COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

MONDAY, 29 NOVEMBER 1999

CAIRNS

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Monday, 29 November 1999

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

Members in attendance: Ms Hall, Mr Jenkins, Mr Quick, Mr Schultz and Mr Wakelin

Terms of reference for the inquiry:

To inquire into and report on:

a) ways to achieve effective Commonwealth co-ordination of the provision of health and related programs to Aboriginal and Torres Strait Islander communities, with particular emphasis on the regulation, planning and delivery of such services;

b) barriers to access to mainstream health services, to explore avenues to improve the capacity and quality of mainstream health service delivery to Aboriginal and Torres Strait Islander people and the development of linkages between Aboriginal and Torres Strait Islander and mainstream services;

c) the need for improved education of medical practitioners, specialists, nurses and health workers, with respect to the health status of Aboriginal and Torres Strait Islander people and its implications for care;

d) the extent to which social and cultural factors and location, influence health, especially maternal and child health, diet, alcohol and tobacco consumption;

e) the extent to which Aboriginal and Torres Strait Islander health status is affected by educational and employment opportunities, access to transport services and proximity to other community supports, particularly in rural and remote communities; and

f) the extent to which past structures for delivery of health care services have contributed to the poor health status of Aboriginal and Torres Strait Islander people.

WITNESSES

Committee met at 9.04 a.m.

ARCHER, Ms Cathie, Registered Nurse Level 2, Specialist in Child and Family Health, Community Health

BROWN, Dr Ngaire, Indigenous Health Adviser, Australian Medical Association; and Executive Officer, Australian Indigenous Doctors Association

CADET-JAMES, Ms Yvonne Lorraine, Lecturer, Indigenous Health, Centre for Indigenous Health Education and Research, Queensland University of Technology

CHANNELLS, Mr Graeme William, Secretary, Indigenous Health Sub-Committee; and Member, Douglas Shire Multipurpose Health Service

HAYS, Professor Richard B., Foundation Dean, School of Medicine, James Cook University

ISHERWOOD, Mrs Rose, Project Officer, Tablelands Alcohol and Drugs Service

KENNEDY, Mr Jim, Inquiry Secretary, Indigenous Health, House of Representatives Standing Committee on Family and Community Affairs

LAND, Constable Jennifer R., FNR Cross Cultural Unit, Office of the Assistant Commissioner, Queensland Police Service, Far Northern Region

LEVERS, Ms Lillian, Manager, Mookai Rosie Bi-Bayan

MEANEY, Mr John David, (Private capacity)

MILLER, Mr Barclay, (Private capacity)

MILLER, Mrs Valda, Senior Health Worker, Yarrabah

MITROVIC-CALVERT, Ms Mary, Community worker, Home and Community Care with Multicultural Affairs and ATSIC

NONA, Mrs Diane Elizabeth, Female Counsellor, Wangetti Education Centre

NORDIN, Mr Bjarne, Secretary, House of Representatives Standing Committee on Family and Community Affairs

PEACHEY, Mr Phillip Neal, Coordinator, Aboriginal and Islander Health Program, Townsville District Health Service

PEETERS, Mrs Lorraine Joan, (Private Capacity)

POA, Mr Arthur, Drug and Alcohol Counsellor, Aboriginal and Islander Alcohol Relief Services

RING, Professor Ian, Head, School of Public Health and Tropical Medicine, James Cook University

SEXTON, Ms Wendy, Acting Aboriginal and Torres Strait Islander Coordinator Health Policy, Cairns District Health Service

TANNA, Mrs Sandra, Chairperson, Mookai Rosie Bi-Bayan

WILLIAMS, Ms Veronica Anne, Health Promotion Officer, Indigenous Injury Prevention Project

CHAIR—Welcome to the House of Representatives Standing Committee on Family and Community Affairs, gathering here in Cairns. It is 18 months or more since the committee was last here. It had a different chairman then. I have only been the chairman in this new parliament, for just over 12 months.

Our proceedings will be recorded for posterity as a committee of the House of Representatives. As this is an extension of the parliament, it is accorded the same respect as the parliament itself.

I would just like to quickly go through the terms of reference. I do not intend to read them all out, but at every hearing I remind myself and those present of what we are trying to do with the inquiry as we come to the end of that inquiry. It is about effective Commonwealth coordination; the barriers to access to mainstream health services; the educational issues of the health professionals; the extent to which social and cultural factors influence health; the extent to which education employment opportunities are counterproductive to health; and the extent to which past structures of the delivery of health care services have militated against better health outcomes.

I like to come back to that each time because it is such a far-ranging subject that I need to remind myself each day that these are the specific issues that we are trying to address in this inquiry.

I now ask you to introduce yourselves and to pick out one or two issues to address us on that you or your organisation would particularly like to bring to our meeting today. We will go into a fairly informal process while endeavouring to come to grips with this very difficult issue.

Prof. Hays—I am the Foundation Dean of the James Cook University School of Medicine which is starting in February next year. I have also worked for the last six years for the University of Queensland's North Queensland Clinical School based in Townsville and the Royal Australian College of General Practitioners. I am here representing, I guess, James Cook University with one hat; also, my predecessor at the clinical school, Professor Peter Mudge, did make a submission on our behalf about a year ago. My particular interest here is the identification, recruitment, support and training of indigenous Australians to be doctors.

You may be aware that a condition of grant of the James Cook University School is that we, I guess, take in at least five indigenous background students. We are hoping to graduate at least five, because the two are different. There are substantial support issues which others around the table are aware of. I have been a long-term resident of the north. I have also travelled around to other parts of the world where similar issues are faced and areas of identifying, recruiting and supporting indigenous students are concerns. In some places it is done quite well and in other places not so well, but I am here to contribute and to learn from this group about how James Cook University can do this better.

CHAIR—Thank you, Professor.

Mr Poa—I am interested in learning about our direction and where we are going and what the community here in Cairns has to offer with regard to resources. I am particularly interested in improving the medical and health education and also to examine the social and cultural factors.

Mrs Isherwood—Good morning, everyone. I am from the Tablelands Alcohol and Drug Service, a new project funded by the National Illicit Drug Strategy in Atherton. I also come from a background of a nurse educator and health worker educator. I am interested in finding out about the progress of the national competencies for indigenous health workers and community education for communities in the needs for a healthy community.

Mr Peachey—Good morning, everybody. I am coordinator of the Aboriginal and Islander Health Program in the Townsville Health Service District. Some of the stuff that I would like to see is, as with Richard's case, employment of doctors but also employment generally, right across the health fields and proper recognition of Aboriginal and Islander health workers on a state and national basis because we do not have them recognised on a professional basis in the health service.

Ms Sexton—I am the coordinator for the Cairns District Health Service, Tableland and Cape districts. I am here to look at training in regard to how it can help with legislation for health workers. That is one of the topics I want to focus on.

Mr JENKINS—I am the federal member for Scullin, an electorate in the northern suburbs of Melbourne. I am a member of the Labor Party. I am here to continue to learn about matters relating to indigenous wellness. It has been a two-year journey and at the start I knew very little about it. At the moment I know a bit more but am still seeking assistance with trying to find some answers.

Dr Brown—I am here representing the Australian Medical Association but also the Australian Indigenous Doctors' Association. In terms of AIDA, we are very much focused on promotion of self-determination and increased opportunities for Aboriginal and Torres Strait Islander people in all arenas, but particularly in education and medical education and to promote people's interest in careers in medicine and allied health, so that we can tackle our own problems in those arenas. We are also focused on encouraging education and opportunities and overcoming stereotypes in a context that is relevant to us culturally. The AMA, the peak medical body, as you may know are also very interested in what they can do in lobbying for better funding structures for Aboriginal health.

Const. Land—I work for the Office of the Assistant Commissioner of Police in Cairns from the Cross Cultural Unit. It is a relatively new unit that has been formed within the community policing area. Today I have come along to listen to what the other people are saying so that I can take things on board to give back to the Assistant Commissioner. As everybody is well aware, Aboriginal deaths in custody and health issues are a very big concern for our police officers out there.

Mr QUICK—I am the federal member for Franklin in southern Tasmania. Like the other Harry, I have been on a two-year journey. I am determined, like all the rest of the members of the committee, to do whatever is necessary in a bipartisan way to get this right. We have been stuffing around for 25 or so years. We are not getting it right. If there are any impediments, let's throw grenades in and sort the system out.

Mr Channells—Good morning. I am the secretary of the indigenous subcommittee of the Douglas Shire Multipurpose Health Service Steering Committee. The question of setting up a multipurpose health service is just being examined. The subcommittee comprises, with the exception of myself, all indigenous people. It held a workshop recently in Mossman to identify health issues there within the indigenous community.

The No. 1 issue which emerged in connection with ensuring that indigenous people can access the mainstream services that are available is the employment of indigenous people within hospitals and within the community health service. The belief is that there is a need for a massive increase in indigenous people employed—male and female—on each shift at the local hospital. There needs to be liaison officers there and also indigenous people in a reception position so that indigenous people are not driven away from the hospital service even before they get to see a medical person.

Secondly, there needs to be a major expansion of community Aboriginal health worker employment with additional training leading to the provision of specialists within the community in drug and alcohol problems, domestic violence, health promotion, and a range of other things. The committee is firmly of the view that the employment of indigenous people in delivering health services is what might begin to make them effective.

Ms Williams—Good morning. My actual position is as a health promotion officer, but I am implementing a pilot system within discrete Aboriginal communities in the Cape area. The pilot system is a health surveillance database where people within the community are able to monitor and evaluate the causes of injuries.

This has been a particularly interesting project because it involves the three main principles about implementing any project within discrete communities. They are: community ownership, which allows the council to have community ownership over that health surveillance database; ongoing support in terms of what is generally required in the broader community, because we know that even little things are big things for indigenous people when they do not have ongoing support; and also sustainability.

The reason for me being here today is particularly as an observer, but also to get an increased knowledge of indigenous issues from around the table. Thank you.

Ms Cadet-James—Good morning. I am a lecturer in indigenous health and I have a background in nursing. I have spent many years working in indigenous health in various parts of Australia. I am interested in having more indigenous people as health professionals in a range of professions, not only in nursing and medicine but also in things like podiatry, optometry, dietetics, et cetera.

The way we can move forward is having partnerships between mainstream and indigenous organisations. I am particularly interested in the social and cultural factors that impact on indigenous health and, more importantly, I am very interested in working towards strategies to help indigenous communities develop their own strategies based on what they see as their priorities, their perspectives and their cultural values and beliefs. Thank you.

Mr Meaney—Good morning. I am currently doing a small consultancy that is turning out to be rather larger than was intended on issues surrounding the availability or otherwise of dialysis units in remote indigenous communities. The feeling is that we have to work fairly quickly in the best possible way of getting dialysis closer to the people, rather than bringing people from their homes, their families and everything else and relocating to areas like Cairns or Townsville for treatment where they do not have that ongoing family support.

Those patients, once they have been stabilised and become eligible to return home, are unable to do so because there are no facilities where they can carry on with their dialysis, even to the point of home dialysis where the person has it set up in their own home. My research so far indicates that that is probably the most effective means of treating a person.

The other issue of long-time interest to me has been the water supply to most of the indigenous communities around the Cape and the Torres Strait. I have done extensive research and a lot of work in that area. The past treatment regimes of some of those water supplies have been suspect, to say the least. I can cite the northern peninsula area communities at the top of the Cape where, for around 36 years, water was pumped from the Jardine River, gaseous chlorine squirted into it and a poisonous cocktail distributed around five nearby communities, purely and simply because the treatment methodology was wrong.

There is now a big movement among people wishing to return to the country, to get back to their homelands. ATSIC had a moratorium on homelands and outstation development because of water supplies. They now require that the water supply be guaranteed safe and ongoing before they will support infrastructure in those situations.

Mr SCHULTZ—I am Albie Schultz, the federal member for Hume, a rural electorate in the south-west of New South Wales. I am a reasonably new member of this committee, having been on it for 12 months now. I am interested in the cost-effective way in which federal funds are being used for indigenous health. I am concerned also that the health packages, as they are distributed, are not getting to indigenous health in the manner in which they were designed.

CHAIR—Thanks, Albie. The next two people are Lyn Cowley and Alan Savage from Hansard. Jim Kennedy is from our committee secretariat. He might like to introduce himself because he has been the mainstay of the committee.

Mr Kennedy—I am normally with the Office for Aboriginal and Torres Strait Islander Health in Canberra. I am on loan to this committee for the duration of this inquiry.

CHAIR—Jim, how many submissions have we had? What is it like to work in this committee? You do not have to answer all of that.

Mr Kennedy—We have had about 90 submissions so far. It has been a learning experience for me in terms of getting information from a perspective different to that which we normally get in the office, which tends to be bureaucratic and focused on government programs. It has been very good to get out in the communities and get the other perspective.

Mr Nordin—I am the secretary to the committee. The normal procedures that we follow with inquiries is just to have public hearings and inspections. From my point of view, one of the good things about the process we are undergoing now is that we are trying, with this further phase, to highlight some of the major issues that we have already identified and get more feedback from the people on the ground about how we should proceed to the report and how we should summarise all of the information that we have gathered to date. I think this is a very useful process to finish the inquiry with.

CHAIR—Thank you, Bjarne, they are good comments. I will do what I should have done at the beginning and introduce myself. I am Barry Wakelin and I am from South Australia. As for the region that I represent, if you can imagine South Australia and think of 90 per cent from Alice Springs towards Adelaide, that is my electorate. The area includes the Pitjantjatjara Lands and the Maralinga Tjarutja Lands, so I have some background in Aboriginal issues and Aboriginal health. But, as I constantly tell my constituents, I know enough just to be dangerous. That is why we come out and listen and get as much information and learning experience for us as we possibly can from people such as yourselves.

As I said at the beginning, I remind myself every time I come to a meeting such as this of what our terms of reference are because this subject is so large and so complex. I would, in the general component that we are going to enter into now, just presume that many of you have read the discussion paper. If not, there are copies of the discussion paper available, so please feel free to take one and glance through it at your leisure. We are really trying to find the gaps and pick holes in it and find what we left out, and there is the general feedback.

Let us look to both areas that we may have overlooked. The service delivery issues are very important. We have a quick check list, and Jim has certainly helped us with it. Additional matters include dental health, mental health—and we have a very good submission from the psychiatrists association in our briefing notes—hearing health, diabetes—and we have some people talking about that. The balance between the needs of urban and rural and remote communities is a real issue for us as we have an Aboriginal population spread right across the length and breadth of Australia. There is the impact of other factors: dispossession, poverty and discrimination—and I think a number of people have already mentioned this morning the ownership of Aboriginal communities' health and well-being—and the impact of the current welfare arrangements. They are just some of the things that I would like to discuss.

Has anyone got a question of me or a question of any of the members? Has anyone got anything that is unclear—someone mentioned the mental health. If not, we will just have a general discussion. I thought I might start with Ngaire because I know Ngiare, which is very unfair but I have to start somewhere. Ngaire, I think you mentioned the word 'opportunities' for, I presume, Aboriginal people, particularly in the Aboriginal health industry. I would try to relate that back to cultural issues and where we think the cultural impediments make it more difficult. Can you enlighten our gathering a little for the committee's purposes. Where do you see some of the stronger opportunities? Can you give us a priority or a feel for some of that? It is a tough question, but I have to start somewhere.

Dr Brown—Thank you. I suppose it is a very broad question in many ways because, as you know, we are not a homogenous group of people and particular problems will vary from community to community, depending on the state and territory that you are in. Overall, I think that my particular interest is in educational opportunities which, hopefully, from there, lead on to better health, better employment opportunities, a better outlook and opportunities in terms of the broader community, not just in our own communities, and what we can do for our own people and our families.

As you know, we are having a lot of difficulty getting many of our children to primary school and getting them to stay there. So we are looking at ways that we can promote that amongst our younger children as well as our high school students. Then from there, hopefully we can encourage them—for us obviously—and interest them in careers in medicine and allied health. As my sister said, it is not just in medicine, being doctors and nurses, but allied health professions as well—dentistry, podiatry or physiotherapy. Also, if you have an education behind you, as we all know knowledge is power and it can broaden your horizons and give you a great outlook to work within not only your own community but across Australia as well.

