northern Territory. It is a new commission. It was set up in the Northern Territory. It was unfortunate that the minister for health made a most unfortunate comment—there are no complaints from Aboriginal people, therefore there are no problems. I do not purport to quote him exactly in that, but that was the context of what he said. It is unfortunate because it does a disservice to the commissioner. The report has an excellent section on issues to do with the Aboriginal community which touch on a lot of the points of control that we have talked about. The report also has a paper about difference and about us using difference to make a difference. It is an excellent paper and it touches on

many of the issues that we have talked about today, including language, including education and including matters of control and matters of access. So I commend that to you. I think that is probably enough and I will be pleased to be able to join in the discussion.

CHAIR—Thank you very much, Stuart. That was a very good presentation, I thought. Did anyone want to pick up anything specific that Stuart said?

Mrs ELSON—With respect to the comment you made about the Army coming in at Galiwinku, were they intrusive or were they inclusive?

Ms Dowden—It is interesting: we actually found the Army's contribution quite beneficial. The health centre was offered the services of the Northern Endeavour section, which is the health section. Initially, when they offered services they were quite interested in putting grommets in ears and in doing a whole lot of procedures to get themselves skilled up, but we were able to say to them as a community and as a health centre that what we needed from them was support with our scabies program. We actually did scabies day in conjunction with the Army. They found it really difficult but, at the end, they were really enthused about the fact that they had been involved in a community development preventative exercise. They wanted to go around and wash people and put cream on. They are real doers, the Army. It was a real education process for them. When they understood they did not have to be actively involved in doing something but just provide support and infrastructure they came on board really well.

Without the Army we would not have been able to do that first program. We have done the program three times by ourselves since the Army has been there but people still talk about the Army's involvement and it gave a focus for the program. We did have reservations about the Army being involved.

The building experience at Galiwinku is that the Army did the homelands houses and at the same time there was a NAHS project within the communities. There were 20 houses built by contractors and two of those houses were being built by local building teams. Just for the record, the Galiwinku building team, the trainees, are the best regarded in the Territory at the moment. They are building houses as opposed to blocks, besser blocks. They are getting through those houses slowly but surely. The whole housing thing has been a very positive experience at Galiwinku.

Mr McMillan—I do not think the issues are juxtaposed. I think that what Michelle is saying demonstrates—as Cheryl said before—the hows about how things happen. The Army could go in and just be the doers and put on the cream and everything, but if we can do things in ways that empower people then we are going to be more effective than just going and doing the job.

Ms ELLIS—Michelle, who trained the building team?

Ms Dowden—The building team has DETYA money, and there is a non-indigenous trainer training six to eight local builders.

Ms ELLIS—How long is that program going to be in place then?

Ms Dowden—I think it is a three-year program, so they are almost at the end of it at the moment. It was a different experience at Galiwinku where the community decided that it was an absolutely impossible task for the local people to build 20 houses. It has been a much more realistic outcome.

Ms ELLIS—I agree with both of you, but the frustration for us is with another subject that has become very dear to our hearts. Whether it is the Army or whether it is the church or whether it is government, it does not matter who it is, if they go in and install or correct a sewerage system or build a house or lay concrete for a basketball court—it does not matter what it is—if they go in and do it and leave with no thought or effort being put into the ongoing maintenance of the thing, then it is basically a waste of money in the long run. We in the committee have talked a lot about how we attach training programs in a meaningful way.

The risk we run is to try and set up little mini universities or little mini TAFEs everywhere or say you can only do it if it is a formally accredited apprentice program. That is all very well if you are in a place where that can happen, but if you are out in the middle of nowhere and basic skills taught in the implementation and building phase are sufficient to maybe upgrade the CDEP program locally so that the people who are trained in maintaining the water and sewerage reticulation system are recognised sufficiently, trained sufficiently and paid sufficiently through CDEP, is that the way we do it? This is the next point of difficulty for us, to make sure that what is put in there in collaboration then becomes a maintainable thing so that not only does the community gain the service or the building but also the members of the community then gain training and recognition for upkeep and maintenance.

Ms Dowden—And then once they are trained there have to be real wages available for them.

Ms ELLIS—Absolutely.

Ms Dowden—I would just like to give an example of the garbage collection at Galiwinku by the local people who receive real wages, good wages. They collect the rubbish seven days a week, whenever they want to. They take the truck home. It is totally their agenda. Sometimes they take the truck fishing, which is fine. But, before that happened, the garbage was collected on CDEP wages. Who wants to collect the rubbish in a community for $9 an hour?

Ms ELLIS—Absolutely.

Ms Dowden—You would not get that down south. This is another issue entirely, but there is a lot of infrastructure and jobs that councils and communities are expected to do that are not necessarily funded. CDEP is good in some ways but it has got downfalls because you are expecting people to do jobs that are jobs that are not necessarily funded through a council budget.

CHAIR—Where you are headed is what is coming through from the community as well. Stuart, did you want to respond to that?

Mr McMillan—I just want to respond to the first part of that question. One of the programs you may not have heard about is that there was an organisation that was going out and RPLing—recognition prior learning—Aboriginal people, mostly my age, middle aged people, who had trained in the mission days as carpenters and builders and so forth. They were going out and RPLing those people so that those people could then be involved in the training of younger Aboriginal people in the communities. Through going through that RPL qualification, then they could attract the necessary funding for the other trainees without that person having to be resident in the community. So that person was able to do several communities in Eastern Arnhem Land, the Tiwi Islands and Daly River area. RPL guys who were in their early to late 40s were able to then be supervisors for the young blokes who were training.

CHAIR—A very important practical matter.

Mr SCHULTZ—That was the question I was going to ask, Mr Chairman. What better practical way can you have of government contributing to something that is going to be positive for the community as a whole and to have people being trained, as Cheryl has described, by builders to build homes and then, after their training program finishes, sending them out of the community to train others? That was the question I was going to ask but you pre-empted me.

CHAIR—Mary, I am determined to get the Aboriginal health worker and cultural issues into this discussion. We are going to run over time but I am determined to have 10 or 15 minutes.

Mrs Salter—I just want to quote one example I heard of last week at a Telstra committee meeting. A member of the Central Land Council described a program that they had set up to deal with Telstra breakdowns in the communities, which is a very important problem. Obviously, you are not in control of modern techniques. Telstra had one well-trained man, a mentor. He approached a year 11 boy from the school for Aboriginals here, Kormilda College, and trained him up to go round to the communities doing exactly what we are doing here, teaching them to maintain the telecommunications outlets. I thought it was much in the same way. It was designed by a member of the Central Land Council and seemed to work.

CHAIR—I happen to have a view that the health worker issue is critical to this whole thing, and I want to hear from anyone who is prepared to contribute. I want to know what effort is being made by THS in terms of the health workers, and I would like to know, obviously, the practical end of the community level, what the reality of it is, and I want to know the cultural impediments. We can talk about literacy skills, which are important. We can talk about the fact that people need and want to live in their own community, which is important, and talk about the linguistic issues which Stuart and Dr Carroll have an interest in, but I just want to know the practical impact and what we can reasonably expect from the health worker component. We can talk about dollars, too, if you like, and we can talk about proper wages and incentives and houses and all of that. But I just want someone to kick the ball around a bit on this issue, remembering the cultural part of it as well. Who wants to start?

Mr Gallacher—I would like to talk about it because this is an area where we have got what I believe to be really good cooperation with Territory Health Services. You need to understand that for a long time there was a disparity between the wages offered to Aboriginal health workers at Aboriginal medical services and the wages that were paid by THS to Aboriginals for their health services. Often the Aboriginal medical services felt they were training health workers to then see them be, in their terms, pinched by THS because they offered better pay.

We have got a really good working group happening now. We have managed to level that out, and we are working towards having one career structure for health workers in the Northern Territory. But I should also say about health workers in the Northern Territory—I think it was Harry who spoke before about going to the lowest common denominator in training Aboriginal health workers—that we have now customised the national competencies for health workers in the Northern Territory. In other words, the national competencies were set, but AMSANT feels they were set too low. We have now customised them and brought them up again to the standard that we expect of health workers within the Northern Territory. Bear in mind that a lot of health workers in the Northern Territory have clinical skills far beyond what people understand health workers to have elsewhere in Australia.

So there are those first two points—one about the cooperation, the second about the competencies. Thirdly, the point about health workers in the community generally is that the Aboriginal community controlled health services have a policy of health worker first. That is, when a client comes into an Aboriginal medical service, the first person they see is an Aboriginal health worker. The reason I bring this up is that we do want to address, and we are still having some battles with the medical benefits scheme people so that we are allowed to bill under the Medicare provisions for that. A health worker often will see a family of people for an hour and a half and deal with a whole range of issues, refer one or two people to a doctor and so on, but the AMS can only bill for the visit to the doctor. In other words, there has been some primary health care work done on nutrition advice, there has been work done as basic treatment of kids' cuts and scratches and so on, but we cannot get recognition for that. That is the last point I wanted to make.

CHAIR—A very important thing. How about cultural? Can you touch on that?

Mr Gallacher—Culture—there are a couple of things. When you say cultural, you are talking about cultural considerations in terms of training health workers?

CHAIR—Yes, and also impediments to reasonable health outcomes, if, indeed, there are any. Culture can be a big subject.

