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Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous Health

TUESDAY, 30 NOVEMBER 1999

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Tuesday, 30 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: Mrs Elson, Ms Hall, Mr Jenkins, Mrs De-Anne Kelly, 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.

Committee met at 9.04 a.m.

BARRY, Mrs Sharon, North Coast Aboriginal Corporation for Community Health

CARNEY, Professor Leo Gerard, Head of School, School of Optometry, Queensland University of Technology

COLLINS, Mr Les (Private capacity)

FATNOWNA, Mr Harold, Health Promotion Officer, Cherbourg Community Health Service

HOLT, Mr Robert James, Chairperson, Kambu Medical Aboriginal and Torres Strait Health Service

KIRK, Mrs Maureen, Indigenous Project Officer, Women's Cancer Screening Services, Queensland Health

McMAHON, Mrs Margaret Betty, Chairperson, North Coast Aboriginal Corporation for Community Health

MADGE, Miss Hayley (Private capacity)

MAINSTONE, Ms Julia Claire, Research Optometrist, School of Optometry, Queensland University of Technology

MALAMOO, Ms Toni, Director, Health Branch, Department of Health and Aged Care

MULHERIN, Ms Karla Louise (Private capacity)

O'GRADY, Ms Rosemary Anne (Private capacity)

PARSONS, Mr Lance, Assistant Director, Health Branch, Department of Health and Aged Care

SALAM, Mrs Lori, Member, Wide Bay Aboriginal and Torres Strait Islander Community Health Service

SANDY, Mr Rudy Roy, Director, Kambu Medical Service

SHIELD, Ms Elizabeth Louise (Private capacity)

SPINK, Mr John, Chief Executive Officer, North Coast Aboriginal Corporation for Community Health

WATSON, Mr Edward James, Mental Health, Cherbourg Community Health Service

CHAIR—Good morning and welcome. My name is Barry Wakelin, Chairman of the Standing Committee on Family and Community Affairs of the Commonwealth Parliament. As you would all know, we are in the concluding stages of preparing our report on indigenous health. At present we are moving around the country as a final check of what we might have left out or what we should not have put in.

I would just like to remind you about our terms of reference, and then I am going to go around the table and ask you all to introduce yourselves and your organisation and give us a couple of key points that you would like to focus on this morning.

The terms of reference are fairly straightforward; it is the 'how' which is the more difficult part. The terms of reference include: Commonwealth coordination; the barriers to mainstream health; the need for improved education, particularly in the medical area, but it should not necessarily be restricted to that; the very important one of social and cultural factors, and how that may inhibit or influence health outcomes; the impact on health status of education and employment opportunities; and the extent to which past structures have inhibited delivery of health services to Aboriginal and Torres Strait Islander people. They are the terms of reference, put quickly.

Can I say at the outset that the discussion paper is really not in any way to be seen as a definitive statement of what our report will be. The report will reflect some of the things in it, but it is really there as a straw man, or straw woman if you like. It is there just for us to say what should be in it or what should not be in it. It is just put there for you to consider.

Things that we have not put in any particular order are dental health, mental health, hearing health, diabetes, renal failure, the balance of urban and rural and remote communities—an important issue that we are grappling with—and the obvious one, indigenous poverty and discrimination, and how indigenous people can take greater responsibility for their own community's health.

In that preliminary statement I have mentioned the terms of reference and things that we have not put a great focus on. In our discussion paper we have just tried to put in the dos and the don'ts. We want this meeting to be free flowing and informal. We need the information from you. We are asking: what would you be doing if you were writing the report, what would be your key factors?

As I said, I am Barry Wakelin, from South Australia. I represent the seat of Grey, which is 90 per cent of the area of South Australia. The electorate has a large Aboriginal component in it, including Pitjantjara and Maralinga Tjarutja Lands. We will start from my left and you might like to introduce yourself and we will go from there.

Miss Madge—I have just graduated from speech pathology at the University of Queensland. I have accepted a position with Education Queensland based in Cairns but servicing the Torres Strait, Thursday Island and Weipa. I am interested in training issues.

Ms Mulherin—I am in a similar situation to Hayley Madge. I have just graduated from speech pathology at the University of Queensland and I am interested in indigenous health.

Mr QUICK—I am the federal member for Franklin in southern Tasmania. I have been a member of this committee for the last couple of parliamentary terms and have been wandering around Australia trying to sort this mess out for the last couple of years. Hopefully, with your help, we can resolve some of the key issues.

Mr Fatnowna—I am the health promotion officer with the Cherbourg Community Health Service. I am interested in all aspects of indigenous health.

Ms HALL—I am the member for Shortland, which is in New South Wales. It is a Newcastle based seat. I am very interested to hear what you have got to say today, particularly on some of the options in the discussion paper which look at funding.

Mr Holt—I am the Chairperson of the Kambu Medical Service in Ipswich, and I am also on Dr Wooldridge's health council.