We are looking at special entry schemes and making them more flexible at universities. For example, we have special entry at James Cook University for next year, at the University of New South Wales and at the University of Newcastle which encourage Aboriginal and Torres Strait Islander people to pursue tertiary educations by having flexible criteria that not only look at their academic performances but also their passion for a particular career, their aptitude and their potential to be great at what they choose to do. It is not only that one step, 'We'll help you get into university,' but there are support networks. So that once those people are there at that institution, for example, they have other Aboriginal and Torres Strait Islander people around them to make that easier.

As you know, we often move long distances away from home to go to university or even to go to high school. Without those support networks—academic, social and financial—it just makes that so much more difficult. So universities are looking at a way to make the entry schemes but also the support networks within the universities far more flexible and accepting in a more culturally appropriate way for these students. If they have never finished high school, for example, or perhaps they have followed another career path, it does not mean they will not make a great doctor or nurse; it means they have other life skills which are just as important. So we like to be able to focus on those issues as well.

So in terms of educational opportunities, I suppose in many ways, particularly to get started, it is more difficult, because you have to draw them out and encourage them. You have to spread the word so that in five or 10 years time we will not always need to go out in search of and spread the message; they will know about programs specifically for Aboriginal and Torres Strait Islander people and know to seek them out. That is part of increasing the opportunities.

I feel it is also about overcoming stereotypes. It is not just stereotypes that the broader community have for Aboriginal and Torres Strait Islander people that we are unemployable, that we are poorly educated, that we are of the welfare mentality. It is also the stereotypes that communities often place upon themselves because they do not see the way forward, whether it be from institutionalised discrimination—for example, distance barriers—or access to services that other people take for granted. It is up to other Aboriginal and Torres Strait Islander groups and mainstream groups to show them that there are ways forward but we have to help them get there.

CHAIR—Self-perception in a community is all important.

Dr Brown—It is self-esteem, self-determination. It is all very well for people to sit at a table and talk about it, but it is not something that you can give or hand over to somebody because that is an opposing definition. It is something that people have to work towards. Without support and structure and direction, it is very difficult just to get started and gather that momentum.

CHAIR—Thank you very much for that.

Mr QUICK—How do we change the education system? It is obviously not working. I do not think we have ever had one Aboriginal child in the Northern Territory, for example, complete year 12.

Dr Brown—I think one last year completed her HSC.

Mr QUICK—Which is absolutely appalling. If the system does not work, what revolutionary steps do we take? You mentioned support networks, and that always comes down to money. How do we put in place the bags of money needed if children, from wherever it is, need to go away from home so that they do not have to worry about filling out Abstudy forms and all the difficulties with those? We have a system in place to say to the kids, ‘Go for it. The support is there. We’re right behind you.’

How do we change that system? How do we improve in rural and remote areas the appalling conditions for teachers? Their motivational skills are not as great as they should be. The schools themselves are absolutely appalling, despite all the modern technology we have in the world. Why would you want to learn in some of the schools we have visited? What do we have to do to revolutionise it so that the retention rates go up through the roof, so that, as you say, the cream rises and we can pick all these people and say, ‘If you want to be a podiatrist or a dental technician or a doctor or a neurosurgeon, go for it’? We have been mucking around for two or three generations.

CHAIR—Ngaire is not an educator, so it is a good tough question, isn't it?

Mr QUICK—Someone else around the table might lead.

Dr Brown—I suppose my answer is going to be one of those touchy-feely ones. Health or education of Aboriginal or Torres Strait Islander people has never been a priority, and not only just for indigenous communities but for rural and remote communities in particular as well. They get fewer resources in basically every field and, of course, because we are at the bottom of the socioeconomic scale we are again the brunt of all of that. How do you increase resources to these areas and how do you increase educational opportunities, get great teachers, great practitioners in any area, out to these communities? It has never been a priority to make sure that these communities, black, white or green, have these resources, and it is about time that it was. That does not tell you how I should fund something, and that not does tell you what dollars are going to be required.

Mr QUICK—Do we follow the New Zealand system where there are total immersion schools, and you have reverse apartheid? It is working in New Zealand where you have got more people involved and a greater range of choices.

Dr Brown—There is a whole number of issues around why New Zealand has been far more successful than, say, Australia in terms of the promotion of the Maori, their indigenous people. That includes that they make up a greater proportion of the total population, that they all speak one language. People will tell you it is the Treaty of Waitangi that basically incorporated them in the way forward so that they would be represented at all levels of the government and the community from thereon in—and they have been.

Also, New Zealand as a country, the entire population, actually accepts the Maori culture as their national culture. That is not something that we do here. Aboriginal and Torres Strait Islander people still remain in many areas a bit of a tourism sideshow; we are not accepted as having the cultural heritage and history of this country. There are lots of issues to that, but they have fought very hard. They are going back to the presentation of services on the marae for everything from pre-school education, where they involve parents in teaching their kids to read, write and colour in before they go to primary school, to elderly care on the marae, as well as the health services, general practice and dentistry, social welfare and the schools—they have language schools and culture schools at their high schools. So there is a whole range of reasons they are so successful, but I do not see that it is something that cannot be done to a degree here if we have that some sort of push.

Mrs Isherwood—I would like to put some of my observations and suggestions to the meeting. My husband and I have lived and worked in rural and remote areas in the Territory for quite a long time. He is an educator. Looking at the education system that we witnessed, I would suggest a couple of things that may help with your queries, Harry. They did have a bilingual system in the Territory. For some reason, funding has decreased for that. In some areas in these remote communities there are indigenous educators who were quite good role models for the children then. It also comes back to community ownership, even in the education system, so another suggestion is for them to have some more community ownership, because education in that way has to have value for the indigenous people.

CHAIR—Thank you. This issue of education is no accident and it is a little topical. You might be aware that the federal minister was in the Pitjantjatjara lands and in Central Australia about a week or fortnight ago with the US Surgeon-General. Many of you would have seen the comments that the US Surgeon-General made in terms of this focus on education and the messages from the community.

Prof. Hays—I will contribute some comments from my perspective of visiting other places. The North American models are probably a little closer to ours than the Maori one. What has impressed me most about some of the models I have seen in North America is that the local communities have a strong sense of ownership and a sense of control over the education bridging programs. A major problem for any health sciences tertiary institution is that Aboriginal and Torres Strait Islander people just do not come through with what we would call the traditional academic performance, and that goes way back. The North American approach is to intervene very early in primary school and provide bursaries and scholarships and summer camps, and to work with families to work with kids. They do it in a very broad way. They are looking to attract people into what initially was a health sciences course—it started with medicine and then broadened. Now, many of the communities just run it as a general tertiary entrance bridging program. They appear to be very successful. I do not think that is a good long-term strategy; it is a short-to medium-term strategy.

There are major disadvantages for all rural and remote educational things at secondary school and there are major disadvantages, of course, for Aboriginal and Torres Strait Islander people. I guess there has to be a reason to do it. I have been a rural general practitioner for much of my life and I have been quite disappointed sometimes at some of the communities I have worked in where the local kids just do not aspire to go to university—these are non-Aboriginal kids from so-called nice homes. A lot of it is about opportunity to attend, it is about distance and being away from support. Of course, these are the same issues, except hugely magnified, for many of the Aboriginal and Torres Strait Islander people. So there is a broader issue of rural and remote problems.

Something that James Cook University would like to have a go at is working with local communities to try to pick kids in primary school, and families, and really support them to see that there is a reason to continue. Part of that is having the role models. I cannot be a role model for an eight-year-old Aboriginal boy in Townsville who might be thinking of going to university. First, it is really too early to think about what they might do at university, but, secondly, I am not an Aboriginal person. Now that more and more Aboriginal health professionals are becoming available, that is a very important role for those people, to be working out in the communities.

Mr QUICK—So you would see the Commonwealth health department or the state health department having a bag of money entitled, roughly, 'Scholarships, incentive awards', so that the local Territory or state education department could access that? You would have an interagency approach, the interagency bag of money, so that whoever comes up with a bright idea is not stymied, as they usually are, by 'where's the money coming from?'

Prof. Hays—Sure. I think everyone likes intersectoral approaches, and that is the right one here. The problem in health, in medical schools, we find, is that DETYA and Health are not quite sure who is responsible for what, so we face that problem. Of course, DETYA

tends not to be directly involved with primary and secondary school education in states, so then you have got to involve state and federal governments. Yes, every debate about money is always: where's it coming from? I would have thought that there is actually lots of money available if things could be done more efficiently.

Mr QUICK—Early intervention and setting up those early intervention programs is a lot cheaper than trying to sort out the mess that we are currently facing.

Prof. Hays—Yes. It is going to have a failure rate and a success rate. But what is important is not that we set those up, but that the communities are involved with setting them up, if they think that is appropriate. It may be that some communities think that is inappropriate, but I think it is worth giving it a fly, if you like, because we have really struck out badly here.

CHAIR—I need to introduce colleague Jill Hall. Would you like to introduce yourself, Jill?

Ms HALL—I am from the New South Wales electorate of Shortland, which is near Newcastle. I apologise for being late.

CHAIR—I did not give you fair warning, and you may choose to do this or not, but I have asked people to pick out one or two points, particularly about health. For instance, an issue you have talked about is the rural, remote, regional, urban issue, so you might like to make a couple of points on that.

Ms HALL—There are two issues that I would like to mention. The issue that you have just been talking about, education, and the importance of making sure that services are available in rural areas. It is all very well to identify the kids later; you need to identify the kids when they are at school, to make it possible for them to succeed. With regard to the rural and remote issue, a lot of Aboriginal people live in regional centres—for instance, in Cairns, Townsville, Newcastle and urban areas in Sydney. With this inquiry, I have been most concerned that we do not ignore the people living in those communities because, no matter where indigenous Australians are living, the health problems that they have are very similar. We must be very careful that we do not just look at it as a remote issue. That is something that I have been particularly interested in.

I have also been looking at whether or not we should be making indigenous health a specialty issue. I would be very interested to hear from the medical people as to whether they think there is value in having a specialty of indigenous health. That not only means a specialty with regard to working in remote areas; it also means that, when you establish a specialty, it attracts more money to it. It is pretty ordinary when you have to look at doing things like that, but it makes it a very serious and important area where doctors, nurses and health professionals work in indigenous health to get experience that other GPs or health professionals cannot get anywhere except maybe working overseas in a Third World country.

CHAIR—Mr Meaney, would you like to comment?

Mr Meaney—Yes. I totally support the concept of education starting with children at the level of primary school. I believe children are at the crux of where we have to go to achieve a decent standard of education. Having said that, I would like to take a step further back. In most of the remote indigenous communities that I have visited—and that has been quite a number over a lot of years—the housing situation is absolutely appalling and the social structure of the communities suffer profoundly because of that. Kids have nowhere to go to sit down after school to do their study and homework, because most often they are in a crowded household with a whole heap of conflict.

There is also poor diet. For three days after pension day kids might get adequate feed. From that point on, for the next 10 days or so of the fortnight, they gradually decline in their level of attention and everything else because they are hungry, and they become non-functional because of that. They are just not going to take on board anything that is being told to them in a classroom anyhow. I think that is an issue that really needs to be addressed. It is part of the serious health problems because people are in that desperate social condition.

Ms Cadet-James—I was going to say something similar to what John has said. I appreciate that there are problems with education and health. I do not really think we can do anything in communities until such time as we look at—and I hate to use the word 'holistic'—the community as a whole. Every community is different and you are not going to have good health if you have poor education and vice versa. Nothing is going to work until such time as people look at that community as a total picture and that has to come from the community itself. I see mainstream people as being a support and a resource to help that community to get where they want to go, but it has to be based on what they see as their needs. They have to have ownership, as a number of people have said. But we have to look at it in a total sense and not just in the sense that education is a problem, health is a problem, crime is a problem and welfare is a problem. Until we stop looking at everything in a fragmented way, I do not think we are going to get very far.

Mr SCHULTZ—The Commonwealth government, through its Grants Commission arrangements, has increased general revenue shares to the states and territories on the basis of higher indigenous populations and remoteness, and all of those sorts of contingencies, but there does not appear to me, from the discussions that I have heard over a 12-month period, to be any great control by the Commonwealth on how that money is being spent. It is obvious to me that a lot of that money is not being spent on indigenous people; it is being spent elsewhere. To me, that is reprehensible in the extreme. I want to bounce off people a question as to whether they believe, as this committee believes, that there should be a lot more accountability and a lot more professional reporting of where the funds are going, so that we do not have this nonsensical situation where money is handed out and nobody knows where it is going. I put that as a general question.

CHAIR—Does anyone want pick that up? Please come back to it if you do not want to jump in straightaway.

Mr Channells—I think that is obviously a very important issue. If the efforts that the Commonwealth is making to support indigenous health are going to work, obviously there needs to be that kind of monitoring. Quite possibly, if states are not willing to cooperate in terms of directing funds where they are intended to go, perhaps those funds should be

directed, as the Commonwealth presently does, directly to Aboriginal community controlled health organisations that will spend the money on those purposes.

I would also like to relate back to the comments that Yvonne or Veronica—I am bit confused—and others have made in relation to education and the willingness of indigenous people to pursue education, particularly in the health area. In the Mossman district, we have an indigenous population of approximately 800. We have eight students completing an Aboriginal health worker course at the local TAFE. We have three Aboriginal health workers employed by community health and a long tradition of effective work in that area.

The submission from our indigenous health subcommittee, from the community, is that the eight young people who are doing this training should be employed as Aboriginal health workers. We believe it would be far more cost effective to have people dealing within their own community, spreading the information and understanding they gain in preventing health problems than it would be to have highly paid and highly trained professionals seeing people briefly for short periods and prescribing drugs which may or may not be affordable and may or may not be taken.

On another issue, for some reason the pharmaceutical benefits scheme does not include, I understand, the ointment necessary to control scabies infections any longer. This can cost, I believe, up to $19 a tube; the cost can be enormous. Chronic scabies infection, as I understand it, is very strongly indicated in later kidney failure. We have five indigenous people from Mossman who travel to Cairns three times weekly—until a short time ago that was a return trip of five hours in total—to undergo four to six hours of dialysis. That pretty well totally dominates their lifestyle. There are some very simple things that may, perhaps, be addressed very cost effectively.

CHAIR—We will go to Yvonne while you have got that on your mind.

Mr QUICK—Graeme has just mentioned 800 people. Should there be a prescribed core basic service requirement for 500, 1,000, 2,000, so that you do have X number of nurses and doctors and dentists as a given? As Graeme said, occasionally you bring in the experts, but every community of a certain size has a core basic medical service, irrespective of which body picks up the tab, whether it is the Commonwealth or the state. Should that be a pre-requisite?

Ms Cadet-James—I understand that there is a formula, but I am not quite sure how that works in practice.

Mr Meaney—I am working on that issue at the moment, dealing with dialysis in remote areas. They say that six people in a community makes it cost effective to establish a dialysis unit.

Mr Channells—As Yvonne has said, I think each community needs to be dealt with in its own right. I think each community needs to be involved in planning. In Mossman's case, there is a particular strength in that we have had a particular series of Aboriginal health workers who have been very strong and have made a very good contribution.

The eight students I spoke of are one per cent of the population. I do not believe there would be another one per cent of the population studying any one course, certainly within our district and probably not within the whole of Australia. If that does not indicate a fair degree of commitment, then I don't know what does.

I think communities are different. I very strongly believe that consultative planning and proper strategic planning need to be carried out at the indigenous level. One of the issues that comes up throughout the discussion paper is planned, assured, long-term funding. I believe that relates to the whole range of indigenous issues, certainly local government type services in indigenous communities. There really needs to be a commitment to community involvement in long-term strategic planning and government commitment to funding negotiated on the basis of that plan.

CHAIR—We might be interested in the framework agreements and the partnership as we go through the morning.