Mr Gallacher—Yes, that is why I am asking for a bit of a definition about it. In terms of culture there are a number of points about health workers. Of course, one of the difficulties that the committee needs to be aware of and that we need to do a lot more work on is getting men to train to be health workers.

CHAIR—That is very valuable; that is excellent.

Mr Gallacher—That is really important. I have just been talking to a group of health workers at Danila Dilba training school over the last couple of days. They have got the biggest intake of men they have had for a while and they are really thrilled with that because obviously that is important in a cultural context. So the training of men is one thing.

The other quick point I would make about cultural consideration is more anecdotal than anything, but it just gives you an idea of what can happen for people. In a couple of THS clinics, because of the way things happen and because of an inability often to get replacement staff, some clinic staff had gone to do a training program in Darwin, which everyone encourages, but at the same time in Arnhem Land a large Aboriginal ceremony was occurring which saw the gathering together of about 600 or 700 people. Because the clinic staff who would have been available to help treat what was a substantial group of people in the one place were away, there was no health treatment available other than to fly in for emergencies and so on. The point we would make there is that one of the things you would hope with the further development of community control would be that a community would say, 'It is not appropriate for you to go on training at the moment because we have this big group of people we are expecting to gather here over the next two or three weeks and we will have to look at when it is more appropriate for you to go training.'

CHAIR—Thank you. Cheryl, would you like to touch on Aboriginal health workers and cultural issues?

Mrs Rae—I really want to support everything that Jamie said there about us trying to get a level playing field, because there is absolutely no point in us competing for a small pool of people. People should choose who they are going to work for for other reasons. I think we will get past that side of things. The other good reason for having agreement about standards is the reality that the skills required in one organisation are just the same as in another. So it is really important that when a person comes in as a level 3 health worker, on their third or fourth increment, everybody is quite clear that that is their skill level and that is respected, they are a professional, in the same way you respect any other professional.

The other important thing to say about that is that Aboriginal health workers are then registered to work in the Northern Territory, so they do have registration and they have to maintain an annual practising certificate. That is actually quite important when you come to that other point that Jamie made about the fact that on many occasions—hundreds of thousands of occasions each year—the health workers are actually doing the work of a doctor. And it is not necessarily because there is no doctor. Even if you have a doctor in a clinic it is still the health worker who is the best person to provide that initial care and initial assessment. In instances where there is no doctor there is no choice, but people can still get very good quality care from the health worker and then from being referred on to nurses.

One of the points we are always wanting to argue quite strongly in relation to the MBS benefits and things like that is that it really ought to be seen that those people do substitute for and do the work of, and they have access to a 24-hour telephone service to check and make sure that they have got everything right. They use that sort of thing frequently. Quite often a health worker might go and have a quick consult with the doctor and say, 'This is what I am seeing and this is my assessment,' and get the back-up and the assurance that things are okay. But, of course, as people get better and better at their job they do not even

need to do that as much. I think that is really vital and it is a big part of how the system works. It is also about the respect accorded to health workers for their professionalism and their ability to do those jobs. I think that is really vital.

The other important role that health workers have is as cultural brokers through their ability to inform other people on the health staff of what is actually going on in a particular case and to help the person or family group or whatever to understand the world of a particular illness and the things they are going to have to face up to and help them understand what is going on. The role is to try and bring the Aboriginal world and the health world together so that people are going to be able to make good choices for themselves and their families.

CHAIR—Do we have enough Aboriginal health workers?

Mrs Rae—No, we do not have enough Aboriginal health workers.

CHAIR—How short are we?

Mrs Rae—Over the whole Territory there are about 170 these days. At various stages over the last 20 years we have been up to closer to 300. I want to come back to this registration point. A lot of health workers moved out of the system at the point registration came in because there was the increase in competency requirement and also because the demands of overtime were taking them away from family life. I would like to think we were a lot less flexible then than we are now in the way we can work out more flexible working hours for staff. But a lot of people decided to give up. Going back to the community health education role, I think there are a lot of very competent people out there who will not meet the registration requirements but we have to find a role for them as health workers. We have to respect their ability, their training and the things they have done, and find a new role for them.

CHAIR—Like a prior learning type model, not necessarily with the competency and registration?

Mrs Rae—That is right—it may not be as a registered health worker that does the clinical work, but we can look at the community health education role.

CHAIR—I am going to have to stop you there because we are running out of time on this. Thank you.

Mr McMillan—I have a couple of cultural things that might be helpful. One of them goes to your report. At 3.41 in the report you talk about who does the choosing and what criteria; then at 3.46 you talk about an elitist choice process. I want to caution you against 3.46 because of your earlier comment at 3.41. The choosing process is important. Communities are not communities; communities are groups of clans. So Aboriginal clans, given the opportunity to send people for training as health workers, are then investing in their own people, rather than the system plucking out those that show promise. Again, that is not a 'just oppose' thing—if the system sees somebody that shows promise in an educational institution, there is no reason that the system cannot talk to the clan about the person and the

promise that person is showing, but the clan can then still be part of the process of sending that person for the training. That person is going to be far more readily acceptable to the community in that type of process.

Mr QUICK—Don't they currently do that with their football? They do not seem to have any problem when it comes to sport. Why should we have a difference between sporting ability and opportunities for health?

Mr McMillan—Because health is a matter of life and death. As an adjunct to what Cheryl said about people that have dropped out, one of the other reasons people have dropped out is because they have been charged with sorcery. They have been charged with sorcery because people have not accepted their role as health workers and have actually believed that they have been involved in the death of people. This is a cultural factor that we need to take into consideration. The acceptance of the health workers by their clans is vitally important to their ability to operate and to their mental health because they are already living with the pressure of trying to bridge two systems of education, two systems of law, two systems of understanding and that is an added pressure to them. There are many good people—

CHAIR—Can I just interrupt you, Trish wanted to jump in there.

Ms Jones—I just wanted to say, Stuart, that I support what you said in terms of the cultural role and the community endorsement of Aboriginal health workers by their communities. Often, particularly for certain communities, the Aboriginal health worker is also charged with other ceremonial activities. In other words, what I am saying is that because you are interested in being a health worker it does not mean that the community supports it, unless you have that special knowledge or that community role through family, or whatever it is.

CHAIR—So there is a bit more to picking the health worker than just a range of traditional European values?

Ms Jones—Yes, there are differences there.

Mr QUICK—Are we talking here specifically about remote indigenous people, or in 3.46 are we saying that, for kids in Redfern—

Ms Jones—The differences are there.

Mr QUICK—So we need a couple of different models.

Mr McMillan—Yes, your point is well taken.

Mr QUICK—So for kids in Redfern, we can say that we have provided family support, additional counselling and have talked to the family. These kids could go to Sydney Uni. and be another Dr Ngaire Brown.

Mr McMillan—Exactly. Your point is very well taken, and the point that I made is very well demonstrated throughout the world in indigenous populations that are non-English speaking, or which speak their mother tongue.

CHAIR—Did you want to make a comment about anything else?

Mr McMillan—There is a really brief illustration about the way people do things. We got involved in HIV education because the health workers said they could not do it because of the sensitivities involved. So they came to us and said, 'Will you please get involved in this, because we need you to be involved in it.' In running the education process, we asked the elders of the particular clans how they wanted it run. That is a standard community development practice. But it was very interesting because, for example, I went to a community to run the program with men, and a colleague went to run the program with women. I went to the elders and said, 'Who will I work with? Which Aboriginal person do you want me to work with?' In that particular community there was a male that I normally worked with, but they chose somebody else for that process.

The person they chose had health knowledge—he happened to be the environmental health worker and had done some training in the health area—and had also been through all levels of ceremony to the highest level. So even though he was a young person, he had shown respect for his own culture and law and had been right through, and he had some knowledge in the health arena as well. The elders thought, 'This is the best person to work with you in this because we know you're not going to get offside in terms of our law, or not following what we would like you to follow, but we also know that this guy is going to understand what we are talking about in this arena and be able to convey this information.'

Ms Dowden—A health worker was going to attend with me, and I am disappointed that they decided not to at the last minute, but it is an example of community life that there were lots of pressures on them to stay in the community. There were a few meetings happening and a few programs, so they did not come. But the health workers and I talked a lot about how we would be coming to this forum and that there would be an opportunity for health workers to have a voice.

We at Galiwinku have just gone through a period where we have had a doctor for two years. There have been doctors at Galiwinku three times before, with gaps in between. One of the things that the health workers shared recently was that they did feel disempowered by the presence of a doctor. That has been linked to Medicare, basically; for the doctor to make money, some of their money is provided through an incentive grant, but the rest of their salary is made up through Medicare. So that immediately means that, whereas the health workers are able to make full assessments of people, they stopped doing that because they understood that that piece of paper meant money. So they would see people and they would send people to the doctor more quickly.

There was also an expectation from the community that because the community had a doctor, he was the best person to give health knowledge. That, I think, goes across all stratas of our society as well—the doctor is often seen at the top and underneath come nurses, health workers, allied professionals. When bringing health workers to this forum to give their

views, it has to be noted that in some communities where there are doctors, they are feeling disempowered.