Mr Sandy—I am from the Kambu Medical Service, Ipswich. I am interested in the economic side of things, social, cultural and heritage matters and the area of long-term funding.

Mrs McMahon—I am from the Sunshine Coast—Caloundra. I am Chairperson of the North Coast Aboriginal Corporation for Community Health. I am also the coordinator of Kabbarli Home and Community Care for the aged. I am interested in all aspects of health and the aged program.

Mr Spink—I am the executive officer for the North Coast Aboriginal Corporation for Community Health, based in Maroochydore. We are working under a specific model of service delivery by the Commonwealth. Dr Wooldridge has put down a specific model, a purchaser provider model, and I am here today with Betty to see if there is anything further that we can get out of the discussion paper.

Mr Collins—I am here today as an individual rather than in my capacity representing QAIHF. I will speak on the issues when they come up.

Mr Watson—I am the chairperson of an indigenous counselling service. I am a mental health worker at the Cherbourg Community Health Service and I am a mental health adviser to QAIHF.

Mrs Kirk—I am here representing Queensland Health for indigenous women. I work in the area of women's cancer and I am interested to see where we can go with women's cancer because there is a lot of work to be done in addressing cancer.

Mrs Salam—I am from Bundaberg. I am a registered nurse and midwife. I was doing education with indigenous women in the Wide Bay region. I am on the ministerial committee for Wide Bay that is looking overall at jobs and stuff that governments do. I am here as an interested party after I saw the advertisement in the *Courier-Mail* on Wednesday.

Ms O'Grady—I am a lawyer and a former nurse, long ago. I made a submission because of my concerns regarding health services in remote areas and particularly the impact

of violence on Aboriginal communities in remote areas—not only Aboriginal communities but particularly Aboriginal communities, regarding this committee's terms of reference. In the mid-1970s, which is effectively 25 years ago, a generation ago, I had responsibility for both the violence and the Aboriginal health references of the Royal Commission on Human Relationships, the Evatt Royal Commission. It seems to me that a great many of the submissions which have been made to your committee run parallel to—and have not moved terribly much further, through no fault of anybody here—submissions which were being made in 1975, to that royal commission on family relationships.

Mr SCHULTZ—I am the federal member for Hume, a rural seat in the south-west of New South Wales. I am a relatively new member of the committee, having been involved in the last 12 months. I have particular concerns about the funding, where it is going and how much of it is reaching the actual coalface of indigenous health.

Mrs ELSON—I am the federal member for Forde in Queensland, which is situated halfway between Brisbane and the Gold Coast. I have been on the inquiry since its inception. My main aim is to make sure that we have real outcomes that the community is going to be happy with. I really have appreciated the interaction with a lot of community groups over the past 2½ years.

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. Scullin has, by the last census, only 500 indigenous people out of a population of 120,000, so my exposure to indigenous affairs has been negligible until this inquiry. This inquiry has been a very good learning experience for me. I am here yet again to listen to your concerns, to hear them and hopefully to assist in what the committee might come up with that will have some lasting effect, in a positive direction, on indigenous health.

Mrs DE-ANNE KELLY—I am the federal member for Dawson, in North Queensland. I am a member of the National Party. I have been on the committee since it started. I guess the most heartening thing about the committee is the bipartisan view toward finding, we hope, a workable solution to the difficulties. I do want to thank you: I know that you have given evidence to many other committees, and we have been gratified by the willingness of people to assist the committee. We certainly want to work through with you to find something that will be workable for indigenous people.

Prof. Carney—I am the head of School of Optometry at QUT. Our school has a particular interest in the area of the ocular health, not only in the provision of optometric services to the indigenous communities but also more specifically in the educational needs, both of optometrists in the area of ocular health of such communities and also in the area of the education of indigenous health workers in the area of ocular health.

Ms Mainstone—I work at the School of Optometry as well, as a research optometrist. I have recently been involved in a study looking at the provision of eye care services to Aboriginal and Torres Strait Islander people around Australia. We are specifically looking at provision by optometrists in Australia.

Ms Shield—I am a social work student at UQ. This is an area that particularly interests me.

Mrs Barry—I am from the North Coast Aboriginal Corporation for Community Health. I am interested in indigenous health.

Mr Parsons—I am the Assistant Director of the Department of Health and Aged Care, responsible for indigenous health in Queensland.

Ms Malamoo—I am the Director of the Health Branch of the Department of Health and Aged Care.

CHAIR—Are there any questions particularly of me or of the committee? If we are all clear about what we are here to do, does anyone want to lead off? If not, I will dob some people in, I suppose. I will start off by making a few comments in terms of general impressions.

We know that 80 per cent of all the services delivered to Aboriginal people come through mainstream health. I stand to be corrected on that, Mr Kennedy, but I think it is about right. Do we have anyone here from the Queensland department?

Mrs Kirk—Yes.

CHAIR—I am particularly interested, not in an adversarial way but in a practical, factual way, in what are some of the blockages and difficulties we have in terms of Commonwealth coordination, remembering that figure of 80 per cent. That is a fundamental issue and one area of particular interest to me.