Mr SCHULTZ—Just picking up the comment with regard to the Commonwealth directly funding the Aboriginal community with their health funds, I have an enormous sympathy for that. Do you think there is a commitment and a very active commitment in terms of the community itself to be able to take hold of that and take ownership of that particular system? If so, what work do you believe has been done to demonstrate that there is a capability of that occurring?

Ms Cadet-James—I think that there are very good models around and very good work that has been done. I cite Yarrabah as an example of a community that has had a problem with suicide rates. They have put into place a feasibility plan. They undertook some studies and found some funding of their own. They have come up with a plan that involves the whole community in every aspect of health. I believe it is a primary health care model, if we are talking about a holistic approach to a community in terms of education, health, infancy—the whole range of things that underlie primary health care models. I know in other communities there has not necessarily been the whole community approach, but in certain aspects of health some very good programs have been developed by health workers which are having a good success rate.

Mr SCHULTZ—Is there any way that we could get access to those sorts of positive initiatives? It helps our case to be able to demonstrate that it is happening. It strengthens the case that the gentleman made with regard to moving away from the states, the territories and the local government in terms of Commonwealth funding. I am not saying that it has been misappropriated, but I have certain strong views about the way in which it has been handled—more importantly, about the lack of accountability and the disgraceful way in which the Commonwealth has monitored it.

Mr Peachey—Harry was asking whether there was a formula for the number of health workers per community.

Mr QUICK—Should there be?

Mr Peachey—There is. If you read the Aboriginal national health strategy, it is recommended that there be one indigenous health worker for every 150 indigenous persons in the population. In the case of Mossman, there should be more than three indigenous health workers. But it comes back to the funding that is provided to the states. We do not have enough funding to implement those recommendations which go back to 1989. There are a lot more recommendations within the NAHS strategy which health services just cannot meet. I just wanted to let you know what that formula was.

CHAIR—That is exactly what we are looking for.

Mr Peachey—I agree with Yvonne. There are communities out there like Yarrabah. Its youth suicide strategy has been around for ages and has made a really big difference. Palm Island is in the process of looking at a whole of community approach, working with the Office of the Premier in the north. The community has taken it upon themselves to do up a whole strategy document. It is not just looking at health; it is looking at health, education, juvenile justice, the whole box and dice. They currently have a submission before the state government to look at that holistically. It has all of the community behind it. So there are role model communities out there ready to go.

Mr JENKINS—I want to return to the holistic community approach. A couple of weeks back we were in the Territory and we had a discussion about how to ensure that communities have the capacity to be involved. I think the committee has been impressed by the instances where the community have had control over things. There are communities able to demonstrate that, and that is not questioned. I do not think we have questioned the commitment. In the discussions we have had even people working in the field recognise that we probably have to do something for a number of communities to ensure they have the capacity to achieve. I am not sure how we go about that. We cannot force it from above.

I was looking through my notes from that day. This is not totally relevant, but somebody was quoting somebody and now I am quoting them. They want to avoid people in the cities waking up with an idea and then dumping it on Aboriginal communities. I do not want to do this incapacity building by saying, 'I have this great idea, just go and do it.' The thing that I have learnt is that communities are so different that there may not be the one model, but we should have the determination to ensure that people are working on it at the local level. Does anybody have any insight about how we should do that? The important thing is that it does flow through everything, including health and education.

Mr Channells—Can I just make a suggestion. This relates to another issue. I am not sure whether this is a long way from the committee's terms of reference. There has recently been a change to the home and community care guidelines throughout Australia. This is imposing an enormous burden on the HACC services in the peninsula which are funded for only a couple of days work a week. They now have an enormous amount of bookwork to do. Often people find that phase of the operation very difficult anyway.

In relation to that kind of situation and also planning from a community base, I was wondering what services may be required. In the health area or other infrastructure areas it may be possible to resource a unit or a number of teams from a unit which can support strategic planning processes within communities. Perhaps they could fly in and, after a

period of familiarisation within the community—I am talking about indigenous people—they could lead the community through the strategic planning processes. I believe this could be a very efficient way of having communities undertake planning and being able to properly assess and express their needs.

Ms Cadet-James—Harry, just further to your question, it certainly does not solve the problems, but it has been my experience that you already have a lot of indigenous people out there working with indigenous communities. They know the people, the problems and the different world views and social and cultural factors that impact on health. It is a very good resource sitting there already. Going into an indigenous community means making the necessary contacts with people, telling people that they can have responsibility and ownership for their planning, then being available as a resource to come in when asked to help that community and provide that resource to assist them in developing plans, running workshops or whatever that community wants.

It takes a long time. There has to be trust. Non-indigenous people will have to remember that it will not be a plan that non-indigenous people come up with. It will be different but it will probably work because it is owned by the people and it is done under their world view and their cultural values and beliefs.

Mr JENKINS—I am interested in the feeling of people around the table about time lines. Throughout this inquiry we have observed the highs and lows. We have visited them. We have been and we have gone away. Sometimes when you see those you can get very anxious. You would hope to be able to change the world overnight but on many occasions people have said to us that it takes a while.

One of the examples of things that have been done positively is the Tiwi Islanders. The chair of the health board, Marius, was with us in Darwin. When we asked him about their community's capacity building, he admitted that it had been over a span of 20 to 30 years. By inference, he said that along the way they had made mistakes, but they had learnt by them. Personally, I thought that was a good lesson. I suppose I then think of what I hope the wider Australian community would want to see. I would hope that they start to be a bit more anxious.

How do we get the balance? Are people happy that, slowly but surely, progress will be made and that we should give the communities the time to do it themselves? It will in part get back to this accountability thing. Unfortunately, the further the bean counter is away from the coalface where the things are happening, the more they will want overnight results rather than let communities say, 'This is progressive improvement and we are on track.' I hope that was not a lecture. It was really just to try to get people to make a comment.

CHAIR—That is spot-on, I think.

Prof. Hays—I want to slightly change the topic and go back to what Jill Hall said a while ago. She asked for a comment about the medical profession and specialisation. I am interested to hear what Ngaire says. I guess I have been a generalist all my life. The thought of developing a new speciality in Aboriginal and Torres Strait Islander health, which I think is going to happen anyway, alarms me if it is seen as an important strategy. What the

medical profession is very good at doing sometimes is letting somebody else look after the problem if they perceive it to be another speciality.

What I would like to achieve at James Cook University is for every medical graduate to understand how to do this better than has it been done in the past. I would not want to see somebody thinking that funding 100 indigenous health specialists in various locations around Australia would make much difference. I say heretical things about medicine. In fact, the biggest contributors to our improved health care have been sanitation, sewerage and better water supply. Some of these revolutions of 200 years ago have not actually hit some parts of Australia.

There is an enormous amount to be done. The medical schools have to do their task. The medical profession has to perform its role. It is a very important role because we, as a group, have not been terribly involved with this in the past. It has been much easier to sit in urban middle-class Australia having a comfortable lifestyle, but we need the medical profession to see that their role is just part of a much broader sweep. In a sense, what is much more important is that things have got better at the community level and in terms of public health infrastructure.

In this part of the world you cannot practise medicine and not have contact with Aboriginal and Torres Strait Islander people if you are doing your job right. What concerns me is that everybody who is working in medicine in this part of the world, if not the rest of Australia, does know how to sit down and talk to people. They have understood the impact of history and lack of social justice on the health care of Australian Aboriginal people. That is a pretty good starting point to them working with communities to go forward. It is an important strategy. The other thing is that you will be disappointed if you think an indigenous health specialist will be paid a lot of money. Medical incomes are tied to procedures.

CHAIR—Do not presume it is going to fix it. There is a much more general issue.

Prof. Hays—There are far more important things.

Mr QUICK—Because James Cook University is doing it so well—

Prof. Hays—We want to do it well.

Mr QUICK—Because you are doing it better than others, there ought to be a thankyou in some sort of monetary terms. The other medical schools that have not even got to thinking about it yet should get a reverse kick in the whatsit because they are not doing it.

Prof. Hays—There is something already under way about that. Ngaire could talk more about it. There is a committee at dean level of the 11 medical schools. We have an understanding. Newcastle University has been doing this much better for a long time. James Cook University is certainly interested. There are two or three other medical schools who are very interested as well. A network of medical schools that take this seriously may emerge. It is early days yet.

I can assure you that the deans of medical schools are enormously sensitive to funding signals, like most in the higher education sector. But to be honest, some medical schools are in a better position than others to do this. I would think a medical school in Northern Australia that does not do this well should lose its funding. It is a dangerous thing to say before we start. You might argue that not all three medical schools in New South Wales have to take this seriously, for instance.

Mr QUICK—But they are the sorts of things we want to hear because we are not going to be coming back and we have to write a report that will change the direction of the ship.

Dr Brown—I would like to agree with Professor Hays. I do not know if it is particularly appropriate to be looking at indigenous health as a specialty when in fact we are not exposing our medical undergraduates to Aboriginal and Torres Strait Islander health to any great extent in any of the medical schools at the moment. So that in fact is where our focus is. We are looking at every medical undergraduate, indigenous and non-indigenous, having exposure to indigenous health in their course work and particularly in clinical experiences so that, hopefully, we can spark their interest in Aboriginal and Torres Strait Islander health as well as all the issues that are associated with rural and remote practice early in their careers.

If people know about things the choice is much easier for them later in their careers. Of course, it is great if you want to be an orthopaedic surgeon or a paediatrician and work in a large urban centre, and that is very much encouraged. It is legitimate within the medical profession. But often other or sub-specialties are these sorts of nebulous entities that float around general practice—sports medicine, women's health, Aboriginal and Torres Strait Islander health, for example. They do not actually fit in anywhere in particular and they have not really been legitimised as career options for our undergraduates. So if we include Aboriginal and Torres Strait Islander health as a core part of the curriculum at our medical schools, what we are looking at at the moment is whether all medical schools will take that on board or whether just some of them will focus on it.

As you know, James Cook has the perfect opportunity to do this very well. The University of Newcastle has been doing it for some time and is actually quite well known for their content. Also, I know the University of New South Wales is picking up and were offering indigenous pre-med programs to bring people into medicine. We have convened the deans of the medical schools to garner their interest in pursuing this and making it a core part of curriculum in all parts of the medical schools. That may not pan out but we are hoping that a greater proportion of those schools will become involved so that a higher percentage of our medical graduates are exposed to Aboriginal and Torres Strait Islander health and communities throughout their medical years. Hopefully, that will not only address people's perceptions of Aboriginal and Torres Strait Islander health, but also they may choose to work in those areas. That will cover work force issues on a much broader scale as well, not just for Aboriginal communities.

Ms HALL—Can I just follow on from that, please?

CHAIR—Yes, Jill. Richard would like to say something, too.

Prof. Hays—Just to say that the approach at James Cook and, in fact, at the clinical school in North Queensland for the last couple of years, is that all our medical students go through a two-day cultural awareness program which is run by the local Aboriginal and Torres Strait Island Partnership Group. We have Phil here who is part of that group, and perhaps he might want to talk about the value. This is one of the few places in the country where all students go through this program. I have to say they do not all like it; it is a very challenging program. But perhaps fair is fair; it has been on the other foot for most of the history.

CHAIR—I welcome Professor Ian Ring. Thank you for joining us this morning. We are just working our way through this huge subject. I just wondered whether you would like to introduce yourself and your organisation, and provide a couple of key points.

Prof. Ring—Thank you very much, Mr Chairman. I am the head of the School of Public Health and Tropical Medicine at James Cook, and on these issues we have been working in close collaboration with the Australian Medical Association and a number of prominent medical figures, not least my colleague Ngaire Brown.

Firstly, I would like to congratulate the committee on the excellent discussion paper which, I think, deals with most of the key issues. Fundamentally, the issue now is an issue about commitment, about deciding we are actually going to do something. The reality is here that we are the only country in the Western world, so far as I can see, which is making so little headway with the health of its indigenous population. That is an untenable situation, particularly when you think that there is nothing about the disease pattern or the history and circumstance of Aboriginal people in this country which is unique. Forcible dispossession, relocation—the main issues—are unfortunately part of a pattern which occurred throughout a number of countries in the Western world, but we are unique in having failed to address that adequately.

The good news is that other countries, North America and New Zealand—not exact parallels, but as close as you can get—have made substantial headway and this gives us, I think, every reason to believe that that kind of headway can be made in this country, as well. Across a range of health issues, Australia has shown that it can do as well as anywhere else in the world. This is an issue which is difficult and complex, but I do not think there is any reason for believing that it is only in this country that headway cannot be made. That is not tenable.

It is easy to persuade ourselves that it is all okay, that this kind of thing happens so slowly that improvement takes a generation andt incremental change will do it. I do not think there is any reason for believing that at all. In fact, if you are the one country which has been making relatively little headway, a little bit more of the same is unlikely to make much difference. If we are to break out of this current mode it does require a degree of commitment and recognising the lessons we have learnt from our experience and the lessons from other countries, as well.

Why should we do it? This lack of progress says something to us, as a people, about what sort of country we are, and it says something to other countries with whom we have to deal and trade about the kind of country that we are. It is my view that it is in the national

interest. This is an issue of fundamental and common humanity but, beyond that, it is an issue which is in the national interest. Whenever Australia wants to pontificate about things—and it has an awful habit of doing that—people in other countries rub our noses in Aboriginal health, and rightly so. It certainly does not help in dealing with trade and our interrelationships with countries that are important to us.

What has to be done? Firstly, if there is to be significant change, there has to be a climate of public opinion which will support that change. The first step is building that climate. That was done before the 1967 referendum, and it is an important issue for the government of the day to take that on as a bipartisan exercise to build a climate for change.

Secondly, this is a complex issue. There are three levels of government and we have many agencies involved. There has to be some way of bringing together a national effort under Aboriginal leadership to tackle this. I do not have any set view as to what that should be. We have done something of the kind with AIDS, but some kind of mechanism for harnessing a national effort is important.

We have been very good about setting targets and measuring progress, but what we have not done is the bit in the middle, the doing bit. We have had a National Aboriginal Health Strategy, which is a great strategy and still good today. It is just a pity that no-one ever implemented it. We now have to get on with the job of saying what it is that we plan to do over the next five years and setting that out in process terms that in year 1 we will have got these services going in these areas, and so on, so that we have a comprehensive, long-term approach to the delivery of health services.

While this is a complex issue going right across a number of housing and environmental issues, and so forth, our first obligation, as health people, is to ensure that we run decent health services. We need a reality check from time to time for people who tell us it is all okay. To my knowledge there is not a single health service in this state which is able to provide a full and comprehensive range of services. I think you will find that that is true in many parts of the country and it applies, not just in health, but also in education, housing, and so forth.

We have to have a plan and a commitment in terms of health service delivery. In the more detailed submission that we have supplied we have drawn on those points in your inquiry and in your deliberations which, I think, deal with some of those issues. The fundamental principle of community control which the Commonwealth, I must say to its credit, has always adhered to, is of fundamental importance. If there are things that the committee can do to ginger up the states a little on this point where they seem not quite as forthcoming, that would be useful.

There are these myths about funding: all this money has been thrown at Aboriginal health and it really has not done any good, so putting more money in would be throwing good money after bad. The reality is that we spend virtually the same on Aboriginal people as we do on the non-indigenous population and Aborigines are three times as sick. It means that there is not enough money to provide the doctors and nurses to treat the sick, let alone to provide the services required to break the cycle. In this the Commonwealth government itself, not by intent but nonetheless, spends for every dollar on non-indigenous people 63c on

the indigenous population. It is untenable for the national government to be in charge of the one government which is not making any headway. I do not blame the current government. This is an issue over many decades, but it is untenable to spend less on people who have worse health.

We need a plan, we need community control, we need a needs based funding formula and we need a national training strategy. With 30 doctors, the number of nurses going backwards, one or two dentists and hardly any allied health workers, this calls for a national training strategy. We need a 10-year to 15-year commitment to address the much more expensive infrastructure issues of housing, environment and education. We have also urged that you track the spending on the Commonwealth Grants Commission. Where states get a loading of extra funds, because of the needs of Aboriginal people, it would be nice to know that the money that they get, because of that need, is actually spent on it.