Culturally, as a non-indigenous person, when you go to work in an Aboriginal community in a remote area, it is important to note that it is another country. That is what a lot of people do not acknowledge when they go to work in Aboriginal health. They just think that they are going to work in Australia where there are Aboriginal people. But you go to work where there is a different language; you go to work where there is a different culture; and you go to work where there are different customs and a different climate. It is a different country. It is my personal view that if people's mind-set is to think that it is a different country, rather than that they are just going to work with Aboriginal Australia, you might get a really big shift in the way people think about cultural issues.

We have talked a little bit about how, if you go to work in a developing country, you get language development and you get a lot more emphasis put on those areas. If you go to work in Aboriginal Australia, you just get your orientation through THS or ARDS. There is no specific time put into language development. If I went to work as a nurse with OSB, CARE Australia or any of those places, they allocate a specific amount of time for language development. I think that is an important point.

CHAIR—That is excellent. We will have a couple of quick comments from Trish and from Dr Carroll.

Ms Jones—It is my view, after working with Territory Health Services over the last four or five years, that it is very clear that when you are employing indigenous people in delivering health services and you are employing them within a Western employment framework, it will create cultural tensions. A lot of those tensions, when we come to health workers at the operational level, come about because of differing expectations from the employer—for example, THS—and from the community as to what the health workers will do and what role they should have. There are also differing expectations from the health workers themselves about their perception of what their role is in the community. It creates a lot of conflict and a lot of tensions.

Amongst all of that, at the end of the day, the health worker is expected to be all things to all people. We experience a lot of burnouts from our more senior health workers. It is very difficult to pull them out from a community where, 24 hours a day, seven days a week, they are working in the community. Trauma, health or stress-related stuff, domestic violence or whatever, are part and parcel of the normal community dynamics. There is no switching off at the end of the day, at 4.30, for these people to take R&R. They are living in that community all the time.

I think this issue of cultural tension is very real. I am not sure what needs to be done in terms of how we immediately address it, but I think there needs to be some agreement or some sort of strategy developed between the Commonwealth and states and territories and Aboriginal community controlled sectors to look at ways of trying to reduce these cultural tensions, misunderstandings and stresses, to allow them to perform professionally and be given support.

CHAIR—Thank you very much.

Dr Carroll—What I would like to do is draw together the theme of educational training of health workers and cultural factors. First, I refer to something that Michelle said in talking about the situation in remote communities. One of the most instructive things said to me by an Aboriginal leader was, 'Don't call us tribes, call us nations.' Nations have their own languages. Some members of the committee have been involved in the land rights inquiry, and you will be aware that one of the major concerns of Aboriginal people in communities is to control the entry of outsiders on to their land. The nation model is a very good model.

I also want to pick up something that Cheryl commented about—bringing the Aboriginal world and the health world closer together. I would like to modify that just slightly. I think we need to recognise that there are two separate worlds, and the nation analogy endorses that, and that our objective should be to help people in each world to understand the other world better. We are not necessarily going to move Aboriginal people into the medical world nor are we going to move medicos into the Aboriginal world, but if each side understands the other we are much better off. I wish to relate that to—obviously as a linguist—the question of language and training and cultural factors.

As we present new information to people, that new information should always be related to present knowledge. Regrettably, in many education systems—certainly for Aboriginal people—it is presented in a vacuum because the student's language is not used. Stuart commented about recognising the community's cultural knowledge base, and that is part of the process.

Bill was very critical of Batchelor College. I commented at the time that Batchelor uses English as its language for instruction. The reality is that Batchelor probably does not have too many other options, but there is potential to modify that along the principle I am suggesting. By all means, let Batchelor have its lectures and primary teaching in English, but within a group of students they would have people that probably speak either the same language or related languages, so they could run a tutorial system which would allow a group of people to speak that language. Many Aboriginals are bilingual and trilingual, so you could have tutorial discussions which would get to the local level but allow them to interact with their own conceptual base and integrate the new information given with their current information.

Finally—this really opens a can of worms and it is probably in Bob Collins's report—there is the whole question of learning style. The white learning style that I have been through, and I have this little label, focused on training people in institutions. Somehow you learn the skill and transfer that knowledge into a different environment. Aboriginal learning style is to train people on the job while they are doing things. The question of transfer is not even considered, and that is one of the greatest difficulties that Aboriginal health workers face. They go to a college and they have to come back into the community and transfer their knowledge. I think even recognising that significant difference is a very important factor, but many trainers do not. Thank you for the opportunity to give evidence this morning.

CHAIR—Thank you. Kay, did you want to put anything on the record?

Mrs ELSON—Yes. I wanted to put a very quick statement on the record. Maisie Austin talked about alcohol like we did not witness it and we were not aware of it, and I just thought we should put it on the record that we have seen first-hand what alcohol is doing to our communities health wise and medically—through domestic violence and so forth. We have not really ignored the fact that it is a big issue out there in the community. We have also seen some good examples like Tennant Creek, where the health workers and medical teams were working, and there were some successful programs out there. So we have not totally ignored it. I just wanted to put that on the record.

CHAIR—Thanks, Kay. I also thank the witnesses for appearing before the committee today. We really appreciate it.

Proceedings suspended from 1.23 p.m. to 1.41 p.m.

AH CHEE, Ms Donna, Cooperative Research Centre for Aboriginal and Tropical Health

ANDERSON, Ms Pat, Cooperative Research Centre for Aboriginal and Tropical Health

ANDERSON, Professor Ian, Cooperative Research Centre for Aboriginal and Tropical Health

ASHBRIDGE, Dr David, Cooperative Research Centre for Aboriginal and Tropical Health

GOOD, Professor Michael, Cooperative Research Centre for Aboriginal and Tropical Health

HILL, Professor Gregory, Cooperative Research Centre for Aboriginal and Tropical Health

HUGHES, Mr Paul, Cooperative Research Centre for Aboriginal and Tropical Health

KEMP, Mr Dave, Cooperative Research Centre for Aboriginal and Tropical Health

LIDDLE, Mr John, Cooperative Research Centre for Aboriginal and Tropical Health

MATTHEWS, Ms Sally, Cooperative Research Centre for Aboriginal and Tropical Health

O'DONOGHUE, Dr Lowitja, Chairperson of Board, Cooperative Research Centre for Aboriginal and Tropical Health

TIPUNGWUTI, Mr Charles, Cooperative Research Centre for Aboriginal and Tropical Health

CHAIR—Firstly, I welcome the board members of the Cooperative Research Centre for Aboriginal and Tropical Health, with a special welcome to Dr Lowitja O'Donoghue. We are grateful that you could all attend today. As you all know, we are members of the parliamentary Standing Committee on Family and Community Affairs inquiring into indigenous health and that is a subject in which you would, and do have, an acute and continuing interest. To begin proceedings, I will ask Dr O'Donoghue to make a preliminary statement. We will then open up to an informal or formal discussion, as you would like.

Dr O'Donoghue—It is very good to see you, Barry. I am a former constituent of the electorate of Grey, but now I am in Chris Gallus's electorate.

Ms ELLIS—I think you were one of mine at one stage.

Dr O'Donoghue—Was I? Thank you for the opportunity for us to come here. You would be aware, if you have seen the annual report and the strategic plan, that we are only

two years into the Cooperative Research Centre for Aboriginal and Tropical Health. So it is early days for us and it is the first cooperative research centre of its kind.

In making some opening remarks, I want to say that the status of indigenous health is unacceptable—and I guess you have heard that over and over. It is so bad that the status of some sections of adult Aboriginal community health is as poor as almost anywhere in the world. But we must do more than state the problems. We must focus on the solutions.

We believe that collaboration and appropriate investment in health care are the keys to improving indigenous health. We strongly believe that undertaking the right research in the right way and making the best use of the research findings can make a difference. Research must focus on issues which are health and health service priorities. The knowledge gained must be linked to strategies for improving health care delivery and services to improve health outcomes. There must be a move from simply demonstrating problems towards understanding what works in practice. Knowledge and understanding gained through research must be effectively shared and given to those who can use it—that is, health services and indigenous people.

In summary, we feel the cooperative arrangements achieved through the CRC model offer an effective model for achieving the necessary collaborative outcomes focused research. Of course, we would be happy to discuss these or other research issues further with you.

CHAIR—I am looking at the distinguished titles in front of a number of people here. I know some of the people and their experience; we might just go around the table and introduce ourselves to each other. Bjarne Nordin is our secretary and Lowitja and I have introduced ourselves. Annette Ellis is the deputy chair. You might just tell us where you come from, your expertise or contribution particular to the board.

Dr O'Donoghue—I would like my board members to indicate whether they are a core partner or whether they are an independent council member. I am an independent chair so I do not represent any of the core partners of the CRC.

Ms ELLIS—I am the deputy chair of the committee and the member for Canberra in the ACT.

Prof. Anderson—I am a non-core member. I am a doctor. I work currently at the University of Melbourne in setting up an Aboriginal health services research program. I have worked in Aboriginal health policy at the Victorian Aboriginal Health Service prior to my current appointments in the Commonwealth department of health.

Ms Matthews—I am the deputy director of the Cooperative Research Centre for Aboriginal and Tropical Health. I have worked in the health sector in the Northern Territory for about 15 years now in capacity building areas and also in remote area services delivery.

Ms Anderson—I am the chief executive officer of Danila Dilba Medical Service, which is the AMS based here in Darwin. Although we are located here, most people who come into our clinic on any given day are from across the whole of the Top End. I am in my sixth year in that position. Darwin is my town; I am from here. Prior to that, I was a trade unionist and

I worked in the Aboriginal education area for about 20 years. I am a home grown local and glad of it.