Another area is definition of the cultural factors. For many people the reality of good health is holistic but there are also some fundamental issues about good health. What I would like this committee to try and define is how we might better understand the cultural issues that impinge upon good health. Those are two areas: the coordination and the cultural issues.

The third one—I will not go any further in my opening comments because I think it gets lost—is also linked to that 80 per cent figure for mainstream health services. How do the mainstream health services operate? We know they are predominantly delivered by states; we know we have the Aboriginal controlled sector, which is a very important part of health service delivery. How does that all fit together? Does anyone want to open up on cultural or Commonwealth-state coordination matters?

Mrs McMahon—I would like to say that the money that goes into mainstream gets lost. If you are working for a community service, you have to be answerable to the funding body and every year you put your submission in. The funding that goes to Queensland Health for Aboriginal and Torres Strait Islander health goes into the hospital system and they can use it for anything they like, because there are no strings tied to it.

CHAIR—It does not deliver specifically to indigenous health services?

Mrs McMahon—No. It should be quarantined for Aboriginal and Torres Strait Islander health but it is not quarantined exactly for that.

CHAIR—Thank you, that is exactly the sort of discussion I am endeavouring to generate.

Mr Watson—Could I elaborate on that. Apparently, from what I understand—I have been on various committees at state level—the funding goes to district managers and there is really no transparency for district managers, to see where that goes. They can divert funds within their own district. In the mental health area we have had some clashes with district managers, because we have inquired where money was diverted from mental health issues and indigenous health to other projects within their district.

There have been moves in Queensland to examine all those service agreements through Health, to look at possible transparency and at that money. I have been arguing for years at that level for indigenous people to be there so that there is a peer review of the district managers, particularly in the state of Queensland, because that is where a lot of money goes. They say there is no-one there for the positions or whatever and they divert that money. That needs to be stopped. That is another area where it is leaking out of actual stuff at the coalface.

CHAIR—Some of the members of the committee here have very strong feelings about the accountability of this money getting through. It is an age-old problem, an age-old issue. We are very open to that sort of comment. We have these framework agreements that have been worked up over the last two or three years and I am sure Robert would be discussing them with Dr Wooldridge's committee as well. We want to try and tease that out. Does any member want to jump in there and want to make any particular comment?

Ms HALL—The report, on pages 15 to 17, sets out some possible directions and looks at funding. As we are talking about funding at this stage, I would like you to maybe turn your minds to the issues here. There are four options. Option A is for the funding arrangements to continue in the current way; the second option is for states to assume responsibility, but from listening to what has just been said I think maybe that one will not be favoured so much; the third option is for the Commonwealth to assume total responsibility for the funding of indigenous health; and option D is a new approach which looks at setting up a separate agency with a high degree of community participation. In other places we have received E, F, G, H options where people have said, 'Well, we do not like any of these options but we think this would work. This would be a great way to fund indigenous health.' So, whilst we are talking about funding, maybe you might like to give us your ideas of how you think indigenous health should be funded.

Mr Collins—On state-Commonwealth coordination and stuff like that I think fundamental issues are not being addressed or not being looked at properly; that is, states operate within a particular legislative framework and the Commonwealth's role in that is largely shaped by the powers in the Constitution.

The extent of coordination, in our experience, has been predicated on the extent of control that governments want to maintain over programs. There have been many

representations made to the Commonwealth government as far back as the Ruddock report and even before that when Wentworth was the first minister for Aboriginal affairs when Aboriginal affairs was a little corner thing in his department. It has been, from my experience, the government's reluctance to shift from that structure which maintains the sort of power that underpins the extent or lack of the way things are happening today and the effectiveness of any approach that might come out of that.

That is one of the very fundamental issues that needs to be addressed. I will talk later on. I am particularly interested in terms of reference F which talks about structures and stuff like that. You mentioned yourself that there are a range of fundamental issues that need to be addressed—but let somebody else have a go for a while.

CHAIR—That is fine. We are very interested in this because we see that as a key to moving the thing forward. Body part funding or the pool funding are critical issues and we just need as much information from you people as we can get on your experience.

Mrs Kirk—Within Queensland Health we have indigenous coordinators for different sectors and districts—I think they are being reviewed at the moment. With the money going into the districts, into the hospitals, it might be better to put it through the coordinators and funnel the money down. There is always a big issue of funding with indigenous health because funding either goes off to the bigger guys who are around in our communities and the grassroots people, the people who are on the ground, get nothing. People like health workers—I have a big interest with remote and rural—and even us lot in the city areas work really hard to get health promotion money and start off at the ground level. Health workers do a lot of hard work and a lot of slogging out in the communities. When they want to put up programs, they go to their organisations, whether a community controlled organisation, Queensland Health or the Commonwealth. They are always being told that there is no money. The health workers are the ones who are the key people in the community. They do all the hard work and no money seems to be getting down to the health workers to put out some of their projects that they want to get off the ground for the grassroots people who are suffering the most. Most of the money is always kept up in administration, or the bigger guys want to keep the money away from the little ones who are working.