Fundamentally, what I am suggesting to the committee is that the committee has a unique opportunity—one which I think is the best in decades. There is the conjunction of the year 2000, the final year of the reconciliation process and the Olympics next year. This provides the best conjunction for the nation to decide that it is not going to go on lacerating itself with a piecemeal, incremental approach which basically does not get anywhere. But a commitment should be made—an affordable commitment, too, I might say. The sums of money involved in providing a decent health service are probably of the order of an extra $200 million which would be achieved over a period of five years and shared between the Commonwealth and the states—much more the Commonwealth than the states because they have not paid their share.

CHAIR—Do you want the states to spend what they say they are spending?

Mr Meaney—The states are spending $2.20. I have talked to Deeble about what he thinks is a reasonable kind of thing. Deeble argues—and I do not necessarily agree with him, but he has been close to these processes for a long time—that, even though the differentials are about threefold, a differential of about 2.5 is eminently defendable, and I think he is right. I think it is cautious. He argues that, because the Aboriginal population is younger, then the need for a threefold differential is not as high. I do not support that because the things that occur in 70-year-olds occur in 50-year-olds in the indigenous population.

CHAIR—We might come to the detail later. Did you want to wind it up? I think you have done a wonderful presentation in terms of the general approach. You have basically said the challenge is there in front of us, and it really is a matter of national pride that we should just get on and do it.

Mr Meaney—Yes. If the committee were to call for a millennium initiative which would make a definite commitment to see an adequate health service provision within a scale of five years time, to make sure that resources are needs based and to address the deeper underlying issues of housing and environmental issues, it would have made a contribution which this country has been waiting for for the last 30 years or more.

CHAIR—Thank you. I think we will break at this point, unless there is something that you wanted to put, Jill.

Ms HALL—Yes.

CHAIR—Before you do, I want to reinvite people to the table. Come forward. We have had a few new people come in.

Ms HALL—I want to slip back to what we were discussing before. I have one question that I wanted to ask. Do you think that it would be beneficial if every medical student was required to complete, say, a three-month placement in an indigenous community as a core component of their degree course?

Dr Brown—Ideally, we would see that as part of a range of initiatives for all medical undergrads. We still think it would be very important that they have course work in lectures of cultural awareness experiences as well as clinical exposures. Unfortunately, because of our bad health, with respect to the things that medical students will see in Aboriginal communities, they will be hard pushed to find them in urban centres during their entire medical careers, if that is where they are going to be centred. It would be a great clinical experience, and students are choosing, either in their major medical elective terms, as part of John Flynn scholarships, or off their own bat, to go to communities for those very reasons. Also, they are a valuable resource in themselves for the community, if they can build that relationship with the people there.

They get great clinical experience, they learn not only about medicine but about culture, history and community cohesion. They provide a service to that community. They are part of the team. They are not just a hanger-on who stands in the background and has to listen to a consultant. They are actually hands on. That, in itself, is another great experience.

Ms HALL—I am sorry if I did not preface what I said with the fact that, of course, it would be a given that the cultural awareness and the course requirements would be completed before they could do a placement.

Dr Brown—Even if we get them going early in their medical undergraduate years, certainly that cultural awareness component would be essential. It would be better still if you get people from a local community to do the teaching of that component.

Prof. Hays—I think that the concept of appropriate clinical exposure is an excellent one. The question is: how? There would be major logistic issues involved in having 1,200 medical students doing three-month programs. I think that we risk perpetuating some of the myths in medical education in white society. At the moment, most of the Victorian medical students who want to do an attachment in Aboriginal and Torres Strait Islander health seem to want to do it on Thursday Island because it is a long way away and it is a very nice, exotic, attractive place. But they will not go to the Koori health centre in Melbourne.

Something which I have learnt is that it is a myth that Aboriginal people live somewhere else. The truth is that they live everywhere. A lot of this stuff can be done by attachments in your own town, including the major cities of Sydney and Melbourne. There are some tremendous community resources to be used locally before we necessarily think about exotic, remote places. There is a risk that we continue with, in a sense, the stereotyping that Aboriginal health is remote, it is sandy blight, it is malnutrition and it is—

Ms HALL—That is one of the biggest issues that I have been pushing throughout the inquiry.

Prof. Ring—I support what both Ngaire and Richard have said. I went through medicine and learnt little or nothing about Aboriginal and Torres Strait Islander health. That should not occur any longer. You should not be able to finish a medical course without an adequate exposure to what is the biggest public health failure in the Western world. We should recognise it for what it is.

As to placements, the practical side of things is always important but, as Richard says, there are a variety of ways of getting it. I would be cautious about any program which ended up sending people who did not want to go to a place where people did not necessarily want to have them. There is a two-way element to this. People have got to want to go and communities have got to want to accept them. It is important that whatever process there is encompasses both those aspects.

CHAIR—Ladies and gentlemen, can we just stretch our legs. I reinvite people to come forward.

Proceedings suspended from 10.33 a.m. to 11.01 a.m.

CHAIR—We have new people at the table so would you give us just a quick introduction and one or two key points from your organisation.

Ms Mitrovic-Calvert—I have worked for the past 10 years with multicultural affairs issues and Aboriginal and Torres Strait Islander affairs. For a short while they broke away from the Aboriginal and Torres Strait Islanders but they have included them again now. I have worked with cross-cultural training for multicultural and Aboriginal and Torres Strait Islanders. One of my main issues at the moment is home and community care services and the accessing of home and community care for multicultural and indigenous people.

I feel that the indigenous people do not know much about health issues at all and how to access them. This is something that I would really like to know more about and discuss as an issue today.

Mr Miller—I have been around here for about 28 years in Cairns. I worked with the Aboriginal health program quite a few years ago for a number of years. For the last year or so I have been working with the Cairns City Council with the alcohol problems among the kids. While I was there the position had run out and they had no more funding so I went. But I have just recently come back and I have been elected to the regional council. We have just come back and we are setting up with the ATSIC organisation. We will have our positions to fit into. We will have to have the zone meeting before we do that. I have been interested in the Aboriginal health program over many years. We have plenty of problems around here—especially the alcohol problem—with all the indigenous people in the outlying area.

CHAIR—Thank you very much.

Ms Archer—I work in community health as a registered nurse in Yarrabah which is about three-quarters of an hour's drive from here. It is an indigenous community of about 3,000 people. I am one of the two registered nurses working in the community outside the small hospital that is over there. The small hospital is a 10-bed capacity hospital. I do not actually know the staffing levels so I cannot give you those. Wendy might know them. My main focus is in child and family health.

Mrs Miller—I am a senior health worker in Yarrabah.

CHAIR—Okay, thank you. Did you have any particular issue?

Mrs Miller—No, not really. I am unprepared at this stage so I will just listen in.

CHAIR—Okay, that is fine.

Mrs Tanna—I am a local Murri. I am a founding member of the Wuchopperen Aboriginal Medical Service. At present I am on leave without pay from my regular job, which is the cultural awareness coordinator for Queensland Health, based at the North Queensland Rural Health Training Unit. I am also the Chairperson of Mookai Rosie Bi-Bayan, an organisation that provides accommodation and support for women and children, mostly from the Cape and Gulf areas, but also from other areas. We not only take pregnant women, but also other women as well.

Ms Levers—I am Manager for Mookai Rosie Bi-Bayan. Sandra just explained a little bit it, a child and maternal centre. I am here today because we saw the notice in the paper coming back from the Cape at the weekend. I said to Sandra at the weekend that we never got much advertising or anything for this meeting. It was only in Friday's paper. I noticed it and wondered whether other organisations around town here knew about it because it was talking about indigenous health right across the board.

CHAIR—Just in response to that, as the committee had been here 18 months or so ago, we are really coming back to re-check with community people. I am sorry if the notification was a little late.

Mrs Nona—I am from the Wangetti Education Centre. I work as a female student counsellor. We have a medical centre there. I would like to highlight the fact that we have not had a dental visit for two years, and we have all indigenous students at the school. Our nurse has to apply each year just to get funds for her wage, which I think is not right.

CHAIR—Who do they apply to?

Mrs Nona—The Commonwealth health people. I have the submission.

CHAIR—You might pass that to our secretary, unless you want to read it now. Do you want to advise us now?

Mrs Nona—No.

CHAIR—All right, thank you very much.

Mrs Peeters—I am a consumer. My issue is the stolen generation, which is a very big health issue because it relates to unresolved trauma. We are affected by unemployment and all those other social issues. I came along to see whether the social issues were being addressed at this meeting because I think Aboriginal health is affected by unresolved trauma. I think all medical practitioners need to be advised or be aware of this.

CHAIR—Thank you very much. I appreciate you being here today. We have got a couple of hours. There are some issues that I certainly need to deal with, and I know the committee needs to deal with. I want to quickly revisit those issues, so people giving evidence might consider these and help us, although they are not to exclude any other issue. I mentioned the framework agreements earlier and the Commonwealth-state relationship. So anything that contributes to how we might try to deal with this issue of our Constitution, how the federation works and how the Commonwealth-state may work together in a better way, will be appreciated. We are very open to that.

This morning I have not heard too much about mainstream health services and how, for example, this community would relate to the Cairns Base Hospital, or whatever you call it. I think we have people here who are health workers from within the hospital. Can you tell us how the mainstream services relate to the Aboriginal control services, and how they relate to the Aboriginal community generally? I think Wendy will be able to say something on that, and others too, please, because we need to understand that.

Education has been given a very good overall discussion this morning, in terms of some of the general issues that we talked about with the visit of the US surgeon-General and our own federal minister. One area that really I would appreciate some advice on is cultural. When we say 'cultural', what are we talking about? What is the reality of culture in terms of health? What does it mean from a practitioner's point of view or from an academic's point of view? What does it actually mean? Can we try to flesh that out a bit? I will leave it at that and try to keep pushing it along to draw out those issues and, as I say, all other issues. Jill, did you want to open the batting and head off with a couple of questions that you have? Alby, I know, will want to talk about accountability and the Commonwealth Grants Commission and issues like that. We have a couple of people ready to go and I am sure others will want to kick in.

Ms HALL—Yes. The issues that I would like to ask questions about at this stage—and I am particularly interested in hearing from people who are involved in the communities—are the options in the discussion paper on pages 15 to 17. We are given possible directions A, B, C and D talking about the direction that we could possibly go with health. This is a very basic summary: A is to support the current arrangements, B is more responsibility for the states, C is for the Commonwealth to assume more responsibility and option D, which is a new approach, is to establish a separate agency with a high degree of community participation. In other places we have also been given other options. It is up to you to give us some idea of what you think would be a good approach.

Mr SCHULTZ—Perhaps an E approach which may be a combination of a number.

Ms HALL—Yes, E, F, G and H or whatever you would like to make it.

CHAIR—Does anyone want to open the batting on that? Do we want the states to run it exclusively? Do you want the Queensland government running it all?

Ms HALL—How would you like to see it run? What are your ideas?

Mr Meaney—I would go for the option where the federal funding went immediately to indigenous controlled organisations appropriately structured and in the community where they are dealing with on-the-ground stuff right at the coalface every day. There are all of these other options and I am interested in D which is just another level of bureaucracy to soak up the funds that are short anyhow—likewise, all of the others. If it went straight to the organisations charged with the responsibility in the community of delivering health then if it did not happen you could ask the question why and look for ways of fixing it.

Mr QUICK—You obviously need to put sanctions in. That is a touchy issue because some people might accuse you of racism, nepotism and all the other isms that are around. But if we go that way and, to my mind, it is a positive way, how do we support and encourage those who have already gone that far and done it and those that are sitting on their hands waiting for the cargo cult plane to fly in again? How do we put some sanctions in to give them a kick up the bum culturally?

Mr Meaney—I think that has to come from the community itself. If it gets any other kicks in the bum it smacks very much of colonialism.

Mr QUICK—We have been there and seen it. We have seen the ones that are doing the right thing, working on a fixed budget for 38 hours a day and not getting any thanks and the others sitting back and still getting the same basic services and, in some cases, more because they are perceived to be more disadvantaged than some of the others who have actually got up and done something. If we do hand it to the communities how do we ensure—

Mr Meaney—It has to be the responsibility of the representative bodies from the community to sort those issues out and ensure that there is a parity in funding and a parity in services, and those who sit back on their hands and wait for somebody else to do it will need to be held up by their bootstraps and told to pull their bloody weight.

Mrs Tanna—I was just going to say that Aboriginal control does not have to be only in organisations and communities, even though I think that is the better option, as long as the framework is a strong steady one. I think that there are Aboriginal controlled programs within government departments that seem to be working quite well. I think that they need to be strengthened more. One of the problems I see is that there are many non-indigenous gatekeepers who are holding back the process and the progress of Aboriginal health.

CHAIR—Have you an example?

Mrs Tanna—I could give you heaps of examples.

CHAIR—But that is very helpful. That is a good example—the gatekeeping that is impeding.

Mrs Tanna—Working in cultural awareness, my responsibility in the North Queensland Rural Health Training Unit is to make sure that everybody who goes to communities, and in fact everybody who works in Queensland health, receives cultural awareness training. I would say that, because we have had some problems within some areas getting cultural awareness into those places, we have just seen some problems in one of the gulf communities. I would venture to say that if cultural awareness was a bigger part of what is happening in those places, the problems just would not be as much. I want to keep on talking but I will leave it there for a while.

CHAIR—You are very welcome to come back. Wendy, would you like to have a go in some of this area? Do you want to come to your particular area as well?

Ms Sexton—I agree with what Sandra is saying, but I think one of the big problems we face up here, in particular with Cairns base where the main service delivery is happening—or with the Cairns district, for instance—is that all dollars that are coming up here in particular for indigenous health are not earmarked for indigenous health. It just comes into that one big pool. When it comes to actually implementing or doing service delivery which focuses on indigenous health, it is just not done because we do not have the dollars to do it. When it comes to putting in what people say we need more of, it is 'Oh no, we haven't got the dollars.'

We have an instance at the moment with hearing health—Phil would probably be able to back me up on this a bit more. We have a hearing health unit that has been set up here since the Aboriginal health program was around. Of late, after regionalisation and now that we have our districts, this unit is not able to go across districts to do training or offer services such as school screening to pick up children's hearing problems because all its funding has gone into a centre's budget. This has hampered it in doing its service delivery.

CHAIR—Which alternative budget?

Ms Sexton—A centre. We do not have an Aboriginal and Torres Strait Islander unit in this district as other districts do. Our Aboriginal and Islander health up here just comes under the community health, whereby in Cairns we have a centre in Edmonton, Westcourt and Smithfield. Yarrabah comes into the Cairns district and so does Mossman and the Aboriginal communities of Hope Vale, Wudjal Wudjal and Cooktown. That takes in the Cairns district health. It is probably something you know anyway. But the indigenous dollars to those districts are not earmarked indigenous. It just comes into the centre wherever you operate from. That is what the services get delivered by.

CHAIR—They are therefore not necessarily spent—

Ms Sexton—On indigenous issues.

CHAIR—Okay.

Ms Sexton—I have a real problem with that. As for the cross-cultural awareness stuff, which Sandra touched on, I see that as a really important issue. At the moment, at Cairns base we are not meeting the minimum standards for cross-cultural awareness as put out by Queensland health. One of the recommendations I made to—I forget the man's name—when he was asking what should be included for doctors when they go to unis and things like that was that in their training they include a cross-cultural awareness module when they are learning to be doctors.

CHAIR—Can you give me one or two things that are practical that you actually have to do in cross-cultural? If there were two things, what would they be? What is critical in culture?

Ms Sexton—I would say communication is one of the main ones.

CHAIR—But in terms of the difference, what would it be? What should I, as a whitefella, mainly respect? If I am going to see an Aboriginal patient or an indigenous person, what should I be sensitive to?

Ms Sexton—That they are an Aboriginal person.

CHAIR—How do I do that? Give me a couple of clues.

Ms Sexton—We have our coordinator over there.