Mr Liddle—I am from Alice Springs; I am the director of the Central Australian Aboriginal Congress. I think you may have met some of my staff yesterday in Alice Springs. I have spent the last 25 years working in Aboriginal health. I was lucky enough to see congress grow from a one-room shack to what it is now. But with that also came changes to the standard of Aboriginal health, both the delivery and the way the services are delivered. I have been very critical of Aboriginal health research over those many years. I was a former member of the Menzies School of Health. I stepped down because I could not cope with research projects being hijacked by researchers, basically. I was very reluctant to come with Pat onto the CRC because of the not-so-hidden agendas of some researchers and their colleagues. By being part of the CRC, we are hoping to control Aboriginal health research. We are very critical of researchers.

Ms Anderson—And we are core partners.

Mr Liddle—Yes, and we are core partners.

CHAIR—Thank you.

Mrs ELSON—I am the federal member for Forde in south-east Queensland.

Mr JENKINS—I am the member for Scullin, which is the outer suburbs of Melbourne.

Prof. Good—I am a director of the Cooperative Research Centre for Vaccine Technology in Brisbane. My interests are in developing vaccines, particularly vaccines for rheumatic fever, which is a major problem for Aboriginal health. Aboriginals have the highest rate of rheumatic heart disease in the world. I am also interested in developing vaccines for malaria. For the last two years I have represented the Menzies School of Health Research as a core partner in the CRC but I now assume a role as a non-core member of the CRC.

Mr Kemp—I am Dave Kemp. I am acting director of the Menzies at the moment. I am not sure if I am actually on the board or an observer at this point. I am a molecular biologist working on infectious diseases. Our group collaborates with Michael's group in Queensland. I am particularly interested in malaria. Also, we have started a program on the molecular biology of scabies, which is very relevant to Aboriginal health.

Mr Hughes—I am a professor of education at Flinders University. Flinders University is a core partner of the CRC. I am the representative from Flinders University on the board for that purpose. I am the director of the Ungarendi First Nation Centre for Higher Education and Research. All of my background over the last 30 years has been in the education field, in Aboriginal education most particularly. As the representative for Flinders, I cover the education side as well as being a contact and a link person into the health operations of Flinders University as a whole.

Prof. Hill—I am from the Northern Territory University. I am here representing the Pro Vice Chancellor for Research in Higher Education. NTU is a core partner in the CRC. Our main inputs are in the areas of education, general health sciences and the nursing profession, community services type areas. We also contribute to areas like biochemistry through Menzies.

Dr Ashbridge—I am presently the Assistant Secretary in Aboriginal Community Health Policy for Territory Health Services. I have a broad clinical background but specifically I have lived in the Territory for the last 12 years working clinically in remote areas and moved through public health and operational management. I am presently in a policy position. My interest is in taking the information and being able to apply it.

Mr SCHULTZ—I am the federal member for the rural seat of Hume, which covers the Southern Tablelands and the south- west slopes of New South Wales. I have had 32 years in the meat processing industry; some would say I am still in it.

Ms Ah Chee—I am the director of the Institute for Aboriginal Development, more commonly known as IAD. I am a non-core partner. I am heavily involved in one of the five programs of the CRC, the indigenous education and health program, looking at the question of the connection between education and health.

Mr Tipungwuti—I am from Tiwi. I am a full blood Aboriginal Tiwi person and I represent the Tiwi people. I am a board member too and for the CRC. I am also a Tiwi Land Council member and a member of the Tiwi Health Board. I am trying to help my people to prevent all this sickness. That is why I am on this board—to get more information on the issues.

Mr QUICK—I am the federal member for Franklin, the southernmost electorate in Australia.

CHAIR—With all this talent and knowledge, what does a humble backbench politician do with it? There are so many areas we could delve into but I would like to go to the executive officer and to Lowitja in terms of how you are drawing it together. How do you prioritise within the CRC the sorts of things you want to make your priorities? Can I lead off with that? Maybe it will give us a bit of a clue about the areas we should be looking at. We could wander all over the track—as you can at any meeting. We ran into John Liddle's point about research this morning. We touched on Aboriginal health workers and cultural issues. I wonder whether we could get a clue on the priority areas.

Prof. Anderson—It might be useful to put the work of the CRC in the context of how research in health worked more traditionally in Australia until more recently. In a sense, most research is what we call classically 'investigator driven'. We have a system that focuses on quality in research such as through the National Health and Medical Research Council. It is basically organised around disciplines. The CRC covers a number of those disciplines. Investigations are directed by the curiosity of the researcher and argued for on the basis of the quality of the research proposal. Whilst we would not want to dismiss what you would get out of investigator driven research, one of the problems with that is it tends to focus broadly on gaps in knowledge and filling those gaps in knowledge, but is not

necessarily about filling those gaps in knowledge which are most important to reforming health care policy and practice.

As a consequence of this, over the last 20 years Aboriginal health research has tended to be basically a descriptive research program that has well described the nature of the problem but has given us very few clues as to what works and what does not work. For example, in the 1970s there were nearly 40 independent research studies looking at and documenting the prevalence of otitis media and one study that looked at a strategy for effective intervention.

How, in principle, you manage your way into strategic or priority driven research programs is something which researchers across Australia are learning about at the moment. The approach we have taken is to think about the broad strengths that already exist within the research framework of the CRC, to identify some broad areas of focus and then link that in terms of broad areas of health focus, such as maternal and child health, infectious diseases, chronic illnesses—all of which are priority issues within the Aboriginal community—to a program that looks at the range of knowledge we need in order to make health outcomes in that area.

For example—and this is a program that the CRC is peripherally involved in but it is also a good illustration—in sexual health, there have been a number of advances in the last two years. For the first time, prevalence data of bacterial STDs is clearly declining in certain remote regions. One of the factors that has enabled that was, first, the existence of a comprehensive primary health care program and, secondly, the ability to develop a strategic research program that informed the nature of how that program was delivered. It looked at investigating screening strategies, but also was linked to a broader program that was investigating, for example, the use of new technologies in the diagnosis of STDs. So, in effect, the program around sexual health had a range of research projects that covered a range of different disciplines. But at a program level they were pointing in the direction of answering the sort of questions that were critical to getting an effective understanding of what constitutes effective quality primary health care service delivery.

Mr QUICK—The Docker River community—they know you exist. What sort of contact liaison is there between what you guys are doing and the needs and aspirations of Docker River, where you have one nurse 24 hours a day, not enough Aboriginal health workers and, linked into that, domestic violence, suicide and alcohol and substance abuse? We have the theory and the areas of health focus. What is the link back to the real world, and how does the link work?

Prof. Anderson—The link works in two ways. Firstly, there is the constitution of the board and who that brings together. This is the first board in Aboriginal health that essentially has an Aboriginal majority and has links with the research sector and the policy and practice sector. There are two issues there. One is to have as part of our program looking at strategies for effective communication coming in from communities about what is important and communication going out to communities about what are the research findings. Also critical is having core partners who are from Territory Health Services, from the Aboriginal health services, which provides a framework for understanding the issues that are critical to the implementation of research findings.

Mr QUICK—How responsive are THS when another part of their government removes bilingual education in the Northern Territory education system? You are developing health focuses. The reason I am asking this is that we have to write a report which hopefully will come up with a series of recommendations. If the government takes up those recommendations, we can move a quantum leap in sorting out indigenous health. That is the reason why I am asking these questions. You have a THS person here. What sort of clout do they have with the minister for education or the minister for transport to say—back to Docker River again—'The road's hopeless, the airport needs infrastructure development'? You might have all the answers, but if there are no bums on the seats out at Docker River, where is the benefit to the Docker River Aboriginal community?

Dr Ashbridge—I cannot keep quiet for too long, can I?

Mr QUICK—It is not an outrageous question, I am sorry.

Ms Anderson—It is.

Mr QUICK—No, it is not. We are here today, with all sincerity and honesty, to pick people's brains and to get some practical solutions. We have our discussion paper. It has taken two years of bloody hard work by most of this committee to come up with these strategies. It is either A, B, C, D or E. You are the experts. We are here to pick your brains for a couple of hours before we fly back to our electorates that we have not seen for a week. We want to clear all the rubbish and all the cobwebs away and have a frank—I do at least—discussion with you experts. We have been farting around—excuse my French—for 22 years on indigenous health. The time has come to stop. I want some answers from you people. We have put the other people around Australia under the hammer—state and Commonwealth departments, interagency development, strategic plans, memorandums of understanding and all the rest of the things. I would like some answers to some serious questions. If that is upsetting you, I am sorry.

Ms Anderson—You do not upset me. What I am saying is that we have AMSs here. There are three of us sitting around the table here. We have been delivering services to our communities for 30 years. Do not tell us because we are sitting on a CRC board that we are not concerned with service issues or delivery.

Mr QUICK—I am not saying you are not concerned.

Ms Anderson—The question was like we were in some kind of ivory tower here, so far removed from service delivery. That is not the case.

Mr QUICK—You are doing some fantastic work, but I want to see the linkages back.

Ms Anderson—That is what I described as outrageous—to assume that members of the CRC board are so far removed from service delivery that they cannot empathise or identify with your Docker River example.