CHAIR—That is the key. That is very important. So can we just keep those sort of comments coming?

Ms O'Grady—I am just thinking that I have no right to be talking on the subject at all because I know nothing about the way health funds are delivered these days; it is just not my area. However, I have been a client of health services in remote areas where the particularly heavy users of those services have been indigenous people in the remote outback, one of whom was at the time my husband. It was, for the purposes of this argument, a mainstream type of service which was also funding, as you say, health workers out to the communities.

Without wanting to sound too cynical, I just wonder whether it might be worth playing around with the idea—given that the function of parliamentary committees is to examine all crazy ideas that are put to them—of looking under this heading, 'A new approach', and just toying around with it. No doubt plenty of you will want to correct my approach. Do not

worry; I am willing to accept that it might not be practical. It seems to me that what we keep hearing over and over again, not only in the area of health, is that we have a vast continent, with a population of 20 million, a centrally based taxation system and a system of grants through a central taxing system. Particularly when it comes to indigenous health, there is no problem about central power because constitutional power exists under sections 51(xxvi) and 51(xxxix) to do practically anything you choose to do, provided you can persuade Canberra to fund it.

Probably everyone in Australia who has a television set has seen Archbishop Tutu recently visiting Brewarrina. When you see the scope of some of the health issues that confront no doubt all indigenous people but particularly people in remote areas where the service delivery issue is so great, I wonder if we ought not to be looking at the possibility, even if it were a limited one—even if there were a time frame on this—of funding organisations such as those non-government organisations like Medecins Sans Frontieres which have a temoignage approach to health issues.

The reason I say that is twofold. One is that, in indigenous societies across Australia now, there is a tendency to contract with government, and this is linked to the general tendering approach of government to contract for services anyway. You can call it privatisation; you can call it whatever you like, but it is linked to diminishing the scope of the government sector. So there is a tendency to contract, to write agreements and to enter into agreements to provide services. There is no reason why, administratively, it could not be the case that we could contract organisations like Medecins Sans Frontieres to carry out at least the crisis related acute work which needs to be done—services which need to be delivered. They are professionals at getting problems solved in remote areas in the short term.

Ms HALL—So you are suggesting directly funding community organisations?

Ms O'Grady—No, I am not. I am suggesting that you actually contract a specialist organisation such as a world professional non-government organisation like Doctors without Borders or whatever. Even if you are not particularly attracted to that idea, you could always limit its term. In my own experience, there is now at least a 25-year-old problem of getting things to the grassroots—for example, you will no doubt all be aware that, in remote areas, particularly in Western Australia where there is a large nematode problem in the soil, there is a link to high levels of diabetes, and there is a very high level of kidney disease throughout Australia.

In remote areas like Kalumburu, for example, where many of my former clients live, notwithstanding the huge steps that are being taken to improve housing and do something about that problem, there is still nevertheless—and there has been for a long time—a need for kidney machines, for renal dialysis machines, which they simply have not been able to get in there. If you had a professional small group—I keep using Medecins Sans Frontiere as the example, because I believe they are very good; I donate to them, of course—

CHAIR—The principle is the thing.

Ms O'Grady—They have got the Nobel prize, so they are uppermost in the public imagination at present. But you understand the principle. You have a small, compact, sharply organised professional team, which is at arms-length, but is committed to and identifies with the issues and the problems. Although it is at arms-length at professional level, it is totally engaged at the delivery of the service and on the problem solving level. That would overcome, in my mind—and I might be wrong here—what is so often the problem. It seems to drag out these problems over so many years and so many generations of the lack of infrastructure which delays the actual initial supply of the delivery of the service, and then also there is deterioration and the difficulty of maintaining capital which is needed in those areas.

You cannot put a kidney machine into every community. You probably could, but it has not been done, and if it had, it would break down and so on. But if you have contracted on a budget an organisation, which can come in, do the job and go out again, fully equipped, fully professional, et cetera, it certainly will cost money, but overall it has the capacity to make a difference by delivering what is needed on the ground very quickly in the short term. Its coming back, going away and coming back not only creates interest, which assists in the education and the involvement of the community because, as you all know, people in remote areas love to have visitors who are actually teaching them something or helping them with something, but solves the problem in the short term. You are not constantly in that position of waiting for Godot or waiting for that solution which never comes because of administrative or service delivery hitches and problems.

Ms HALL—What role would you see the community playing in that? Sorry, I know you wanted to speak for ages.

Mr Watson—I have been fortunate enough to go over to Ireland in 1996. I saw a situation over there where Ireland and Portugal were regarded as the two poorest countries in the European Union. The European Union, to save embarrassment to the rest of the world if they talk about human rights issues and things like that, poured billions of dollars into there. There were people going around each area. I was both in the south and in the north of Ireland and they were going around asking what those communities needed. They had an open chequebook and they said, 'We need a doctor, a nurse, facilities and probably two vehicles.' They did that, and I fully commend that idea. We have discussed it at length up at Cherbourg about possibly getting the World Bank or someone else to fund us to bring in those doctors.