Mrs Tanna—I would say, in a nutshell, history and kinship but I would absolutely hate to separate that from the rest because it is far too vital. When we go to Cairns base and other hospitals with people who do not want to spend too much money on cultural awareness because they do not think it is important, they say, 'Just talk about communication.'

We say, 'You can't just talk about communication because if you don't really know what is happening in that person's mind, how are you going to know what they are really communicating?' The cultural awareness that we actually do has been cut down from three days to two days so we are always cramming. District managers and others do not want to spend all this money on cultural awareness, even though it would make their jobs a whole lot easier in the end. I would say that is a really hard question because you cannot separate all the issues that we have to talk about. You cannot cram in 200 years of history, or colonisation, into just two topics.

CHAIR—Certainly acceptance and recognition.

Mrs Tanna—Absolutely, and acknowledgment too. That is a lot of what the issues are that the Prime Minister talks about. The acknowledgment is not really there.

Ms Cadet-James—Cross-cultural awareness in education is really a great starting point. I teach in that area myself too. I also think that if we are going to be committed we need to take it one step further. It has to be a commitment that is taken on by organisations to make sure that there is a strategy in place so that the organisation changes its practices. It is no good giving cross-cultural awareness to people if they are going to go back into a system

where they are not allowed to apply what they have been taught. They cannot do that if the whole organisation does not have a commitment to saying, 'These are the strategies we are going to put into place to make sure that indigenous people's needs are really looked after when they come to this service'—whether it is community health, rural health or whatever.

With that, I think that we need to be reminded continually that knowledge, expertise and skills come in different packages. Indigenous people have a whole range of knowledge that is just as important as non-indigenous knowledge. Therefore, when people are planning, right from the assessment stage indigenous people need to be involved. It is no good involving people down the track when the strategies have been put into place. They have to be involved to put across that world view of cultural values and belief right from the time the people get together and say, 'We have a problem' or, 'We have a need.' It is no good doing it down the track. At different stages I think it is really important to have that partnership between mainstream and indigenous people. At any one stage there will be different leaders. Sometimes there will be indigenous people that are leaders and sometimes it will be non-indigenous people that are the leaders. It depends on what you are talking about at the time. In terms of whether this is going to work, who should be involved and who should be the leaders at this particular time, that will change if it is a true partnership between the two groups.

CHAIR—Is there someone from Cairns who works with Cairns hospital? You are the people from Cairns.

Prof. Hays—My point of view is as somebody who has been through cultural awareness programs as well as being brought up in the region. Now I am requiring that all our academic staff go through our cultural awareness programs, and all our medical students will. We have been doing this for a couple of years, and the thing that the non-Aboriginal students value most about the workshops is the opportunity to listen to people's stories. For the first time, sometimes, in their lives they actually listen to Aboriginal and Torres Strait Islander people as people rather than as patients with a health problem, because, yes, everyone can be a patient from time to time, but this is a very personal relation of stories.

It is very easy for us to think that the stolen generation was a long time ago and there are not many of them left. We are surrounded by them. It is very easy to think that deaths in custody occur somewhere else, but the prisons are part of our community. It is very easy to think that all those sick Aboriginal people we see on TV do not live here, but they are here. We are surrounded by them, and many of our Aboriginal families have very frequent deaths in their families and extended families. It is not about people like me talking; it is getting the people who belong talking about those issues. We have had several almost career changing events at these workshops. And it is simply listening.

CHAIR—It is not a difficult, complex thing. It can be very complex, but it is that essential acceptance and listening.

Prof. Hays—Shall we just say it is hearing, not listening.

CHAIR—Okay.

Ms HALL—Thanks very much for your answer to the first part of the question on funding. There are three components to the next part, and I will ask them all together. One is on the current practice of funding programs for one thing, then 12 months or two or three years down the track you find out it is a very successful program and then it is not re-funded. What is your answer to that? Do you think there should be a lump sum given to a community and then that community is able to prioritise the areas and the programs that they want to run, or do you think the current system of funding specific programs is the best way to go?

Two, what do you think of the coordinated care programs? Maybe you know the Tiwi island program. The Tiwi island people are very pleased with the results that they have achieved up there, but, on the other hand, NACCHO has said to us that they have some concerns and that maybe it is taking away from community control in some ways.

Three, do you think that, with the current way programs are funded, the communities that know how to play the game and fill in the forms are the ones that get the funding and are not necessarily the communities that are in the greatest need, so that the communities that are in the greatest need are the ones that miss out because they do not have that knowledge to fill in the form and play the game?

Mr SCHULTZ—Can I add a question with regard to the funding allocation. The funding allocation is very professionally manipulated to build up an empire of people who devour a large percentage of the funds with their organisational structure, in terms of supplying people with cars and those sorts of issues. Is it true—this is the information I keep getting—that there are people out there who are frustrated because they have an enormous need for those funds but they are continually being told, when they question why they have not got them to deliver a very positive health outcome, that they need to go elsewhere and then they find themselves facing a very high brick wall to try to get some satisfaction? In other words, in short, how much of the funding, regardless of where it is targeted, is reaching the people in need? And do you think there is a need to get to the nitty-gritty of identifying where the government can tighten up the administrative role in those funds?

CHAIR—There is a number of questions there. I do not know if anyone wants to have a go at one of them or a part of them. John, would you like to lead off?

Mr Meaney—First of all, I would like to take issue in general with the shortfall in funding overall in health. The federal government currently has upped the ante on the Medicare levy in order to support troops in East Timor to clean up the mess of the Indonesian government regime. We support the same regime with massive amounts of foreign aid which usually end up in the clutches of corrupt elite. The other issue is that the same politicians who organise all this at the top are usually taking their advice from senior bureaucrats, and it does not matter what political flavour of government is in, it usually ends up the same: the first thing that gets hit is health, welfare and education if there is a shortfall in funding somewhere. It is about time the politicians took the bullet and bit it, kicked those senior bureaucrats firmly in the back of the lap and told them that they are not running their own agendas anymore, that the elected representatives are going to make some decisions on their own about where those initiatives should end up.

CHAIR—Can you give us some detail? Can you give us a program and an example where you have seen it happen?

Mr Meaney—I am recently retired from the state department of Aboriginal and Torres Strait Islander policy and development. One of the excuses I used was poor health, because my rickety frame did not want to do it any more. But the other reason, and probably more to the point, was that, as Sandy mentioned before, there is this top-heavy level of gatekeepers. This is a department dealing with Aboriginal and community development, and I was employed as a community development officer. We had a charter to go out and say to people in the communities, 'We can give you a maximum of $30,000 in order to generate a community development plan.' The community then goes away and puts in a submission and they get their $30,000, or whatever, to do their community plan. The plan comes back and there is no money to implement that plan. You have lost the impetus, you have lost the enthusiasm, and the plan is stuck on the bloody shelf. What are you going to do with it—wallpaper the gunyah? That is how it is.

At the same time there is this increasing level of gatekeepers. And some of them, I might say, are totally inappropriate to that area of work because they are totally unsympathetic. They are there for their own particular agenda, to climb the career ladder and, as soon as they have achieved a level here, they might hop off somewhere else and try to achieve a greater level so that they go out on a better pension at the end, and they have absolutely no interest at all in achieving development out there in the communities.

CHAIR—Thank you. Jill, are we getting somewhere near your issues?

Ms HALL—Yes. I noticed Yvonne was responding with body language when I was speaking before. I would be interested to hear from her.

Ms Cadet-James—There has been some success with funding individual programs, but, as I said before, I do not think it is going to work if everyone is just out to look after a particular part of the body, whether it is the eyes or the ears or whatever, because of the mass problems in some of the communities. It is pointless having a big regime to look after, say, eye health if there is raw sewage pouring through your community and through your house and there are 10,000 people in your house and the kids are starving. Looking after your eyes is great. However, there is a need to look at the bigger picture and look at how we are going to deal with that. Eye health might be one of the problems in that particular community, but it is not going to solve the underlying problems.

Ms HALL—The issue of the communities in most need missing out on funding—would someone like to take that up?

Ms Mitrovic-Calvert—I would like to be able to say that there should be a grants advisory committee looking into how grants are allocated. As I think Barry said, there are the people out there who can manipulate where the grants are going, to where there is not really a need, when those grants are allocated. This advisory committee could look into it to see if that community, which is only empire building for themselves, really does need that funding and whether that funding is being addressed in the right way.

CHAIR—Would it include people from the Commonwealth, the state, or both, or from the local or regional level? What are we talking about here? We have this Constitution and this Federation. What we are going to be required to do is to make practical recommendations which are really to do with the machinery of government. Whatever our personal frustration might be or whatever our ambition to achieve something might be, there are limitations on members of parliament within the Constitution. We need to try to understand the levels of government. Are we talking about Queensland? Are we talking about the Commonwealth? Are we talking about the regional level?

Ms Cadet-James—I think it is the whole lot. I have been working in communities for quite a long time. You might get to a community, if you were a state or territory representative, only to find that your Commonwealth counterpart has been there the day before with a different bucket of money and looking at a different issue. You might also find that on the same day you are there you might have representatives from other government departments that are looking at things which are similar to what you are looking at, but you have no idea what is going on interdepartmentally. So it is across the board. People jealously guard their program or what they are doing. There is not even communication between the departments at the state level, let alone between the two levels. Then you have the local government issues as well, where people are doing different things.

Mrs Tanna—I think there is also an issue with people responding to what government grants are available rather than what needs are actually there. From my experience with Mookai Rosie Bi-Bayan, we have been successful in getting some moneys for an 'our way, strong way' program which is dealing with the nutrition of both infants and mothers. We have been frustrated all along the way in terms of time frames. Somebody mentioned time frames before. Our time frames here in Cairns do not correlate with what happens in Brisbane and neither does it correlate with what happens in the communities. So that has been one area of frustration.

The needs that the government requires are not always the priority that the community sees. When we are talking about funding of body parts, we have been focusing on the nutrition of babies and mothers, but we also have to look at the bigger issue of what is actually provided in the stores. How much are those foods and does the price of those foods go up when the wet season comes? What happens with the GST and all those sorts of issues? There are other related factors. There are the social implications with so many people living in the house and so many mouths to feed, including the little ones. John and Yvonne have both talked quite a bit about that.

We are seeing that even though we are focusing specifically on a body part—two body parts, the mother and the child—there are much wider implications and we have to look at those things more broadly. So the money is not enough. Also, the way that we are required to spend the money is not what we see as the priority.

CHAIR—That is what we are trying to do, particularly with, say, option D—a pooling approach which recognises that each community is different and there will be different priorities. But the pooling of Commonwealth, state and other money should be targeted at that community need. The issue that we immediately come up against is what we call community capacity to define.

Dr Brown—There are so many things to comment on with respect to all of those issues. I feel that it is a Commonwealth responsibility. It should be under the umbrella of the Commonwealth, which looks at the coordination and accountability of funding for Aboriginal and Torres Strait Islander health. Of course, the Commonwealth will tell you that it spends a lesser proportion overall on Aboriginal and Torres Strait Islander health. The states will tell you that they are therefore taking the responsibility upon their own shoulders.

Most of that money is taken up in transport issues and tertiary care, because our people are so sick that, by the time they get to a medical institution, they will go straight to intensive care—do not pass go; do not collect $200. They suck up resources in that way. Only a small proportion of that spending, I believe, is going to specific medical issues, to health services or particular body parts grants. The idea of coordination and accountability for any funding should be overseen by the Commonwealth. It should be a national priority. Otherwise, depending on the individuals—

CHAIR—Should it be pooled? Can we get to the nitty- gritty of the framework agreement? I hear what you are saying about the national part. Do you want to respond to that?

Dr Brown—In terms of the framework agreements, I think they are a great idea. It is bringing different groups together and they are agreeing on a principle that they should all be involved. But where is the accountability in that? What is going to happen if they do not keep up their end of the bargain in a framework agreement? Nothing, at the moment. If that money is made part of that agreement, if it is a matter of saying, for example, 'You said you would provide this service for this number of communities with this funding; you didn't do it,' therefore they should lose in some way, that is one way of looking at it. There has to be something tied into the framework agreements so that, be it states or territories, it is worth their while that they partake and that they take responsibility. Does that make sense?

CHAIR—That is fine.

Prof. Ring—I would like to support the notion of funds pooling. We have these framework agreements at the moment and they are an agreement to cooperate, if people want to cooperate. It is essentially words at this stage. It is a vehicle which, if used properly, would work. The way to get better value out of that is funds pooling, whereby it is an agreement process so that funds are linked to the achievement of outcomes: 'I give you X dollars, you produce Y services at these levels of volume, quality and price.' It is a fairly tight agreement process within the context of a long-term planning framework.

The other essential requirement is that, at an area or regional level, it is community controlled. You have community control, you have a long-term plan, you have agreements and you have funds pooling. The lever on this might well be that the Commonwealth will have to address the issue of spending less on people who are sicker. When it does so through the MBS and PBS, it could use its dollars to lever more action out of the states. You might have a ratio of two to one, Commonwealth to state, or something of that nature, which would see equity between the Commonwealth and the states. Something along those lines has been found to work in other areas and offers reasonable prospects of being accepted by

the Commonwealth, states and communities, thus moving forward in the way that is necessary.

Mr QUICK—What about needing to include framework agreements not only with Commonwealth and state health, but with housing, juvenile justice, education, and in the provision of decent infrastructure for communities? How the hell is it going to work? From what I have seen of local government, having wandered around remote and rural parts of Australia, if the Commonwealth is going to pick up the tab, they figure that they are saving money here; the roads are hopeless and the airport infrastructure is pretty terrible. But so what?

The Commonwealth-State Housing Agreement is a prime example of how hopeless framework agreements are. You have a framework agreement with Commonwealth-state housing, Commonwealth-state health, Commonwealth-state education—which I say is bloody hopeless, as a former teacher and principal. This is going to be a super framework agreement with sanctions. But how are we going to sanction, for example, Ipswich City Council regarding the road out to community X, 200 kilometres away, which is under their auspices? They will say, 'Where are we going to find the money to put in a decent road?' They might not have any sewerage system, or they might not have a decent teacher who is culturally aware.

CHAIR—We are defining the problems, but we are not doing too well on the solutions at the moment. However, it seems to be coming through that the framework agreements are still our best hope under cooperative federalism. I think Ian is saying the pooling gives us a better hope than other options.

Mr QUICK—I was really impressed with Ian's presentation. It really set a fire going in my belly. I would like to think that somewhere in the six states and two territories there is this big bag of money so that no-one can have an excuse to say it cannot be done. The money should be there to ensure that Jenny, with her innovative system to stop the incarceration of young kids in prisons, deaths in custody stuff, has what she needs. The money should be there so that the teachers out at Kintore in the Northern Territory get adequate resources. It should be there so that any of Richard's students who are out wherever they are get what they need. No excuses should be accepted. How do we put that in place, Ian? We can send rockets to Jupiter and get back messages but we cannot provide basic human services to people in our own country.

Prof. Ring—Three layers of government does not make it easy, but it is not impossible. There are a couple of answers. In terms of health services, we need to recognise that it is patchy, rudimentary, fragmented and care focused at the moment. Ngaire is absolutely right, the Commonwealth pays for care; it does not pay for services to stop people getting sick in the first place. That needs to be rectified. We need to have a view of what adequate health services are like and a commitment to get there in five years or, at the outside, 10 years. We have to resolve that that is what we are going to do as a nation—ensure that we are going to have health services of a kind that you can see in other parts of the country.

We need to get away from the notion that a two-tier system is okay for the non-indigenous population. It is not okay. We need to resolve that we are going to fix that in five

years. We need an agreement process which sets that as a goal, a process which levers the states into action through the Commonwealth redressing its own responsibilities. Such an agreement is a workable arrangement because it is not a leap into the dark. This is the way much government business is now transacted. As for the funds pooling, there will be a bit of jockeying over that, but that is probably doable to a greater or lesser extent.