Mr QUICK—I never said you could not empathise. I want to know the links, so that when we go out to Docker River and talk to the sister out there we can say that all these wonderful things are happening.

CHAIR—Territory Health Services was endeavouring to say a couple of words about the issues Harry raised—infrastructure issues and decision making processes.

Dr Ashbridge—The links with education are clear. Improved health and improved education are picked up by the CRC. I will not comment on the bilingual program. I do not think it is in my brief to do that.

Mr QUICK—Is it a hindrance?

Dr Ashbridge—The point would be that improved education is associated with improved health outcomes. I am not in a position to judge whether bilingual programs work or do not work. That is not my area of expertise. I cannot comment on that.

Mr QUICK—Can Mr Hughes?

Mr Hughes—I am not a supporter of bilingual education. I think there is a great problem with what the Northern Territory Education Department has done. It is a matter of how you preserve one language on the one hand and allow for the development of English language on the other, as a short reply.

Dr Ashbridge—We, Territory Health Services, would openly acknowledge that the resourcing of service delivery in remote areas is difficult and is under-resourced. The rationale for that under-resourcing, we would argue—I did not come here to talk about this, but I think it would be shown to be correct—is that the amount of resources which the Northern Territory government, through Territory Health Services, puts into primary health care expenditure is significantly more than the allocation through the Commonwealth Grants Commission. The process of service delivery throughout Australia in the primary care sector is usually funded directly through Commonwealth sources—Medicare, MBS and PBS. Those sources are not available within the Northern Territory and the remote areas to any great extent. The service provision falls back on the local jurisdiction. When you take that into account the figure for the Territory, relative to other states in terms of state expenditure, is substantially higher than anywhere else in Australia.

CHAIR—We had a figure of about $40 million this morning.

Dr Ashbridge—There is $40 million to $50 million in terms of MBS and PBS. We acknowledge that those areas are under-resourced, but our effort, I do not believe, is under question.

CHAIR—No. The interesting thing is that the MBS delivery is doctor based delivery. Because we cannot attract doctors to regional and remote areas we do not draw on the service in the same way that a few suburbs in Sydney do, at the rate I heard on Monday, and in Western Australia, of over $900 per individual per annum. They are the sort of practical things that impact, I guess.

Dr Ashbridge—Certainly, our view is that the model of service delivery is not one which is duplicated from the western suburbs of Sydney or anywhere else in Australia. What needs to happen is different strategies for a different work force. That is part of the rationale for why we need to do things differently, not only because the health problems and the work force are different, but because of the location and the types of resourcing. So some of the research issues which need to be addressed are not direct implementation of findings elsewhere but health services research about how to apply that knowledge in a context which is different from the rest of Australia. So the resourcing issue is not one of duplication. The level of resources needs to be applied in a way which is relevant to the circumstances. You will never get doctors to live in a population of 200.

CHAIR—Like the Tiwi Island coordinated care trials and those sorts of things. We have got off to a lively start.

Ms Anderson—I remind the committee that the AMSs have a large network across the nation through our peak body here in the Northern Territory, which you spoke to earlier today, the Aboriginal Medical Services Alliance NT, which congress and Danila Dilba formed in the Northern Territory. Part of the reason was so we could act collectively to change the national agenda, which we did.

We also feed into the national body, the National Aboriginal Community Controlled Health Organisation, which has 100 medical services across the country. So the Aboriginal population has covered the nation fairly well in terms of service delivery.

Some of the issues that you raised in your discussion paper are correct in terms of the fact that there are certainly not enough health dollars going into Aboriginal health. We need to access MBS and PBS better because these desperate times need new, exciting and innovative ways of funding and what-have-you. You have alluded to that in section D, one of the parts which we are also very interested in.

CHAIR—Or even E.

Ms Anderson—I particularly like D, and we are doing some work on that. So there is a whole network and a whole wealth of experience and expertise within the Aboriginal community who can talk very eloquently and very elegantly about Aboriginal health. The fact is it is just not resourced, and we can do better than we are doing through some cooperative and collaborative arrangements, which is epitomised by all of these people coming together as a CRC board.

Ms ELLIS—I wanted to ask a fairly general question, but I will open it up to Lowitja or whomever else may be placed to answer it. Before you came in, I quickly scanned through the document we got which talks about the CRC. Given that we are almost at the end of our process, we have been exposed to very long and very detailed lists and discussions about all of the major health problems affecting the indigenous community. In saying that, I want you to know that we understand that that means broader than just literal health problems, that there are a lot of other associated things that come with it—education and so on. Tell me how the CRC operates. Do you have a list of priorities in terms of areas to which you would like to see research directed, and/or do you have people come to you and put up ideas for

research that you then approve of or disapprove of and take on accordingly? Can you give us any examples of the sorts of research that may have already been undertaken in whatever way you operate? It is a very general question, but I do not know a lot about the CRC.

Dr O'Donoghue—I might get Ian to answer that as he has the strategic plan. We have actually made the strategic plan available.

Prof. Anderson—In answer to your question, we do both. The CRC is just concluding its second year of operation. Our priorities in the first 12 months were to operationalise the CRC and actually develop a cohesive board and an executive structure. That was an unusual circumstance because this is the first time where you have essentially, but not entirely, an all Aboriginal board actually giving direction to an essentially, but not entirely, non-Aboriginal research organisation.

The priority health conditions that we have focused on—and this part grew out of the existing capacity within the CRC research structure—include social and emotional wellbeing, issues of substance abuse, stress and youth suicide. I focus on infectious diseases, such as respiratory disease, scabies and other skin diseases, such as otitis media. I focus on chronic diseases—particularly on the development of an integrated approach to chronic disease prevention and management—and I focus on maternal and child health. Those broad research focuses just point you in the direction of the sort of research activity that you are going to do, but it does not give you many clues as to what type of research action you are looking for.

In addition, we have a focus on research that works to build individual and community capacity, particularly research around control and responsibility for decisions, education and learning, and the effective use of information, such as information coming out of research findings. There are research activities that focus on improving health care, such as self-care, primary health care models and new models of care delivery. Also, there is research that has worked at discovering new health knowledge, such as in the biomedical and population health and social sciences health, but again, it is within a strategic framework that is looking to link research activity with the development of health outcomes.

Within that framework, in terms of our management structure, we are developing broad areas of focus, commissioning research and asking our executive to go away and look, for example, at research around renal disease and develop an integrated research agenda. We are also considering proposals that are coming to us from researchers and core partners. It is a combination of the two but it is essentially all within a strategic framework.

Ms ELLIS—I do not want this to be seen as a provocative question. It probably is, but I do not wish it to be. What is the budget? How are you funded? Is it just Commonwealth funds? Where does it come from? I just want to grasp how you operate, basically.

Prof. Good—All CRCs get a Commonwealth grant of about $2 million per year, plus or minus a few hundred thousand dollars. This CRC gets a grant which is similar to that. That grant has to be matched—at least double—by in-kind contributions from the core parties. I have not got the exact figure but the overall operating budget of a CRC would be between $5 and $6 million per annum.

Ms ELLIS—That is to operate as an entity and to commission research as well?

Prof. Good—That is exactly right.

Ms Matthews—It is a seven-year funding period.

CHAIR—So that figure relates to a seven-year period?

Prof. Hill—Per year.

Prof. Good—The strength of it—the point has been made which is worth reiterating—is that it is a cooperative research centre. It is a lot of money, but it is bringing together expertise in different organisations to tackle, in a strategic manner, the very important health issues.

Prof. Anderson—That investment is also buying institutional support. The fact is that Territory Health Services actually has to make an investment in the CRC in dollar terms. The idea is that that buys the kind of leverage within THS to take the findings of the research that it jointly is commissioning with the other core partners and members of the CRC.

Ms ELLIS—At the end of a research project, to whom is your particular project fed? How do you then use it? Is it through governments at federal, state and territory levels? I am sorry to sound so naive but I really want to get a good understanding.

Prof. Good—There would be many ways in which successful research outcomes are taken up. They could be taken up by other sections of the community, by people overseas, for example, depending on what is discovered, but more particularly by Aboriginal groups within Australia. Successful outcomes would be taken up. For example, a research outcome might be the development of a new vaccine. We have just been approached by Smith Klein Beecham to test a very exciting pneumococcal vaccine because that is a major cause of ill-health amongst Aboriginal kids throughout Australia. If that research project is successful, we will have demonstrated that this vaccine is effective and that vaccine could then be licensed throughout the country. So that is how it is taken up. That is one example.

Ms ELLIS—This is my last question: I know that the centre is only just two years old, but how many research projects have you managed to complete? Have you managed to complete any in that time, because it is not a long time?

Dr O'Donoghue—Yes, we have, but I do not have the figures with me. We have completed some. We have about 20 in the pipeline.

Ms ELLIS—So it is well and truly up and running.

Dr O'Donoghue—Our business manager recited it all to us yesterday, but I do not have the figures with me. It is not a bad record.

Prof. Anderson—One of the areas that the CRC is actually developing a focus around is better understanding the link between research, policy reform and practice reform. We are probably at the cutting edge of that in Australia. This is not generally well understood. Most researchers traditionally think that you publish in a peer review journal and then somehow, by osmosis or by some mystical process, those research findings are taken up by policy people. We do not accept that. We cannot give you all the answers at this stage, but one of our focuses is to better understand the relationship between research and policy.