In Ireland, they went around and came back in three months time. No strings attached like we have got here in Australia with all the paperwork that bogs people down and all the rest of it and so-called accountability. The accountability actually falls on the hands of you guys, because we are in the situation where we are fourth world.

With that in mind, a friend of mine—my lady's cousin—is a doctor from Ireland. She has come here twice to Australia for a two-year period and now she is a naturalised citizen. But when she was in Western Australia, she was told in no uncertain terms by the AMA not to teach primary health care to those people that she was working with. She ignored that. The doctor's team that comes in and fixes up the problem should also teach the local people

primary health care things and how to deliver those services. That is the sort of stuff that I would like to see happen.

CHAIR—Obviously we have collected a body of evidence, and I was just asking Bjarne, our secretary, about the Broken Hill experience where the New South Wales government has contracted out some mainstream services to the RFDS, I think. These sorts of models are developing, so it is not impossible to do it. The other part you have just mentioned is community ownership and community capacity: we come in, make the quick fix and then we need to sustain it. You have mentioned the vital link that we have to go on and make it sustainable. Nevertheless, these are small beginnings.

Mr SCHULTZ—That is in line with the concerns I have regarding the industry that has built up between the Commonwealth and the coalface, the industry in between at the state level absorbing an enormous amount of the dollar. I think the suggestion is very sound, but a variation to that is: why wouldn't we give the funding to the Aboriginal community and allow it to subcontract out to organisations such as those? That puts the full dollar in the hands of the people who are not benefiting from the current system to the extent where, in many instances, they are probably only getting around 10 cents in the dollar of the allocated funding.

It is obvious to me that the accounting mechanism we have in this country is just inadequate—inadequate to the point where much of the money that comes from the Commonwealth, through to the states, territories and local government disappears in the system. That creates massive problems for the people who are out there screaming for the services.

It is very depressing when this committee goes to isolated communities to see a health worker working 24 hours a day because she is the only health worker around. The reason she is the only health worker around is that there is simply not enough funding to allocate to the training of other health workers. That, to me, is depressing to the extreme and an indication of just how the system itself has manipulated the monetary funding to build, as I said earlier, the empires that are living off the taxpayers' dollar that should be going to and is earmarked for indigenous health in this country.

Mr Collins—This sort of approach has been discussed over the years. Whilst there might be some short-term merit in terms of it being an emergency response type of thing, it can easily be used by governments as an excuse not to provide comprehensive and sustained effort in addressing Aboriginal health. When we talk about Aboriginal health we are not simply talking about reducing the incidence of diabetes; we are talking about the wellness of the individual, the family, the community and the environment in which they live.

Mrs McMahon—I find that the state government and the federal government do not combine to work together for the Aboriginal people. They are talking about training health workers. The Queensland state government does not look upon our workers as health workers. They are now called something else, and they have to have a diploma like a nurse's. I have had plenty of arguments with the district manager up there and also with Queensland Health as to why we need to have these people trained to do these things. You cannot get a job in Queensland Health unless you have these diplomas. They cannot use

them, because they are not allowed to take blood pressure and they are not allowed to give injections. The nursing staff of the hospital would soon kick up a stink, because these people have only done this 12-month diploma course to get these positions.

We wanted a hospital liaison officer up here. They used the same terms of reference for her work as they would have for a nurse, and the wage is only an AO2 wage. It is absolutely disgusting. They have had the money up here for three years, and they cannot fill that position. The Gympie Hospital has no district health workers at all for the simple reason that they have this stupid idea that the Aboriginal workers must have these diplomas to get these positions.

An Aboriginal liaison officer, in my eyes, is a person who goes around the wards to see if any Aboriginal people are there. They help them to fill out forms, and they to talk to the doctors and relay what the doctors are saying to the Aboriginal patients and to their families so that they know what is going on, because half of them do not know what the doctors are saying. Why does she need a degree to do that? We are having lots of problems. Up north it is all right to call them health workers because they go out and do that work, but in the inner city they are not allowed to.

CHAIR—So they do not get a job in a hospital because they are not allowed to do basic injections and those sorts of things?

Mrs McMahon—They can get a job in a hospital if they can do that, but they cannot use it. It is like putting a dentist to work as a vet. You have to have the qualifications of a dentist—

CHAIR—As I understood it, you said there were no Aboriginal health workers at Gympie?

Mrs McMahon—No, there are none.

CHAIR—And why is that?

Mrs McMahon—Because of the diploma they are supposed to have, and they cannot use that diploma within the position. All the nurses in that hospital would go on strike if the health workers in that hospital were allowed to take patients' blood pressures and temperatures, because they do not have the same qualifications.