On the other issues, I guess all of these things have got to be tackled issue by issue. Where are we in housing now? Where are we in education now? Where should we be in five or 10 years time? We ought to say that this is where we are now and this is where we are going to be. That is what is lacking. We have to get away from this bid-driven process. A bid-driven process means the person who is the best bid writer gets it. We need to get something on a per capita needs based approach, rather than a bids driven thing.

I do not think there is any easy, quick answer on this. It is agreements with teeth that is needed. The Commonwealth must exercise national leadership by using its funds as a lever on the states. It should write it all down as to where we are going to be in X years time and then have that regularly monitored and reported on. But, in the end it is an agreement process—I will give you X dollars and you must produce these specifications. I suppose underlying that is the sanction that if one agency does not do it there is the option of thinking of other agencies.

CHAIR—I am glad you did not say withdraw the funding because the service has still got to be delivered.

Prof. Ring—Absolutely. Punishing people with bad health is not good administration.

Ms HALL—Maybe some of the community representatives might like to comment on what Professor Ring just said. Also, I always think that incentives work a little bit better than sanctions. Maybe that could be something that people might like to comment on as well.

Mrs Tanna—I would like to see something much more practical being done at the grassroots level. I lived in Alice Springs for a while and saw the UPK stuff work quite well. That was transported to a community organisation here and, as a result, they went into a community in the Cape. Lillian was actually a part of that healthy habitat that took place at Pormpuraaw.

That was really about practical things like making sure the light switches worked, all the toilets worked and all the drains worked. The people on the ground were able to see that instead of having tradesman coming in and promising to fix up some stuff, they were able to go in and make sure that those things were actually happening at that moment. I think people should be able to see that there is not only the intent to do good, but the action as well.

CHAIR—That is the theme of this morning—just do it.

Mrs Tanna—Yes. I was going to add somewhere else, but I cannot remember.

CHAIR—It will come back to you and you will get another crack at it. I am going to ask Jim Kennedy a question. Jim, soon you are going back to your normal job where you are going to be one of those Commonwealth gatekeepers. What is the practicality in all of this? As a long-time public servant, and after having seen two years of this, can you give us a glimpse of the practicalities? You have as good a glimpse of this as anyone. You have worked on it. You might even pick up on this issue that Professor Ring spoke about. I want to draw the staff in here because they work with it.

Mr Kennedy—You are very good at putting me on the spot.

CHAIR—Yes, but you know it, and you know it well too.

Mr Kennedy—The practicalities are that the states themselves operate a health system where indigenous health services is only one part. They probably have units, as we do in the Commonwealth, that see indigenous health as a high priority. But they also have a lot of other units that see their own particular area of expertise as a priority. You will always have those competing interests operating right across the bureaucracy. What we need to do in the report, and at the bureaucratic level, is make sure that indigenous health becomes the number one priority right across all of those bureaucracies.

The practical issues are there so that, by and large, the amount of funds spent on indigenous health, both at state and Commonwealth levels, is actually not the highest amount and is not the highest draw on the budget. There are major concerns, at both state and Commonwealth level, about the increasing draw on the budget of other things such as high technology and all those sorts of things.

One of the major difficulties is to make sure that indigenous health becomes, and stays, a high priority. In terms of doing that, a pooling approach which actually takes an amount of money is essential. The difficulty of actually agreeing on what that amount of money is, and ensuring that that is sufficient to do the job, taking that out of that bureaucratic process and letting people get on with the job, is the key to the whole thing, rather than continuing to compete year after year for what the resources should be and how they should be used.

CHAIR—Thanks, Jim. Graeme, do you want to add something in terms of the general principles?

Mr Channells—Quite a number of us were inspired by the things that Professor Ring has said, but he is talking about a doubling or trebling of funding if better health outcomes are going to be achieved. That is the figure being talked about if better health outcomes are going to be achieved. Unfortunately, I just do not see anything happening. The committee may have plenty of things in mind, but I do not see anything like that happening at the moment. Framework agreements are not going to inspire anyone. I do not see anything happening that is going to lead to that kind of a change in outlook on the part of parliament, or on the part of the people of Australia. Is anyone doing anything about that?

CHAIR—In terms of?

Mr Channells—Information. For example, in the clear major points about indigenous health status in the discussion paper it is at least three times worse than the rest of the nation. There are simple facts like the fact that Aboriginal people tend to die 18 to 19 years younger than the rest of the population. There is not even half a page devoted to those things. There are two or three pages of information about trends and changes within the generally abysmal health status that exists, but the story is not put across there.

This may not reflect what the committee is attempting to do. It may be holding things in reserve. I would think that, if one wants to communicate a situation like this, then the facts firstly have to be put forward. It needs to be managed in the way it is put forward in terms of how media are involved and opinion leaders throughout the community are drawn into the process. These things do not just happen; they have to be managed. I am not confident at the moment that it is going to happen.

CHAIR—Graeme, thank you for that.

Prof. Ring—I regard it as essential to build a climate of public opinion to support action. In some way you have to get across a general picture in human interest to tell what is happening. Aboriginal people that I know are sick of spending so much time going to funerals. Without saying what vintage I am, out of the people who were in my primary class, I think one died of a suicide. To my knowledge, every other person in my primary class is alive. Aboriginal people of the same age tell a totally different story. That is a story that people need to understand to get some idea of the impact of these issues in human terms.

On the amount of money, I do not have the numbers in front of me, but the health part of this is eminently doable. I was discussing it with John Deeble, but I will not tell you where. I can check the numbers for you. Say we are currently spending at a government level, then 600 needs to go to 800 to provide a decent health service, or something of that order. It is in achievable bites. An extra $50 million next year and then a further $50 million the year after make $100 million and so on, building up to $250 million over five years. That has to be set in the context of $100 million for infrastructure on Bougainville, $100 million for Kosovo refugees and $1.X billion on Timor. If there is a national will to tackle these things, I do not believe the money for the health part is the issue, provided it is done in a staged, well thought out agreement kind of process.

CHAIR—Thank you for that. I think we are ideally poised to maximise the pressure on that. I am readily convinced that either side of politics will commit themselves to it. The only reassurance that the executive or those who are going to be most powerfully influenced to make the decision need is that the resources expended give us some kind of outcome. My own personal belief is that there is a will to double or treble. We know nothing is certain in life, apart from death and taxes. The reassurance that we will get some reasonable outcome is our challenge. We know we have to do it and we are here today to try to understand how. You have helped us immensely in that and in your submission. Richard, did you want to jump in there?

Prof. Hays—Not at the moment.

CHAIR—To answer Graeme's suggestions earlier on the discussion paper, it was deliberately broad brush with a whole lot of things exactly for this discussion. As Jim or Bjarne said earlier, the whole purpose of that, and the unusual nature of this committee, is that we have not just sat in isolation. We have come back trying to canvass and to gain from you the definite 'No; we don't want that'. We want new ideas. If you were writing the report and you had five bites of the cherry, what would they be? That is essentially for all of us here today, particularly the people of this region, to tell us what your main points would be if you are writing the report.

It is as open as that; we have no preset ideas. We think we know a lot of the problems, but, by gee, we are really grappling with what the solutions should be. I do not underestimate the will in the parliament as a matter of national pride, or whatever we call it—Professor Ian Ring's perspective—but there is no doubt about the will to succeed—but how? We basically want you to tell us today. We have our own ideas but we are not preset. Let us keep going; let us press on and not be daunted. I said that I would be quiet and then I went on for another five minutes. Jenny, do you have something to say?

Const. Land—I have come here today to represent the AC; I prefer to just sit back and listen to the issues as you bring them out. In respect of the issues that Professor Ring has pointed out—for instance, our world status in relation to indigenous health—from a personal level, I think we are a relatively new country and we should not be too hard on ourselves on being up to date with everybody else around the world in terms of delivery into health areas. The important thing there is that there is still a lot of healing to be done within this process. This might take a long time to come to terms with. I think everybody is very well aware of what I am talking about in that area.

Another thing is that, working on a daily basis, police officers are referral persons as well. For us to do our job to the best of our abilities, we need to be able to refer our clients to the different organisations within the town to help them with their particular problems if they have any. Whether they take that on board or not is really up to them. But we need to know what is out there. I have found that a lot of things out there have really doubled up. People are doing the same things in a lot of different areas. An example would be juvenile justice areas, and dealing with juveniles. There are so many different programs; they are all trying to do the same thing. A lot of moneys are being soaked up in that.

I would say that it is the same in the health area as well, with the different agencies, and from all the different levels of health services across the board. I cannot really comment, but an interesting area would be the aged and the services within the community for the aged. A lot of people are still very ignorant about what is out there, what is available and how to access them.

What I am trying to say is that a lot of people are quite happy to access a mainstream service. Sometimes they really do not want an Aboriginal and Torres Strait Islander service. At the end of the day, what we do give out should be combined as a community as a whole. We should try not to differentiate too much between us and them. That is about all I have to say.

CHAIR—That was terrific; thank you for that. I am glad I asked you to speak. We have to press on. It is open for business. If you were writing the report, how would you write it? What are your priorities?

Mr Miller—Since I have been working with the government, I have noticed the health issues in areas. Even years ago, I said to my family that I would like to take them up to the community and have them live up there for a while, just to see how other people live. This is where a lot of people fail. Government bodies and that sort of thing do not go into these areas enough to search around and maybe live in the communities for a certain period to understand the problems in these areas.

A lot of it is with health, as we have all been talking about this morning. Over the many years, people have been trying to rectify these matters but I still see people coming to Cairns for treatment, and that sort of thing. Why should that be so, when moneys have been poured into the funds to help Aboriginal health. They are still not getting the full amount of it. When people come to Cairns from the communities, what always happens is that they come into these areas and get stuck here. Getting back home again is the big problem. They get caught up here with their own relatives, and things like that. The chairman, or whoever is running the community at the time, does not want them back there again. If you ask about the reason, they say that things have happened in the past and they do not want them back in the community. But the thing is, who has to put up with the people living in these areas?

I believe that people have a right to live where they want to live. When people live in a community, with its kinship and traditional ways, they should go back into the community, into the ways they have been living over many years. They have been brought up that way.

Why is their health deteriorating? We should be up there at this stage. Next year we are in the year 2000. How far are we going to go before things get better? As Professor Ring was saying, people are dying in the communities. We always seem to see a lot of funerals from day to day. A lot of them are Aboriginal people. So where is the failure? That is what I am always asking. There is a failing situation there. Is health going ahead? What is going to happen in five years time? Are we going to come back around the table again and try to sort things out? Are we going to get anywhere with the situation? Are we going to build on the meeting we have here today, or whatever, no matter what it is?

While I am working on this regional council, I will be making sure that funds go equally to all communities to deal with such issues, and in the right manner. Nobody will be getting more than they deserve. I will be working hard. I am sure that a lot of people have been working with Aboriginal health programs, and those sorts of things, over the years, and they have done a lot to try to overcome the problems that they have been facing. However, I think there are a lot more. As Graeme said to you this morning, they have had field officers up there, health workers, in the Mosman area. That is a good thing. We need those people in those areas to deal with the Aboriginal people in those areas, to be able to understand. You have to be able to talk to Murri people in the way that we know. As you said this morning, you do not know our real problems. You have to get the information from us. We certainly will give you all the information that is required at this meeting here this morning. I believe there is a lot to be done. We just hope and pray that things will get better. It is a long, hard road. I think that is all we can do—just keep plugging away at it.

CHAIR—Thank you very much for that, Barclay.

Ms Sexton—Just to go on from what Barclay is saying, I think earlier the NAHS report was mentioned and the recommendations from that. We also mentioned that it had not been implemented. I think one of the big problems at the moment with indigenous health is that a lot of our dollars go into staffing and that staffing is generally registered nurses or doctors in main hospitals. But on our communities, if we go by the NAHS report recommendation for registered nurses, it is one registered nurse to every 300 people.

Going back to the Aboriginal health program days, when the Department of Aboriginal and Torres Strait Islander Affairs used to employ the nursing staff when the hospitals came under that, you only had maybe two or three registered nurses on any one community. Now if you go out to the communities—and in particular it is the Cape communities I am speaking about—you will find anything up to five or six nurses out there, and you might find that there are only two or three Aboriginal health workers.

If we are going to look at health holistically and focus on primary health care, the responsibility for the service for our health comes back to the people. In my opinion, we need to look closely at those recommendations and those ratios and we should be employing more health workers out there who can be responsible and take over the health service in their communities.

What we are seeing out there now is that we have nurses there, and I am not putting nurses down, so please do not think I am. I know we are going to have a need for medical people out there. The ideal thing is to have a doctor on each community, but we have not got that. We are supposed to be working in preventive areas in primary health care, and at the moment we see our communities operating from 8 o'clock to 12 o'clock with just a basic outpatient clinic closing from 12 o'clock to 1 o'clock and opening 1 o'clock to 5 o'clock. In that time of 1 o'clock to 5 o'clock that should be when programs are being delivered in the community, whether it be a nurse or a health worker. Currently you do not see a lot of that happening. We mentioned before about monitoring and evaluating programs that go out. I do not think that this does happen enough and that should happen.

But to get back to my point about more health workers, I think it goes back to history where Aboriginal and Islander people have always been told what to do, when to do it and how to do it. We see a lot of our health workers hang back because there are just too many other staff there who have taken over and are doing the duties in the clinic, and our health workers are not coming forward because of this. But, given the opportunity, one way to improve Aboriginal and Torres Strait Islander health is to have our people out there actually doing the job. That means reducing the numbers out there of non-indigenous or non-health workers like registered nurses and putting in more health workers.

CHAIR—Thank you very much. The comment has been made in other places to us that the career structure and the job opportunities for Aboriginal health workers are very limited. Did I take it from your comments that the opportunities may be there, but there is no-one available? Can you help me with that?

Ms Sexton—The opportunity is there with health workers at the moment. They go through health worker training. I am just talking for this area here. There are a number of tertiary institutions offering health worker training. In Cairns here we have the AIHWEP or the Aboriginal and Islander Health Worker Education Program, or we have the Rural Health Training Unit which offer training courses.

What I see as one of the big problems is that our health workers come in and do the training, but, when they go back to the community, they have not got the opportunity to implement it. One of the big issues that comes out a lot is with registration for health workers. Health workers come in and do the training, but, when it comes to going back to implement it, they cannot because they are not covered to administer drugs, issue drugs, do suturing and those types of things.

I know in the territory health workers who have gone to Batchelor are covered over there. They have got their registration over there. If we are going to make indigenous health a real priority we need to look at it on a national scale. We need to start recognising health workers as a profession and start pushing for this registration.

One of the problems I have faced here when doing this position of coordinator, is that I tried to get health workers come within the Cairns base to practice. I have been around and interviewed different clinical nurses and specialists within the hospital and I asked them how they would see a health worker fitting in to a health worker role working in the Cairns Base Hospital. They could not give me a real duty statement as such. One of the things I asked them was, 'Do you see them doing basic clinical skills, such as taking temperatures, blood pressures and pulse, testing urine and that sort of thing?' They said, 'Oh no, they cannot do that because then they would be stepping on the nurses toes.' I thought, how ridiculous is this? We talk about improving the health service for indigenous people.

CHAIR—And this is what you would think was a relatively simple thing?

Ms Sexton—Yes.

Ms HALL—How many Aboriginal people are working at Cairns Base Hospital and what positions are they working in?

Ms Sexton—There are no health workers at Cairns Base Hospital. There are three indigenous liaison people; a male and a female who do eight to five, and then we have a male—

Ms HALL—Eight to five?

Ms Sexton—Monday to Friday, and then we have a male who comes along from four to midnight from Wednesday to Sunday.

Ms HALL—That is the liaison officers, is it?

Ms Sexton—Liaison officers. That is all we have got in the hospital. We rely a lot on the community health workers and then we have Wuchopperen Aboriginal Medical Service.

Wuchopperen has their clientele and then the community health staff out there have their clientele. But they all end up in Cairns Base Hospital, because we service the whole of the cape and all of Cairns down to Innisfail.

CHAIR—I can see Phil shaking his head there and he looked keen to say something a while ago.