CHAIR—No doubt there is a significant aspect of, 'How do we apply it?'

Prof. Anderson—One of the very good and fairly concrete illustrations might be some of the work around scabies, if we could talk about that.

Mr Kemp—For example, this is one program which has reached an end point within the last couple of years. We took up the question of whether scabies mites on children and dogs are the same mites. This is a vexed question. Many people have gone around communities giving out Ivomectin soaked dog biscuits over the years, but there was never any evidence of whether it was doing any good. We have used modern genetic fingerprinting techniques—exactly the same techniques that were used on Monica Lewinsky's dress. I say that so that you understand the power of these techniques.

Ms ELLIS—We are very impressed!

Mr Kemp—We have been able to show that the mites on the kids are completely different from the ones on the dogs, so all of that has been a complete—

Ms ELLIS—The mites are different?

Mr Kemp—The mites are different. Mites on human beings in the Territory are much more similar to mites on human beings in Panama than they are to the mites on dogs in the same house.

Dr Ashbridge—The things that we do not talk about, I guess, are the things which you do not proceed with. In the past they may have gone up as research projects and they may have come to a conclusion; they may have got into a peer group journal. The bureaucracy or the health service provider would have said, 'We can't do that. This is too expensive. It is too hard to implement.' Those decisions are actually made around the time that the research proposal is going ahead. For instance, one of the contributions that a service provider might bring was, 'Well, it's not a bad idea but we can't deliver that. It's too expensive or it's not a priority for us.' So it ends up not being supported by the service provider. In that sense it is not only managing the positive, it is also managing the research agenda more broadly than that and linking it to the capacity of the service providers.

CHAIR—John Liddle, I am particularly interested in your wariness. I think it is a very important part because essentially we are practical people—I, for one, do not have a university education—who try to deal with practical issues. There are various levels of skill within our parliamentary committee.

Mr Liddle—The same as our board.

CHAIR—Yes. I guess I am asking you to explain that wariness and how you came to your decision, basically.

Mr Liddle—I suppose my personal wariness of researchers has been as a result of a research project that was undertaken on my family group back in the late fifties, early sixties. At the time the researcher came in to the community where we were living and befriended us. At the time he was a very nice man. He wanted to help people. But we did not realise what he was doing at the time. He basically documented a lot of secret, sacred material, published it in a book that is somewhere over in West Germany now. The book is in most of the libraries around Australia, but a lot of the information that he was trustingly given has been misused.

At that time Aboriginal people were not used to dealing with researchers. People were just escaping from being herded in to places like Docker River. I am talking about the south-west of the Territory. The assimilation policy was on its way at that time. It was in its hey-day. Aboriginal people did not have any rights to speak of. There was always someone deciding what was best.

I look back at that book every now and again when I am feeling happy in order to make myself depressed. That gives me a new lease of life to go on and fight for the good of Aboriginal people. But that is not to say that I do not appreciate and respect the commitment that researchers and institutions like the Menzies School of Health have put in to the Aboriginal health debate over the years. They have achieved a lot of good. But what we are trying to do, what I am trying to do, is to get health research focused and make it useful research, which are the words that I usually use. I consider that a lot of research has been airy-fairy type research and it is basically for the individual researcher and sometimes it is of little or no use to communities.

CHAIR—That is why David's point about it being assessed early is so important.

Mr Liddle—Yes. It has taken a long time for us to get to this stage. When Pat and my organisations were approached by John Matthews, who was the director of Menzies School of Health a few years back, we said, 'No, stick it up your jumper,' because we just did not want to get into bed with our enemies, basically. So we have turned a pretty big circle to befriend our enemies, basically. We are working with them and we want to be part of the system. We do not want to be subjects anymore. We want to control the system.

CHAIR—Yes, very much equal partners.

Mr Liddle—Yes, and that is why we insisted on being core partners, of course.

CHAIR—Okay, that is great. Thank you.

Mr JENKINS—I am pleased that that question has been asked and answered because I think it sets the scene in trying to understand what the CRC is trying to achieve in connecting with those for whom they are really doing things.

I have only had a chance to quickly look through the documents. The three pages had a whole lot of dot points that had arrows to things that over the last couple of days, let alone the last couple of years, the committee has been looking at—for instance, more appropriate means of Aboriginal community control in accordance with the principles of the Alma-Ata declaration. We have been trying to come to grips with building community capacity for that.

Perhaps it is because I have a science degree that I am thinking of the CRC as a scientific sort of model, but I am not quite understanding how it is going to achieve that holistic approach with the breadth of the institutions you have brought together, the community agencies themselves, so you have an end result of your research that is going to have an effect on training people as well. Is that the understanding that I can get of what the CRC will do? The research itself is not the end point. You are not a service provider so you do not implement it, but do you have an involvement in trying to implement things?

Prof. Hill—The CRC concept has evolved over the last five or so years. We talk about expecting CRCs to have a seven-year lifespan, but we are reviewed every couple of years and if you do not measure up they take the money away. The way CRCs are reviewed relies very heavily on what sort of a report card the stakeholders give. So CRCs have to do research, but they also have to communicate research results. They also have to train new researchers, they have to have education programs. So it has gone right away from the straight science model where you must have the extension of results as well. CRCs must have very good relationships with stakeholder groups and they are called partners because, if any of those groups start saying bad things about you and review time comes along, you are not going to continue. By their very nature and the definition of the way they are judged, it has to be a collaborative exercise. You really cannot have researchers locked up in the wet labs doing their work without any contact with the real world. It just does not happen in CRCs—or not the ones that continue, anyhow.

There are about 60 CRCs in Australia now, and I suppose every time reviews are done a number of them are turfed out because they are not meeting those criteria. But I think with this particular CRC it has a real challenge because the stakeholders are a pretty tough mob, as you can see, and we have to work very closely with our clients if the thing is going to succeed.

Mr Hughes—In addition to that, in terms of the Northern Territory University and Flinders University, research also should inform practice and teaching. So one of the outcomes from a Flinders University point of view is that the research that this CRC does should inform the actions of the Flinders Medical Centre and the teaching operations inside the Faculty of Health Sciences and so on, both in terms of clinical practice at the hospital level and also in terms of the teaching that might be applied for doctors or nurses or health workers and so on. What we learn out of this ought to be turned into better teaching and clinical practices as well.

Mr JENKINS—And perhaps, too, the health services, and especially the community controlled ones. Are you starting to see this as an opportunity for you to come up with the ideas that you would put forward for the other partners in the venture to research? You are not only getting over the hurdle of this great blob of mistrust or, as we were told today with

the Tiwis, just being researched and researched, but are you now seeing that you have some form of control as well to come up with the ideas or to pose the questions and see if researchers will take them up?

Mr Liddle—I suppose, to be brutal, when the AMSs want to do research, the research is not really as credible as it could be without the name of an institution behind it. My organisation has been in existence for nearly 30 years—27 or 28 years. We have done a number of major research projects into renal disease, mental illness and others, women's health, just to name a few. But it would have been great if we had some research institution supporting us. It would be better for me to bring that along to a hearing like this and say, 'Look, we are in conjunction with this research institution that has credibility.' That is basically the reason why we have become partners and we are trying to control the types of research. It has to be useful research—not to get the research done so that it gets thrown into a dusty corner somewhere and forgotten about. We want something that we can actually use.

Prof. Anderson—I think the CRC would be a waste of time if the core partners could not actually shape the priorities. They are the ones that are going to have the best knowledge of what gaps in knowledge are absolutely critical for their service delivery or their policy development.

Just reflecting on how the CRC is different from other research activity I have been involved in, I was CEO of the Victorian Aboriginal Health Service for some time. That is a fairly large Aboriginal community controlled organisation in Melbourne, and we had developed a research program as part of our service delivery. We were addressing issues that we felt were really critical for us to move ahead or to address emerging concerns. We had, for example, research work around injecting drug use. We also were developing research looking at emerging issues for Aboriginal youth.

The problem that we encountered was that, in order to produce research that was credible, we had in a sense some institutional isolation from the centres of excellence in research activity so that in terms of research project support our program was somewhat weaker. But what that process did, and I am sure this is similar in Central Australia, was that it enabled and convinced people who had had a very recent history of quite exploitative research practice to understand that research that focuses on priorities that are important to service delivery and framed within a way that is going to produce results that can be implemented realistically in a sustainable way can actually make a difference. I think it is the next step to actually then look at how those collaborations could be further strengthened to a structure such as a CRC.

CHAIR—Could I make a suggestion? We have about 30 minutes available to us as I understand we want to finish at about 3 o'clock. A number of people want to ask questions and I am not meaning to intrude, but we are going to run out of time. The otitis media example is an excellent example. What was it—40 projects? One is actually on the 'how', amongst a lot of other things. Is it possible to pursue two or three examples—and we have already had one or two. I do not know where we were at with otitis media. Is it possible to follow through with practical examples at some point? I am notorious for not having enough time, but I will go to Pat, to Alby, to Kay Elson and to Jill Hall.

Ms Anderson—Michael Good wants to give an example. I have one example as well of the major projects of the CRC, and so does Michael. I will give you that one, if you like. It is an interesting one in that it is a major project in terms of money, outlay, from the CRC. The government a little while ago set up around the country about 11 emotional and social wellbeing centres. There are two in the Northern Territory operating at four sites: Danila Dilba and Wurli Wurlinjang in Katherine and congress and NPY Women's Council in Alice Springs. We work in conjunction with the two sites.