CHAIR—I think we ran into something like this in Cairns yesterday.

Mr Sandy—Regarding the new approach, I think it is about time we did have a new approach to funding for indigenous people, whether it is health, housing or whatever. When funding was given out in the past—and I would like to cite an example: the deaths in custody funds—very small amounts of it got to where it was supposed to be going. We had moneys going to police departments and to every other department, I think, except to Aboriginal people. We were building beautiful lockups with a lot of the funds.

CHAIR—We had some good examples quoted to us yesterday in Cairns, yes.

Mr Sandy—I think that is just one of the issues we need to really look at. Indigenous health has not improved at all. All the money you have thrown at it from Canberra has not improved it. Just yesterday the mortality rates came out once again, and I think they have gotten worse. So what do we do? We have to hit the problem from the bottom: we have to start getting our people jobs and getting a lot of this rubbish of putting us down out of the newspapers.

I saw an article in the *Courier-Mail* the other day in relation to racism in reverse. One of the leaders up in the gulf suggested that the health workers in Doomadgee should do a little bit of cultural training. Because he said that, some of our politicians and also some of our newspaper people were saying that it was racism in reverse.

When Australia goes over to Asia and starts looking to do trade with them, they do not mind learning a bit about the Asian culture, do they? Yet when we attempt to ask Australians to learn a bit about our culture, it is racism in reverse. I think it is about time we started to do something.

CHAIR—As you would appreciate, we run into this issue of cultural training regularly. We hear lip service. In many ways maybe some good work is being done. It probably is in many places in the state systems. What would be one or two key issues for you in that cross-cultural training? What would it be? Can you specify what needs to be in cross-cultural training?

Mr Sandy—Maybe there needs to be an incentive to certain professions to go out and spend a bit of time in some of these communities because no community is the same. I think this is where we sometimes lose the plot. We are doing this on an Australia-wide basis when we should be cutting it up and directing it into particular areas. There are a lot of things that the Commonwealth can do to assist indigenous people within their own communities in relation to employment. There was a suggestion made that maybe giving some sort of tax concession for industries into some of these communities may be a way to go because something has to be done in relation to the unemployment.

CHAIR—You are absolutely right.

Mr Watson—I think a fundamental key to any cross-cultural training—and I have been doing it over the years with some other people—is communications, customs and protocols. Those three fundamental things are very important, to know where the other person is coming from, how they react to it, and things like that. It can fit any of the models right across Australia as far as individual groups go.

CHAIR—That is critical, isn't it?

Mr Watson—Yes.

CHAIR—It has to be general enough so that they get the principles.

Mr Watson—It is national, yes, in amongst all the different tribal groups in different areas.

Mr QUICK—Can I put two groups under the hammer by saying that we have got the School of Optometry and we have got two recently graduated speech therapists. What do each of those do in the way of preparing people in Queensland to work in indigenous communities? Can I put them under the hammer? Do they do something or nothing?

Ms Mulherin—I was going to mention that throughout our four years of training we only received one one-hour lecture on indigenous health and that was by a person from the school of indigenous health at the university. They just came to us and mentioned a few issues that needed to be considered. We have come out of our degree now. Hayley mentioned that she is going to be dealing with this kind of community in the Torres Strait Islands and we do not have that sort of training. As you were saying, every area is different. There is a very good idea on page 21, 3.20: once you are in that area, you actually can have some orientation with the local indigenous health service. Maybe a health worker could help you there.

CHAIR—Thank you, that is excellent. Do you remember what came out in that one point from the one hour in the four years?

Ms Mulherin—Probably that we are inadequate because there is so much that we need to know.

CHAIR—That is your memory of it. That is fantastic; thank you for that.

Prof. Carney—I can only speak for the School of Optometry here at QUT and not for the other schools in Australia. The report does comment on the fact that it recognises that there is an increasing number of complex areas for all of the health professionals to deal with—therefore it becomes difficult to maintain activities in all areas. In this particular area, we have lectures within our final year where we are dealing with some of the more specific clinical issues that are coming forward from our own unit at QUT and giving some of the issues of cross-cultural training that are required. We also have a clinical service, which the school operates at the Aboriginal Health Centre at Woolloongabba, and all of our students are rostered to go through that and provide service within the Aboriginal community itself there. That is within an urban setting, obviously.

As we see it, our other responsibility is to provide continuing professional education to the optometric profession. In that sense, we provide lectures at both national and state conferences in this area, particularly related to issues of ocular health and how our particular profession can interact appropriately. Indeed, we have run teleconferences around the country for professionals. These are the sorts of approaches we have had. We can all do more, but at least we attempt it, I think.