Mr Peachey—I was just following up on what Wendy was saying. Everyone has got to go back to the NAHS report, but in going back to that we have to do what we have done with the Royal Commission into Aboriginal Deaths in Custody and get the states to sign off as to what they have done towards meeting the recommendations. We recently had to sign off on the RCADC and a lot of the stuff that was required. Not a lot of improvement has been done, but at least they are following up on it, and it puts the onus back on each of the states to actually do something about it.

All the states and the Commonwealth have signed off and made indigenous health a national priority because they all signed off on the national goals and targets. But when they gave us the national goals and targets, it comes back down the line to the health workers with no additional dollars to implement the national goals and targets.

We have now been told we have to reduce the difference between life expectancy between indigenous males and non-indigenous males over the next 10 years by a percentage, but no extra funding came with that in terms of health workers.

CHAIR—Who told you that?

Mr Peachey—Those are the national goals and targets.

CHAIR—Within the NAHS report?

Mr Peachey—No.

CHAIR—In the framework?

Mr Peachey—No. The state and Commonwealth ministers met up here two years ago I think it was, and they all signed off on the national goals and targets for indigenous health, including lifestyle targets.

CHAIR—But no resources?

Mr Peachey—No resources came along with it. They are all written into the district health services service agreements to get the money out of corporate office, but again there is no funding attached to it. So we do not get any extra health workers.

CHAIR—This is very important to me. I am sorry for mentioning it in these terms, but I do not know how to mention it in any other way. Who funds you? Is it a regional health service based in Queensland Health, or whatever you call your state organisation? How is it done?

Mr Peachey—I work in the Townsville district health service.

CHAIR—I picked it up this morning.

Mr Peachey—So it comes back through the state government.

CHAIR—There is very little connection across to the Commonwealth; there is a bit of Commonwealth?

Mr Peachey—I work with the Commonwealth department of health workers in doing our planning. One of the big things there is that the Commonwealth provides one-off funding for the drug and alcohol prevention program. That only goes for a certain period and then it just drops out. There is no momentum to carry it on. That is just one program, for example. They fund a lot of that.

CHAIR—That is the practical. As you say, it comes down.

Ms HALL—So your position is funded through the state and you have got permanency? It is not something that needs to be applied for every three years?

Mr Peachey—You can give me a pay rise. It is a permanent position. It started from the Commonwealth. Wendy and I are employed under the Aboriginal and Torres Strait Islander health policy for Queensland. That funding originally started as a new initiative strategy set up by the Commonwealth but it now should be built into the base budgets for the district where we are currently located.

Ms HALL—Your position is state funded?

Mr Peachey—Yes.

Ms HALL—What is the commitment to Aboriginal health in Queensland? Is it good?

Mr Peachey—The Director-General has made indigenous health one of his number one priorities. He has built that into all of the district service agreements across all 39 districts. We have got to address the national goals and targets at the lower level with no more money. Queensland has also got an indigenous employment strategy where it is putting the onus back on the districts to say everyone is aware that we need more Aboriginal and Torres Strait Islander people. This is the initiative and we need to get them employed at all different levels.

The other thing is that there is a lot of talk of mainstream, which is a state health service, versus the community controlled services. In Townsville we see the mainstream services—which is the hospital and community health, which is still state health—and the community controlled services all as one big agency. At the Townsville Aboriginal and Islander Health Service, you can only get so many employees to do stuff in that little bit of building.

Out here in the big world we have got all of the community health and the hospital. Wendy might come down to do immunisations and they say they want Wendy one day a

week. Townsville district have said to state health that they could have Wendy for one day a week for their immunisation. You can have the podiatrist one day a fortnight, you can have the nutritionist, and all of that. It is just to make better use of the resources that are out there because a lot of times it has been seen as a them and us when really they have got the same clients as we get inevitably in hospital. So to save them getting to the hospital, we have taken that step and said to utilise our resources.

CHAIR—How long has that been working like that?

Mr Peachey—Just on two years. It is getting better. We now run cross-cultural awareness for all of the doctors that go through Richard's training. We actually run cross-cultural awareness programs out of the community controlled health service so they have got to see Aboriginal and Torres Strait Islanders while they are in their training.

CHAIR—You can see some positives there. You can see some good things.

Mr Peachey—There are a lot but the thing comes back to funding. All the hospitals in Queensland appear not to be funded properly because they all go over budget. That funding inevitably cuts back. Inevitably that hospital goes over budget. It takes our resources in the community. We are getting told that we cannot do our program because we have got to save the money to cover the hospitals.

Mr SCHULTZ—We have got a Clayton's strategy from the Queensland government. We had Wendy talking before about a simple issue like Aboriginal health workers at Cairns Base Hospital who cannot get the message through the system that they need to be trained for obvious reasons. You are telling us that the Queensland government has got this new beaut strategy that is two years old and delivering absolutely nothing because they are underfunding their hospitals.

Mr Peachey—Which strategy was two years old?

CHAIR—I think you were a bit more positive than that.

Mr Peachey—No, I did not say that the strategy was two years old.

Mr SCHULTZ—I am sorry. I misunderstood you.

Mr Peachey—Our strategy is working with the community controlled health service.

Mr SCHULTZ—Okay.

Mr Peachey—That is a local set-up.

CHAIR—That you do yourselves?

Mr Peachey—Yes, within our district. The district manager is right behind us.

CHAIR—It just makes the point again.

Mr Peachey—Yes. Getting back to cross-cultural awareness, that needs to start in the schools. A lot of our kids are hearing impaired and that started at a very early age. Even before they get into school, we have got to have a program out there that addresses the zeros to fives in hearing health, because that is where a lot of the damage is done. It is no good trying to fix it up once they are at school; they are behind the eight ball already. With that, I will shut up for a while.

CHAIR—That is terrific, Phil. That is exactly what we are looking for. I have got to go to Yvonne, John, Harry and Richard.

Ms Cadet-James—I want to support what Wendy was saying about health workers. I do not think people actually realise what a fantastic job they do on a limited amount of resources. Certainly, it has been my observation that it is not recognised as a profession. The common things with nurses, if you have a health worker, is to say, 'Now you're going to train to be a doctor or a nurse.' It is not recognised that being a health worker is a profession in its own right, with very adequate and very important skills in a number of areas. Not only do we need more of them; we need the recognition by the other medical and allied health professions that health workers are a profession in their own right.

CHAIR—Recognition?

Ms Cadet-James—Yes. I have observed inequalities going around some of the communities too. You see the registered nurse in a three-bedroom house in the community for the length of the contract and the health worker is living in a shed with a little baby. There is no priority on the housing list whatsoever. This is a person that is part of the community, knows the community and lives and works in that community. I think the inequality of that is just disgusting.

CHAIR—Bjarne or Jim might be as good as anyone, but other members might like to chip in. The Aboriginal health worker issue has been consistent. We have talked about, at just about every meeting, the training issues, the recognition, the national competency and those sorts of things. There was something the other day about national competency, but it just will not come to me. My memory is letting me down. Can anyone give us a brief oversight of where we think the matter of Aboriginal health workers is at at the moment?

Dr Brown—I know that they actually had the national conference here about a week or two ago where they discussed these very issues and then incorporated them.

CHAIR—I thought someone could give a snapshot of it. We have come across this so consistently right across this whole issue—the recognition, the importance and the pressure that Aboriginal health workers come under in the community. There is also an issue in the Territory, as I recall, about a debate about the competency.

Mr Kennedy—There are national competencies and they have been agreed. There was some concern initially from the Territory that they were not sufficient to recognise the differences in the Aboriginal health worker's task in that Territory, but they have been amended since then and they have agreed to them. So they are essentially agreed, but there

are no standards in terms of registration of health workers, the agreement on the role of health workers or career structures for health workers anywhere in Australia.

CHAIR—We have to do more work.

Ms HALL—That is right.

Mr Peachey—The national competency standards have been agreed to by everyone, except the National Aboriginal Community Controlled Health Organisation. That is where the stand-off is at the moment. We do have a national review of health worker training, and part of the review team's role is to look at the registration and/or setting up an association, whether it is on a local, state or national basis. Again, the Commonwealth went and paid for a project, which was conducted by Glenis Grogan, to do exactly the same thing a few years ago. So why do you have to go and reinvent the wheel when you have that project document sitting in your office in Canberra?

Mr QUICK—Phil, should there be a national registration, rather than state registration? Let us get away from the rail gauge mentality. For example, people traverse two states and the Territory to get to their homeland. To my mind, irrespective of whether you work in Queensland or Western Australia, there should be a national registration for Aboriginal health workers. So if you decide to pull up stakes for whatever reason and go back to your homeland—in, for example, the Pilbara—you should be able to carry your piece of paper with you and just take up your job. I thought we had moved on from the rail gauge mentality, and the sooner we have a national scheme, the better.

Mr Peachey—That is what we are looking at as part of that review. So if you are working as, say, a level 4 sexual health worker in Cairns, you can transfer that exactly to the same position in WA and also make sure that the salaries are the same, because a health worker in Queensland gets paid less than a health worker in the Territory or South Australia or WA. There is no national pay scale for Aboriginal and Islander health workers. One of the problems with that is for Aboriginal and Islander health workers under that national competency. You can have competencies all the way up to taking blood and all that kind of stuff, but under the drugs act, health workers are forbidden to do so. That has to be signed off at a state level. So it is okay to have a national—

Mr QUICK—But we are here to change that if that needs to be changed, because that could be part of our recommendations.

Mr Peachey—That is something you have to look at.

Mr QUICK—Should we do that?

Mr Peachey—You have to look at it in line with if they are going to have national competencies. It is silly when you have a health worker that can go up so high and have this much competency, when under the state legislation they are not allowed to do so.

CHAIR—We hear that loud and clear. Thank you, that is excellent. Wendy and Cathie, would you like to add something?

Ms Sexton—I was just going to add something in relation to career structures. In Queensland we have a career structure, and I think Cairns is the only district health service that has implemented it properly, but I would say that there is a need for a national one.

CHAIR—Professor Hays, I presume you would like to say something on that same issue.

Prof. Hays—No, it was said by somebody else.

Mr Meaney—I am going to take a little step back here. Phil earlier mentioned the deaths in custody money that came out to the states. A lot of this was supposed to be directed into health, and this is the issue I have always had with Queensland health in this area. That money was instead channelled through the legal system to build new places of incarceration around the community. Mornington Island—$3½ million worth of pink elephant up there nobody uses; Wudjal Wudjal community—$1½ million worth of pink elephant there that nobody will use because it is near a cemetery. That is heaps of dollars that could have been in there implementing this strategy now of getting a decent and appropriate career path for health workers.

Half of these people—maybe not so much in primary health care now because they have been battling long and hard to get where they are for a career path—in environmental health and any other professional levels in the communities are still on bloody CDEP wages. They are getting the same two days a week money as everybody else in the community and they sit back and say, 'Why the hell should I do this because I am only getting CDEP anyhow?' This is the issue I have with the Queensland government because they will not support. They have had the money come through from these initiatives and they spend it on inappropriate bloody white elephants, or pink elephants, or whatever you want to call them.

CHAIR—Thank you, John. Professor Ring.

Prof. Ring—All Aboriginal health workers and their equivalents around the world have been the backbone of health services and health service improvements over the last 20 or 30 years. On the other hand, training for many Aboriginal health workers is a year or two years and so forth. There are two issues here. There are links with the community and then there is the ability to tackle a very large broad and complex job. One of the things that needs to be done is to provide a progression path for Aboriginal health workers into the tertiary stream so that they would have the same status, recognition and salary and be licensed to do various procedures and treatments as their counterparts do all around the world.

I do not think anyone believes that these issues are so easy that somehow or other they can be successfully tackled with a lesser level of training than applies in almost every other discipline. I am not saying that everyone should do it. What I am saying is that for those who wish it, have the inclination and the ability, that progression path needs to be there to put health workers on at least an equivalent sort of platform. There are programs around. We have one at James Cook University. There are others at other universities. In general, they are early and underfunded, but I think it is an important step.

You asked indirectly before: if the money went into health services, would it really improve health? I do not think there is any concrete answer to that. I have not a doubt in the world that there would be significant improvements in health, but health is not just about health services and housing and environmental issues. There is another element which has to do with the healing component, which has been referred to earlier; that is, in a sense the way you feel about yourself and the way others think about you, the control that you have over your own life, the meaning that your life has for you and how that is perceived by you and others.

I do not want to raise contentious issues like treaties because I do not see a treaty happening, no matter whether it might be seen as desirable but treaties were central in both the New Zealand health gain, in my view, and in the North American one—no matter how vaguely worded a vague reference to medicine chest can be interpreted by the courts as an obligation to provide a comprehensive health service. There was discussion earlier: how long does it take? The Maoris dropped the death rate by 30 per cent in a decade. Big health gains can happen very quickly. I think that was driven as much by the courts interpreting the treaty of Waitangi and giving real teeth to it as the health service changes that accompanied that.

I do not know if people saw what I personally thought was a very moving interview with Archbishop Tutu on the *7.30 Report*, and he has been on other public forums as well. But this goes to the heart of the relationship between Aboriginal and Torres Strait Islander people and the population as a whole and its governmental leaders. I think national symbolic gestures can have an influence on health no less central and no less important than the health service changes. There will be undoubted changes and improvements—health service improvements, no doubt—but its control over your life and the meaning and purpose in your own life and the way that is seen by you and others has an equal importance perhaps. Australia as a country has a way to go in addressing those issues.

CHAIR—I can only agree. I think the principle you put before is that sense of self worth, that sense of yourself is critical to the overall sense of wellbeing. I can only agree with you. Thank you for your comments.

Prof. Hays—I just want to raise a comment which goes back to the health care budgets being squeezed and this particular program falling off the truck. I am sure this is an issue all around the country. This part of the world, though, is one of the fastest growing. The Townsville District Health Service is growing by 10 to 15 per cent per annum and its budget is not. I think Cairns has a similar problem. This is particularly a problem in coastal North Queensland, the Gold Coast and the Sunshine Coast. So it is the high growth areas of the country.

In a sense, maybe there is a role for this committee to think about mechanisms for funding that more rapidly follow changes of population growth and service, because there is a significant delay. What Phil said is correct: the thing that drives the Townsville District Health Service budget is what is happening in intensive care, cardiovascular surgery, combined oncology and those kinds of really expensive ticket items which are now progressing way beyond target as they meet the needs of a formerly under served population.

In regional Australia, there is this kind of catch-up which is going to be a particular added problem to the issue. It is much easier to chop this section than it is to close ICU. I do not know if the managers are trying to pick on community sections, but the truth is that it is easier to close community programs than to close ICUs and theatres. A bit of that goes on. Some comment in that regard would be useful.

Just to pick up on what Ian Ring said, something that impressed me most about the successes I have seen in North America was that some of those rural and remote first nations people are indeed first nations people legally. In 1871 they had a treaty with the US government. There was a bit of a war, which was acknowledged, and they technically did not really win, but they had a treaty. At the moment, they can bypass the state governments in the United States and go straight to the Commonwealth government and say, 'I'm meeting you as the leader of one of the first nations of this country and we want to do this.' I know it is probably unattainable here but it is really impressive.

Mr QUICK—Nothing is impossible.

Prof. Hays—Go and sign 100 treaties; that is what I am suggesting.

CHAIR—Professor Hays, thank you for that. We need to start winding it up. I am debating whether to go around to everybody for a 30-second statement, just to say whether you thought this was a useful exercise and whether there was one point you really wanted us to take away. I have a particular personal interest of my own, with Graeme Channells, in the reality of the multipurpose centre and how it works across with framework agreements and servicing indigenous people. I just want to signal that.

Mr QUICK—Professor Hays mentioned in his opening statement recruitment of professionals. I know Jill is always on about more indigenous people being in the urban areas, but that is another problem. What revolutionary things can we put in place, all things being possible, to get paediatricians and ophthalmologists out on a regular basis? Do we have a task force that goes out, so that there is a rotational thing around these regional and remote areas? Is that the starting point? Do we then move to the next step? What do we do? Do we give them an extra $50,000? Should their Medicare provider number be postcoded so that if you go out there, you get an extra 20 bucks a person? What sort of revolutionary things do we need to get them out there so that you do not just have a visit once in a blue moon from a dentist, a speech therapist, an audiologist and so on?