I think at the same time that we received that money, congress and Danila Dilba got together because we wanted to put up a research proposal to the CRC so we could do participatory action research over the first three years of our two regional centres here in the Northern Territory. The purpose for that is that we in the Northern Territory are actually doing service delivery. The other regional centres are actually writing curriculum. We did not want to do that. We wanted to do service delivery with some training component. What we have decided to do at three of the sites is take a whole range of expressive arts, therapies, if you like—and that was a very subjective decision—and look at them, and a whole range of different modalities and therapies and techniques, put them together with the Aboriginal world view, if you like, and look at the situation that we are in today psychologically and emotionally as a result of the impact of colonisation and the stolen generations and all of that, so that we can get out of it therapies which we believe at this point will be different. We will modify and adapt—things like sand play, moving pictures, all that range of expressive arts. I lost my train of thought there for a bit. We believe they will be a different modality or therapy.

There are no indigenous groups in the world doing this. That is why it is an important piece of research to do with the support of the CRC, to actually examine the interface with these mainstream and probably very middle class therapies. We do not go to one-to-one counselling. We are doing it within a community development framework, so it is not just an ordinary one-to-one service. We will be dealing with it in a community framework so that this impacts upon as many people as possible. So the research project is examining that interface between those therapies, if you like, as it meets us and what we do with it and what we turn it into and how it works.

We are looking at why we made that decision to take that particular modality or therapy, how it worked, why it worked and why it did not and so on, so that we can say at the end of three years, 'This is who we are and this is what we tried and this is what worked and what did not work and we offer it to you.' That is to the indigenous community not only nationally, but internationally because there are no indigenous people in the world looking at their emotional and social wellbeing needs in the same way that we are attempting to do as a result of the CRC project. The other aspect of this is that we have to market this to our community. So it is a fairly important project for us.

Ms HALL—Have you got a control group as well?

Ms Anderson—No. The two researchers are actually spending different times at each of the different sites and recording what is in all. One aspect I forgot about, with the NPY in particular—although all of us had made allowances for this—is that there were going to be traditional healers. I can't pronounce it.

Prof. Anderson—Ngukurries.

Ms Anderson—There will be the ngukurries in the centre. All of us have made provision so there is that component. What we are trying to do now is to look after, in a holistic way, mind, body and spirit so people can claim back who they are. The CRC is recording all of this.

Prof. Good—Just briefly, I would like to mention two diseases which are of epidemic status in the Northern Territory or amongst the Australian Aboriginal populations. They are rheumatic heart disease and renal disease. Both these conditions are caused by a whole multitude of factors, socioeconomic in particular. From an infectious ideology point of view, there is one germ which is very much responsible for both glomerulonephritis and rheumatic heart disease, that is, streptococcus pyogenes. I would like to mention a research project briefly here that really started with scientists at the Menzies School of Health Research in the CRC and also in collaboration with the Queensland Institute of Medical Research. The scientists here, Dr Sriprakash and colleagues and David and colleagues, have developed ways of typing the organisms with the techniques that he described before. They have been able to identify local isolates of the germ. That is very important because it has given us strategies to develop vaccines against that particular microbe by stitching together basically the sequences that are unique to each of the organisms that are found predominantly in the Northern Territory.

Through a long collaborative project, we have got to the stage now where we have developed a vaccine which is effective in laboratory animals and which will be going into clinical trials—probably in South Australia initially—next year, phase 1. If they are successful, we would be looking at, maybe for the CRC for Aboriginal health, subsequent clinical trials up here.

I have only mentioned the biomedical research aspects but a very important part of this is education. Geoffrey Angeles at the Menzies school, in collaboration with his colleagues here in Aboriginal communities, has developed books describing in picture format and some words what these conditions are caused by. One of the problems is people just do not know what gives rise to or what causes rheumatic heart disease because it is a major cause of death worldwide and in Australia. Aborigines have the highest death rate in the world from this disease. It is a very serious condition indeed. If people can be educated about factors contributing to it—overcrowding, the need for penicillin for a sore throat and the need for regular penicillin prophylaxis for many years—the incidence of the disease will decline. But, of course, if we can develop a vaccine, that will contribute also. I would also like to stress that the major cause of this disease is the socioeconomic problem, overcrowding and poverty, really.

Mr Kemp—Could I just add something to that? The scabies program is also part of that. Scabies mites burrow through the skin and they provide the sites in which the strep infections actually get in. All of this work that Michael has been talking about and the work I have been talking about is part of the same program in a sense.

CHAIR—Ischaemic heart disease, too. We had somebody suggest to us on Monday that that was one that was there and not as much to the fore as rheumatic heart disease.

Mr Kemp—To be honest, ischaemic heart disease is much more common than rheumatic heart disease.

CHAIR—That is right. That is what he was saying. You would say that ischaemic is recognised as the one much more important.

Prof. Good—The thing about rheumatic heart disease is that it is not found in non-Aboriginal Australians. It is a disease in this country that is only amongst indigenous populations. It is found around the world in developing countries. It is a disease of poverty and overcrowding, whereas ischaemic heart disease is found across the country.

CHAIR—Just to focus, Professor Neil Thomson was surprised. You may be aware of his work with information technology, the clearing house. It is incredible what you can do with a laptop—punching in and all the rest of it. You can just gather the stuff like a vacuum cleaner from all over the place. Can I just leave that and, if I have got time, I will come back to it. I need to go to Alby.

Mr SCHULTZ—Do not worry about me because Annette and Harry covered my two questions.

Mrs ELSON—My question is probably a more practical one. Originally, I was going to ask about your research into medical and social issues, but I think we have covered both of those. I am trying to get the bigger picture because I did not know about your organisations until I got here today. I am trying to picture what the board is. Is it a body of people that we see here today? Is it a paid position or an honorary position? Do you pay researchers to do your work for you? Is that the make-up of the board?

Dr O'Donoghue—It is honorary.

Mrs ELSON—You are a board that looks at the issues of research and which ones are going to be looked at. Is that right?

Dr O'Donoghue—Yes, we would have submissions to us at every meeting. It has been quite a difficult CRC to actually get in place. As people who have been talking today would say, I do not think there has ever been a time when any of us would have sat around a table as equal partners—and a lot of us are fairly senior people in terms of where we have been and what we have done and so on—but this is the first time that we have ever had an opportunity to sit around a table as equal partners to actually talk about research. We do not want to do research for research sake, and we make that quite clear. Every time a submission comes to us, we want to know whether there is a body of research that has already been done in relation to it. If there is, we want to know where it is, what has happened to it and why it has not been used to improve the health service of Aboriginal people.

We do not want to support research anymore for people to get their degrees or for people to get kudos. We want research to be done that will make a difference out in the community, and we want the stakeholders to know why research is being done. At the end of the day, it is the community that needs to make whatever lifestyle changes need to be made if that is what needs to happen. At the end of the day, it is the Aboriginal people on the ground who

really need to know what the research is about and what they need to do to improve their health and so on.

We have been wrestling with this matter of trust, and I think it was a matter of only a few months ago that we eventually decided that we had to have a retreat with our project managers, with our staff, with us—the board—and so on to sit around the table and be quite frank and open with each other about how we are going to operate. It has been difficult, but we have had that. I think we were more open. We felt that the Aboriginal side of things at the retreat was much more open and people were prepared to put issues out on the table.

Basically, researchers are not prepared to be open with us. We have told Michael only in the last day or so how much we appreciate his contribution to our board. He is the first non-Aboriginal person most of us are aware of who, although he has not realised it, but unconsciously, has been able to challenge us about our position and those sorts of things, and it has been really great to be able to have that.

So we are a board that has quite separately come to terms with where we are all coming from—that we in fact want to see a change in the health of our people, and we are keen to do it. I think this meeting or the last meeting is when it culminated in our thinking that we really are a group of people who can work together and challenge each other about things, and it has come together in a really good way. But it has not been easy.

We challenge our project officers about submissions that come before us, and if we do not have as many projects completed it is because we have not approved many of the projects that have come before us. We want them to go back and prepare and deal with it.

We are not prepared to accept a submission that comes to us without them having canvassed all the issues and so on. I think project officers and researchers have found that difficult. But we are serious about this first CRC and we are here to make a difference. There will be some initiated research, and there will be other research that will come to us, of course, from project people. They will not all come from communities, though; some will come through AMSs and so on. It is early days for us, but I think we are really quite excited about the fact that we can make a difference together. We have never had this collaboration before with the institutions.

Mrs ELSON—Thank you. I congratulate you and hope everything turns out to be what you envisage. Can I just ask one other very quick question. We have heard a lot of evidence about deafness with Aboriginal young people, and one lady this morning from the Deafness Association said up to 90 per cent of young people under the age of one have a hearing problem. Is there any research being done on that at the moment?

Prof. Good—It is due to otitis media. Most of the eardrums are perforated in the first couple of months of life, and the organisms which are responsible for that have been documented—mostly pneumococcal and haeamophilus influenzae. One initiative, for example, will be this vaccine trial, if we take it up, which will be aimed at reducing the incidence of that particular disease.

Mrs ELSON—Thank you.