Mr QUICK—It seems strange that optometry in Australia has connotations with Fred Hollows and Eritrea rather than optometry and Professor Carney and indigenous health. What do we do to change that? Obviously, we are out saving the Third World but we are not saving the Fourth World that is in our own boundaries. And despite what Ms O'Grady is saying, that is the wrong approach. We have got the skills and expertise here. It is a matter of getting the bureaucratic hurdles out of the road and saying to people, 'Let's go and do it'. If money was not an object—and our recommendations hopefully will come up with the

right strategies that will include proper funding—what would you do differently? In your four years, do we have flying teams out to the worst places to try and bring them to some sort of standard?

Prof. Carney—If I could speak primarily on the educational issues; there are provision of services issues there that you have raised as well. I should point out that the issue you have raised of the Fred Hollows approach outside of Australia is an ophthalmological one, but it is still the same approach that you are raising. As I see the issue from the point of view of the optometrist services, it is that optometry has the advantage that it is distributed very widely throughout our community. It is not concentrated within the major cities and areas, so there is an opportunity there for service provision. Our aim within the educational arm is to make people aware of the particular training needs that are there. If the provision of services were able to be funded in an appropriate way, provided there was an understanding of the particular needs already in place, inroads could certainly be made.

Mr QUICK—So is the Commonwealth or the state in Queensland the stumbling block, or both? We are here today, warts and all, because we want to know. You are covered by parliamentary privilege, so you are not going to slander anybody.

Prof. Carney—Our research optometrist, Julia, who has been involved in our study, wants to comment.

Ms Mainstone—I have recently been looking at the data we collected from a survey earlier in the year looking at where people were actually providing services. There are areas of the country where services are being provided. Queensland, in particular, is quite well covered—North Queensland to the Torres Strait Islands. There seems to be a very ad hoc approach. Different organisations are involved. In certain areas like Western Australia, I got back very little information. I tried ringing the state and Commonwealth health coordinators in the areas of eye health programs and different government departments seemed to have no idea who was providing services. I thought they would have had a list or register of people who were providing services, but I could get no information out of them. They just told me that I would need to ring around all the optometrists in Western Australia to find out who was actually providing services. It appalled me that that information did not seem to be known.

There is a willingness out there. There are certainly people who answered our survey, who said that they would be prepared to offer services but they did not know who they should approach. There are people who are involved in providing services in remote areas of South Australia, in particular, who said they would have to pull out in the near future because of funding problems. I think their funding was coming from Aboriginal community health organisations. There was no input from state government directly or no organisation there. They were commenting that they were going to have to pull out in the near future, if they had not already done so. There are certainly issues there of people who are very committed, but they are finding that they are not going to be able to keep going in the area.

Mr QUICK—I have a last question; people around here might know the answer. Do specialists visit Mornington Island on a regular basis or do people have to be flown out to the nearest 'big city' at tremendous cost?

Mrs Kirk—Those specialist services go into our rural areas every three or four months. If they have a problem in between, where do they go for specialist services? I have just done research on breast and cervical cancer in our communities in Queensland, and most of the women there are saying that these fly-in, fly-out services are not good enough because they are only supposed to be sick when those services are coming in.

Aboriginal health workers are all on a 12-month funding agreement all the time. We bust ourselves to do these programs every 12 months, and then we always have to search around for funding all the time. Why do Aboriginal health workers and Aboriginal Health have to always fight for funding every 12 months? These positions should be permanent. Most of the mainstream services all have permanent staff. Why aren't Aboriginal health workers and Aboriginal workers in health permanent? My job is not permanent. I am on a 12-month contract. I am not the only one. There are hundreds of us around Queensland and around the states.

Mr QUICK—Who decides that they only get a service every three months? Why not every month or every fortnight?

Mrs Kirk—District managers. It is because of the money, the funding.

Mr QUICK—We heard yesterday that there are national goals and targets and the Commonwealth and state health ministers sat down and agreed on these. So we can go back to Jill's original question. If the states and territories are stuffing it up—I have yet to hear of any state that is doing it right—why don't we just take it out of their hands? We should say, 'Sorry, you have had 25 years. You have expended billions of dollars. We will contract Professor Carney and Karla as speech therapists, and we will fly in as often as you like. They will set a going rate and you will get the service you need.'

Mrs Kirk—Yes. We have to find another way. Half of those people out in the remote areas—for example, in Mount Isa or Mornington—have to catch planes with their children. There is no accommodation or money when they get there, and they cannot take escorts. For most of these people in these areas, English is their second language. They have to take somebody along to escort them because they have never been to these sorts of places, even if they have to come further down here to Brisbane. The system frightens them, even when they land at the airport. If there is not a health worker or one of us are there to meet these people at the airport, they will just turn around and get back on that plane and go home. They are frightened of the system. There is no help through the system for them.

CHAIR—I just want to invite the Commonwealth officers, Lance and Toni, to comment. Going back to the earlier answers from our eye people, what sort of machinery is there in place on top of this coordination? Can you give us some enlightenment on what sort of coordination there is? I understand some of the Commonwealth-state issues. I do not know that anyone ever understands fully the Commonwealth-state issues. Can you give us some enlightenment about what coordination there is. What efforts are made in that area?