Prof. Hays—There are a raft of packages and you cannot do just one. You have got to do the lot. Unfortunately, until now, outside medicine, not a lot of these have been applied. There are two issues: recruitment and keeping them there, retention. There is a lot of evidence in recruitment that if you recruit people who know what it is like to live in rural and regional Australia, they are far more likely to do so later in life.

I am a good example of that. I was born in a town which had a population of 2,000 people. I spent three years living and working in Sydney and I hated it. I could not leave fast enough. Usually you hear the reverse—people from the city who cannot live in the country. With respect to Commonwealth government initiatives, state initiatives, there are many now out there recruiting people into medical schools. It is still mostly focused on medicine. I

think it has to be extended across the board to get those in. We know they are four to five times more likely to go back—not 100 per cent, but they are much more likely to go back and work outside capital cities later, in any discipline.

Another aspect involves training people outside capital cities. We have only got two medical schools now, with James Cook starting in February, that are outside a capital city. Of course, Newcastle is still a pretty big city. It is hard to describe it as a country town. There needs to be this shift of medical education away from the big cities and the big medical schools need to be putting more of their facilities in rural and regional areas. Flinders is the other really good example of that, in Darwin. UQ has had a program up here which is now becoming a James Cook program. By and large, it is possible to do medicine. Most medical schools have very few rural background people in them. They do not get exposed to rural issues except in a demeaning way. There is a whole set of issues to do with how medical schools and medical education operate. You have to have postgraduate training available as well.

Once you get people out there, the next critical step is who their life partner is, because most people will happily work wherever they are and they do not notice where they are, but they might have partners or family issues that intervene. So a very critical issue is choice of partner. That is really tiger country. I cannot get into that too much. There is no doubt that if you get rural or regional background people together, they are more likely to select each other. One of the greatest tragedies is that a lot of rural women in particular would go to an urban environment and get married to some urban specialist in law or commerce who cannot get a job outside a capital city. It is a very common scenario.

Another step is keeping them there. This is where the financial incentives help. Most rural practitioners in medicine earn a lot more than urban practitioners. It is different in the other disciplines outside medicine. I think they need to have salaries boosted. Even so, in medicine, some aspects need to be more highly paid because the cost of living is higher and the cost of running a practice is higher. We have done a lot of research up here. We have recommended strange things, like every three years giving rural doctors a bit of a sabbatical so that they can go away, recharge and come back, because the workload is high.

There is a whole raft of strategies which we could talk about for a week. Sadly, very few of those directly pick up on Aboriginal and Torres Strait Islander recruitment issues. Some medical schools state that their tours around rural schools also target Aboriginal students, but I do not actually think that is true. I think you need a completely different strategy. I presumed your question referred more to anybody doing medicine and ultimately working in a rural area.

Mr QUICK—We have had this posed to us: if they do go out and do three years at Yuendumu, Kintore or Bathurst Island, how do we put in place a scheme so that they can come back to Sydney or Melbourne if they want to send their kids to high school and so that they are not disadvantaged in the hierarchical medical system and are not punished for the expertise they have gained?

Prof. Hays—In actual fact they are not. This is a common mythology—that people who do that suffer. I think they mostly get picked to do very good things. That has been my

observation and experience. But it is a perception. Yes, you determine a definite career structure. I think people who spend five years in very remote areas probably need to have a home unit bought for them on the Gold Coast as a reward. I actually do not want a Gold Coast unit. I think many people are made to feel guilty when they go and spend five years in the country and then leave. They feel they are failing, when in fact they should not be made to feel that way. They have done a good job.

Ms HALL—When we were talking before about treaties, Lorraine said she was particularly interested in social and emotional issues and the trauma that was being caused by the stolen generation. I imagine that issues of land, ownership and reconciliation treaties would also be involved. I thought that she may like to come in on that issue.

Mrs Peeters—Most of us in this room know that history related trauma, being dispossessed, is the core of our health in communities. I wanted to touch on health workers. Health workers are out in those communities. They wear many hats: they not only do the job they are hired to do, they are baby-sitters, they are mental health workers—they are everything. Their career job is not recognised as it should be, I do not think.

In answer to the question you were asking before about programs, I think any programs going into communities should be really looked at hard to see if they are done in partnership and that the community this program is going into is consulted as to whether this is what it needs. There are too many programs where people in organisations have made big dollars on writing them up, throwing them into communities and saying, 'Hey, this is what you need.' Communities are not consulted enough on that. Too much research dollars are going out to academics on indigenous health without indigenous people being consulted. I think that needs to be looked into.

CHAIR—Just to reassure you a little—it may not very much, but a little—we did have in the cooperative research centre people in Darwin, and sitting on their board are a number of community based Aboriginal people who have made exactly that point. They were assuring us that they really do work very hard to keep the community focus there, so that is just a little step forward. Back to you.

Mrs Peeters—Consult is the word here. No matter what mainstream body is going to communities, they must consult with those communities. That is why I said if I have something to take into a community I just do not hop in a plane and arrive. There are protocols one must go through; they are done through any community controlled organisation, like the Cairns AAC, to get permission to go in those communities. I think communities have had enough of being told, 'This is good for you.' Yarrabah has come out and said, 'Well, back off, we are going to do it our way.' I think that is a really good example you can learn a good lesson from with regard to health money. To give the power back to communities is really empowering those people in their health.

CHAIR—Thank you very much. We will need to start going into the winding-up process. Professor Hays, thank you very much for being with us and contributing.

I will persist with getting a 30-second wrap from each person on their main issue. Can I come, selfishly, to Graeme on the multipurpose health service and how it is going. I presume

you mean the new Commonwealth program. Can you give the essence of it, or perhaps just a brief history, and how it works? That is a small community model, as I interpret it, that brings things together. It seems to me it is a model that has a lot going for it, but no doubt it requires certain management skills, which are very important as well. Would you like to comment on that and perhaps link with the framework?

Mr Channells—Actually, our multipurpose health service is not yet operational. I did give you a report of the Indigenous Health Subcommittee's report to the Steering Committee, which is involved in setting this up. Although that has been distributed, it has not yet been commented on by the Steering Committee, so we are in very early stages. I am aware that there is a pooling of funds from both Commonwealth and state sources, but we have not yet seen a draft organisation chart or any kind of material like that that will show us the overall structure of what might come about. It is in very early stages. It started in late September and there is an attempt, because of a desperate need in the aged care area, to have it finished before Christmas, which is what is expected. We understand we can expect some kind of reply from the state within two weeks, and we would expect a very early reply from the Commonwealth also.

CHAIR—Could I ask about the aged care issue. I think you have given me the answer. There is an urgency in the aged care area?

Mr Channells—It was really the demand for a nursing home which initiated the push in many ways. We have one 34-bed hostel within the shire, but no nursing homes. The hospital in the last three years has discharged 40 people to nursing homes outside of the district. There is no accommodation whatsoever occupied by indigenous aged people within the shire. It is a really desperate situation and we understand the best we might do is about 15 beds.

CHAIR—Thank you very much. Does anyone have anything in particular they would like to throw in? If not, it looks like we might have talked ourselves out.

Prof. Ring—I would hope that this committee would end up having a clear idea of where we want to be as a country in five years time. In my view, it would be along the lines of having effective, comprehensive, primary health care services for every Aboriginal community in the country. We should have an idea of not only where we want to be but what we would have to do to get there by way of funding, training and so forth. But without that statement of where we want to be we are going to drift on in the same way as we have been drifting along in the last several decades.

CHAIR—Thank you very much.

Mr QUICK—Have you any idea of what we call our report to give us that impetus and that sort of momentum to drag the rest of Australia with us? I know I am putting people on the spot but we can have all the ideals under the sun, we can take up Professor Ring's challenge and the challenge of all the messages we have heard, not only here today but around the rest of Australia, but unless we sell it as a package with a distinct message as you have said, it is going to be—I would like to think it would not be another report on the shelf. This is a bipartisan committee and we are all determined to get it right this time.

Ms Mitrovic-Calvert—I would like to think you look in the direction of more workers going into the communities and fighting out issues at grassroots level. Cross-cultural awareness is a big thing for mainstream workers as well. They really need to know the Aboriginal culture.

CHAIR—Valda, how are you going over there? Do you want to say something?

Mrs Miller—I was really unprepared for this meeting. I only read about it in the newspaper, so I knew it was on. Otherwise I would have come prepared. There are a few issues that bother me. One is what Wendy spoke about in the shortage of the health workers in our community. We have already heard we should have one health worker to 150 people; we have only got four health workers to 3,000 people at Yarrabah.

We feel we have to have more health workers on the job which would be more preventative and take education down in the community. In 1997 and 1998 we had 14 graduates and at the end of it there were no jobs for them which was pretty sad. That was a pretty big let-down for me as a senior health worker. All I have now is myself and another two employed there by council, and about eight CDEPs, but it is very hard to train them over two days. It is very hard to send them out into the community because they will tell you that they are CDEP workers. I am also concerned about the family life of some of our officers. I have heard a lot on this floor today about how successful our program is on suicide prevention at Yarrabah, which is very good.

I was away all last week doing my journalist diploma at TAFE. I always think that I am not too old to learn a little more. Just coming from there to this meeting today, I do not know what the health risk will be for me when I go back, but I am worried about the two weekend workers. We have two full-time workers on the family life promotion office dealing with suicide issues. I have found out that there is no funding for the weekend workers. The family life promotion office has kept the suicide program going really well. We had a lot of rotten suicides out at Yarrabah. What I am concerned about is how we are going to get funding for the next weekend workers. That is all I have to say.

CHAIR—Thank you very much.

Ms Archer—I would like to thank Lorraine very much for her words of wisdom and I respect her as an elder. I do not know if anyone acknowledged the traditional owners when we first came in this morning. I would like to say I acknowledge the traditional owners of this land. I believe, as a nurse working in an Aboriginal community, that there is no way that a medical model is going to be able to address the issues of indigenous health in Australia until the underlying socio-emotional issues are addressed. I would like to ask you to please work to address the healing of the people of the land.

CHAIR—Thank you very much.

Ms Levers—I want to speak about my organisation, Mookai Rosie Bi-Bayan. It has been running for 16 years. We deal with our women from the Cape and our children that are referred by the Royal Flying Doctor through the clinics up in the communities and also from the Cairns Base Hospital. Over the years we have been struggling with funds through our

organisation. We have been recognised as a very unique place where, when our children come from the Cairns Base Hospital, we fatten them up and send them back home again. But there is no such follow-up programs when we do get home. We do write letters to the clinic to let them know who is coming over to keep an eye on them.

The clinics, or the health workers like Wendy, were saying they are not allowed to go out to do their j

obs. When women and children do go home, the women have to take their children to the hospital. I think that the indigenous health workers should be allowed to go out into the communities to feel their way around and speak to the mothers on how their children are. Sometimes down the track, six or 12 months later, we have the same children back again. We should be able to go out.

CHAIR—Have that outreach?

Ms Levers—Yes, have that outreach and go up to the communities to keep that all happening. We are always fighting for our money. Every time we put in for grants, we find that we are fighting very hard to put that across. I do not know whether that is because we are not writing in a way up to standard. Some people cannot read between the lines or something. I do not know what it is, but we do put in good submissions to both the departments, whether it is Commonwealth or state.

CHAIR—Thank you very much for that.

Mrs Tanna—I just reiterate how important cultural awareness is. Something New Zealand has done is incorporate cultural safety mechanisms. That means that something of the traditional people is represented in the health services where they go and get their services from. I think that is what is lacking in this country. We need to feel a whole lot more a part of the system. That is certainly something that we have borrowed from New Zealand when we talk about cultural awareness.

Ignorance remains a huge part of the oppression and that is true on both sides of the fence, whether you are indigenous or non-indigenous. If we are going to continue sending non-indigenous peoples out to communities—that includes community organisations- within places like Cairns, Innisfail or Brisbane or wherever, they also need to be culturally aware of what the situation is in that particular community. If they receive cultural awareness in Cairns, they cannot automatically assume that is going to be enough for when they go to Aurukun or Perth and so on.

Professor Hays was talking before about first nations and treaties and things, and I think that is a very vital part of this. Having done four or five years of cultural awareness workshops, I have found that people still say, ‘We are indigenous as well, we were born here. We are native as well.’ We need to start looking at that term ‘first nations’ because that is really what we are.

I do not mean to be rude, but non-indigenous people have been introduced to this country, just like the rabbits and the foxes and the cattle. I do not mean to be rude, but we

know that those things are not a part of what made up this country in the first instance, whereas we were here. Once we get acknowledgment of that and once people understand a little bit more about our history and where we have come from and where to from here, those things may improve a lot more.

CHAIR—Thank you for your thoughtful comments.

Ms Cadet-James—Just continuing on from what Sandra said, it has got to start in primary school or pre-school or kindergarten because if our kids do not at that stage see that they have a role in this country and can be proud of the indigenous people and their peers, whether indigenous or non-indigenous, and if they do not know where they are coming from and what they have got to offer, then I do not think it is going to happen. It is too late to be doing it when people are adults working in the system. That understanding and recognition has got to come right from when kids, both indigenous and non-indigenous, are small enough to understand and have an awareness of it as they grow up through adulthood.

Ms Williams—I am no expert on health as I have only been working within health for about nine months. I was actually listening to everybody else talk. Over the last couple of months I have been working for Queensland Health and I believe that the actual service delivery of an organisation is the sole responsibility of that organisation. If people from within the general public are not accessing your service, then the way in which you are doing it is inappropriate. I believe that indigenous people, over a period of years and years and years, have been overworked. We were probably multi-skilled before multi-skilling was introduced in the 1980s.

People have a tendency to forget that when we are talking about cultural awareness, or a whole range of issues, it is not an indigenous issue, it is actually a problem by the service provider, and in my circumstance it is Queensland Health. I have observed that in implementing a health surveillance database within discrete communities you cannot go into a community and ask them how we can reduce the injuries without giving them information. It is a useful tool for communities when they have a look at the information that they generate and give back to the council clinics within the community.

I have also noticed that politics have emerged within the communities where there are very powerful and dominant family bases which basically have attained a power base.

One of the principal factors that I have noticed over the last couple of months is the consumption of alcohol. It goes back to what Lorraine and Cathie were talking about before, the underlying issue that we suffer oppression, dispossession and the breakdown of the family structure within indigenous communities.

When we were trying to implement any alcohol related projects within the community, we found that because a lot of the communities have a reliance on alcohol as a means of generating employment and income into their own community owned canteens, that became a problem. Any projects aimed at a reduction of alcohol consumption can cause problems. If you go into a community and say, ‘Alcohol is an issue within your community,’ they will say ‘No.’ It is very hard for them to identify that because they are getting this money. This is what is generating employment. I guess that is all I wanted to say.

CHAIR—Thank you very much. I did say a 30-second statement or whatever, but anyone can jump in if they want to. Otherwise, we will just give it a couple of minutes and then I will wind up proceedings. Is there anything anyone particularly wanted to say?

Mr Meaney—Professor Hays stole a march on me when he talked about professionals going into communities needing an appropriate life partner and all that sort of stuff. The only thing I would wish to add to that is that those people being recruited to go and work in indigenous communities who come from a non-indigenous background, apart from having the appropriate cross-cultural training, also need an absolute 100 per cent commitment.

CHAIR—I do not see anyone else coming forward. Therefore, it just remains for me to wind up proceedings. We do not know what we are going to write yet. We all have some ideas, but the challenge for us is to sit down and write something that can be useful for the next 10 to 20 years, let us hope. So, please wish us well because we are going to need all the support we can get.

It now remains for me to thank you all very much. When I was in Cairns, 30-odd years ago, I got wonderful health care when I hacked myself with a cane knife, and I survived to tell the tale. Ladies and gentlemen, thank you very much.

Committee adjourned at 1.12 p.m.