Ms HALL—Firstly, I have looked at this document and some of my questions dealt with that, but I would like it if you could just draw it out a little bit more for me. I see here the types of projects that are approved. Firstly, do you, as a committee, have set criteria for approving projects? Secondly, there are the ethical issues. I was interested in that, particularly when I heard what John had to say. Do you have your own ethics committee, where you look at all those ethical issues? Thirdly, you have talked about some of the projects. Could you give an example of how the projects are being completed. I suppose, to some degree, the one that you are talking about—rheumatic heart disease—is one where, once the research has been done, it has been handed over to the community and actually implemented. That is nearly there, but maybe you have an example of something that is actually a, b, c?

Prof. Anderson—In terms of criteria, there is a process which we have been working on around the development of research proposals. That process basically, as we have indicated, can come up in an investigative driven proposal from a researcher or come down from the board when we commission research around a broad strategic priority. The criteria therefore are embedded in the process. In essence, it has to be of high academic quality; it has to be a feasible research project; it has to fit within our strategic framework or our set of strategic priorities which we have determined, and I described those before; and it should be leading broadly to the development of solutions that are feasible, sustainable, implementable. In terms of the ethics issue, it is actually a principle of research that the boards who are involved in commissioning research do not actually make the ethical assessment.

Ms HALL—Do you have those set?

Prof. Anderson—The ethical process in this case goes through the Joint Institutional Ethics Committee at Darwin hospital, which has a specific and a developed Aboriginal focus. It is more difficult to describe an example because of the fact that the CRC has been running for two years.

Ms HALL—It is not very long, I understand.

Prof. Anderson—Within research time frames, it usually takes about 18 months to conduct a research project. I might come back to the other example—because this is the model which has shaped our thinking—that I alluded to earlier, which is the STD rates. We know that Aboriginal people have high levels of bacterial STDs, and this is a very significant problem. We know from our research evidence that this is largely, not entirely, a problem of service delivery. There has been an integrated research program developed here in the Northern Territory that looks at a whole range of issues around improving the quality of service delivery around STDs. In essence, in order to have a good sexual health program, you need to have effective education, you need to have a mechanism for community control, you need to have good quality clinical services and you need to have an appropriate and effective screening program. All of those elements need to be integrated.

In the case of this program, I guess it is not a question of saying that the findings were handed over. In actual fact, the service deliverers and the communities themselves were involved in receiving research questions, because they were the issues that they thought needed investigation. So they were involved in the process of setting the research questions,

they were involved in developing and implementing the research and, thereby, the implementation and feedback group was almost seamless. I can only informally quote this information, but over the last two years, we have seen a 40 per cent and 20 per cent decline in bacterial STD rates. This is unheard of in Aboriginal Australia. It is one of the first times where I have actually seen an example of research being implemented within the context of a community controlled organisation and that organisation being intimately involved in the development of that research agenda.

CHAIR—Thank you.

Dr O'Donoghue—There are ethics committees though, aren't there? It is not just Darwin hospital.

Ms Anderson—Part of the joint ethics committee is an Aboriginal ethics subcommittee, and they have the power to actually veto. They sit first before the joint ethics committee, and the chairperson of the subcommittee then presents to the joint ethics committee the findings on those research proposals that are put to the joint committee. That chairperson then sits and makes up part of the joint committee. The Aboriginal ethics committee has the power to veto as well. So if that subcommittee says no, that is it. In fact, the joint ethics committee does not even discuss it.

Ms HALL—So it takes into account much more than just the medical issues that the mainstream ethics committee will look at?

Ms Anderson—Absolutely.

Ms HALL—That is great.

Ms Anderson—It looks at it in its widest application, not just the science.

CHAIR—I have a question on NHMRC and their connection. What is the relationship?

Mr Kemp—A lot of the projects that Michael and I, in particular, work on are NHMRC funded projects. So that is brought into the CRC as in-kind contributions. The actual money from the Commonwealth cannot go in, but the money from others can. For example, my salary is paid by the Northern Territory government and is therefore an in-kind contribution, because I am putting that effort into all of those research projects.

CHAIR—So it is clear and transparent.

Prof. Anderson—The other connection is at the level of policy. Until recently I was a member of the Strategic Research Development Committee of the NHMRC, which was heavily involved in developing an approach to priority driven research. It is informed of what we have done here at the CRC, but it is also informed through my link.

CHAIR—Thank you. I wanted to raise capacity building, as the phrase has developed. For us, a key issue is—and here we are getting away from your core function—as Harry Jenkins would say, 'We can talk the talk, but can we walk the talk of Aboriginal control,

Aboriginal ownership?' There is an issue of capacity building—all those old cliches of paternalism and all those things. In terms of capacity building, could anyone help me in terms of where you think it is at? Do you want to have a go at that?

Mr Hughes—I will say a little about it. As part of an educational function—which is not just a matter of the education of being at school or things like that but education across the board in terms of school kids, adults and whatever—there is no doubt that, amongst our communities, we need to build our capacity to understand more about the things that need to be done within the communities on the ground and for which people need to take personal responsibility. For people to be able to take personal responsibility, there needs to be available to them better schooling facilities, better learning facilities, better vocational facilities, better adult education facilities and all those sorts of things. As I come from outside the Northern Territory, I think the Northern Territory has a long way to go before it puts all those things together in a reasonable sort of way. Part of what the CRC ought to be doing is providing information to all of the organisations involved about the sorts of things they need to do to improve if the capacity of knowledge and information base of our own community is going to be there to allow people to take control over their own personal agendas and then cooperatively take control over the agendas of those learning institutions. There is a lot of work to be done in that area for sure.

Ms Ah Chee—I think it is an interesting question that we need to further explore about the actual connection and importance of education to health and health outcomes. It is something that this CRC board is exploring in terms of one of its programs.

Prof. Anderson—It is actually quite a complex question that you asked because not only is it about looking at research that understands the process of capacity development, but the CRC has to actually operationalise principles of capacity development. It does that at the board level; it does that in terms of having quality collaborations with Aboriginal communities in which people learn. It has a training program that is focused on both recruiting Aboriginal people and creating quality, non-Aboriginal researchers who can work well with Aboriginal people. Furthermore, the research outcomes are part of a broader capacity development process providing knowledge about what works in health care and providing that knowledge in a form that is useful and usable to communities. Capacity development is integral to the whole way in which the CRC should work.

CHAIR—Thank you very much.

Ms ELLIS—I have a very quick final question out of left field a bit. To which federal ministry, if any, do you have an attachment? The reason I am asking is because I would hate to think that the vaccine test run in South Australia results in being totally successful and then there is no money to implement a national program without saying, 'Make savings in box X to implement it,' because in Aboriginal health that is the worst thing you can suggest we do. That is the reason for the question. Where does it fit and with whom? What liaison is an ongoing liaison in terms of what you are doing and your expectations? I know you cannot predict that in the year 2002 you need $7 million to do X, but there is a connection.

Dr O'Donoghue—Minister Wooldridge.

Prof. Good—Dr Wooldridge, obviously, but the CRCs come out of the Department of Industry, Science and Resources.

Ms ELLIS—That is what I thought.

Prof. Good—I think Nick Minchin is the boss. With respect to something like the testing of vaccine, vaccines cost hundreds of millions of dollars to develop, not tens of millions of dollars.

Ms ELLIS—I know.

Prof. Good—So we have to get industry support to do that. That means patenting inventions and licensing them. One of the conditions of a licence is that this particular vaccine will be made available in Australia at or before any other time it is made available elsewhere in the world.

Prof. Anderson—I might be able to just reflect on my experience as a bureaucrat. One of the critical factors that always undermined us in terms of the argument with the department of finance, PM&C and finally with cabinet, was our lack of knowledge and our lack of information. I was involved in a process of putting up a program to fund the provision of pneumococcal vaccine to Aboriginal communities—this is a different sort of pneumococcal vaccine. We actually had evidence that it worked and that it made a difference in indigenous communities. That got the argument up. Knowing what, in the policy world, are the critical bits of knowledge that make a difference with the financing people is a really critical component of that.

Mr SCHULTZ—I would like to make a quick comment in relation to the comments Harry made earlier when we first started off. I want to say to you, Lowitja, and your CRC group that the nice thing I have found as a new federal member of parliament after 10½ years at state level is that I have come onto a committee that is totally committed to fast-tracking the need for Aboriginal health outcomes, and it is done in a bipartisan way. We are of opposite political persuasions and we are working together as a team. I have never seen that to the extent to which this committee operates in the 12 years that I have been involved in politics. Sometimes questions are asked that are a bit sensitive to people because they have been taken the wrong way.

The point I am going to finish up on, Mr Chairman, is this: we as parliamentarians are the people that cop the flak for the things that do not go right with these particular issues. Whether we do it or not is immaterial. We cop the flak, and we are trying to get into a situation where, when we deliver this report, it is the report that has the proper and the best outcomes that you have seen on the issue of Aboriginal health for many years. I just want to make that comment to each and every one of you. We are totally committed to what we are doing, and sometimes we get a bit vigorous about what we are doing. I am not making an apology for Harry; I am of a similar disposition to Harry so he understands what I am talking about.

CHAIR—In other words, what Alby is saying is that we have a vested interest in doing our job as well as we can. Lowitja and your team, thank you very much. It is much appreciated.

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

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

Committee adjourned at 3.06 p.m.