Ms Malamoo—There is the framework agreement. That involves the Commonwealth and state and the community controlled health sector, as well as ATSIC, and I think you are aware of that. There are arrangements on individual programs—for instance, eye health,

which is pretty much being discussed at the moment. That involved a coordination arrangement between QAIHF, Queensland Health and the Commonwealth in terms of rolling out the program in Queensland, because it moved from being a state based model to being a regional model. That is one particular program that has worked. The community controlled health sector may beg to differ on that, and I guess we would need to discuss that further. I thought the eye health model was a pretty good program that we rolled out, and there was coordination around that.

The other one was sexual health strategy in Queensland, which involved the community controlled health sector, the Commonwealth and Queensland Health. That involved a position of negotiation between the community controlled health sector and Queensland Health, with the Commonwealth involved in terms of ensuring that the process was clear. I thought that was a pretty good initiative in terms of coordination. Do you want any more examples?

CHAIR—I would just like to raise with you what the Australian National Audit Office noted on the framework agreement. They said that there was no recourse for the Commonwealth Department of Health and Aged Care where states and territories did not comply with the requirements of the agreement. So, in other words, we can have some great agreements, a lot of agreements, but there is absolutely no binding authority whatsoever to do anything. Whilst I accept that the frameworks are a step forward, what I am trying to understand is how effective they are at the end of the day if the states decide they are just going to go their own way. That is the key question for us, isn't it?

Ms Malamoo—It is based on goodwill and the spirit of the partnership.

CHAIR—No compulsion.

Mr QUICK—And no sanctions.

Ms Malamoo—That is entirely a position that Queensland Health may want to take and the Commonwealth, in terms of trying to get to some agreed arrangement with a major health provider, would try and better. There is need for improvement. This is the first stage.

Mr QUICK—With due respect, the first stage has taken 25 years. In the latest *Bulletin* we have Michael Wooldridge and the US Surgeon-General going out and saying that we are bloody hopeless. There need to be revolutionary steps, framework agreements, national goals and targets, and core numbers of people on the ground. All those are in place but no-one adheres to them. People go their own sweet way.

Ms Malamoo—I think the health system is very complicated. It is not only indigenous health that is complicated; I think the health system overall is complicated. It involves a number of stakeholders. It is not only Queensland Health, it is not only the Commonwealth and it is not only the community controlled health centre. There are other players here. There are the GPs, AMAQ, ophthalmologists, optometrists and just any number of other health professionals you would like to consider in terms of delivering health services to Aboriginal and Torres Strait Islander people.

CHAIR—Thank you for that.

Mr JENKINS—I do not think you should attack the framework when perhaps you can attack the Constitution, if that is all right. This discussion is very interesting because it raises the notion of body part funding which is what, on many occasions, people have said that we should be moving away from. I am just trying to get that in context. I understand that even where the state department controls things we had some advisory body from the local community that would set the needs and priorities for that community. We still might want to bring specialists in, but where we are talking about an overall program such as eye health or something like that, in a number of places around Australia people have said that we should move away from that model. So I am just trying to get those sorts of comments that have been made to us in context and have response from people here today.

Mr Collins—I want to talk about that culture stuff you were talking about first. One of the fundamental problems with the way that cultural awareness and cross-cultural education is approached is that most of the people who try to deliver have difficulty determining the difference between tradition and culture. Culture is an evolving sort of process and I suppose it is largely affected by one's socialisation. The diversity of the experiences that different communities have will shape their culture. The thing about culture is that you will have a particular culture and I will have a particular culture. All of the components and elements that go to make up a culture are similar but it is the interpretations that we place on those through the environment we live in, the experiences we have, and the way we perceive things, that make the difference. When you are talking about cross-cultural awareness you need to be aware of those sorts of factors and not get hooked on the idea that it is about traditional practices, although traditional practices are part of our culture.

On the structural sort of stuff, the problem with things like the framework agreement, whether they are well-intentioned or not, is the lack of enforceability. The way that state governments operate is within a particular legislative framework that is allowed by the Constitution, and the Commonwealth does certain things that are empowered by the Constitution. With a framework agreement, and it is the same with the Council for Aboriginal Health which was set up under the National Aboriginal Health Strategy, there are policy initiatives and they rely heavily on the spirit or the level of commitment of the parties that are involved. I guess it has some relevance to the question that Harry was asking before about the 25 years and what had been done.

I guess that governments are continually faced with the political question of meeting the expectations of the status quo. Expectations of the status quo have been so influenced by science and the medical profession that we see the vast, overwhelming majority of health service funds being concentrated on tertiary care. In order for governments to remain in favour and stuff like that, these are policy decisions that governments make and, inevitably, that leaves very little resources to address things on the ground at the primary health care level. That is demonstrated in every bit of research. Projects at the primary level were shown in a study in, I think, 1978-79 to save the Australian economy around $7 billion over five disease categories. We are going to constantly be faced with that problem.

We have heard all the rhetoric about affirmative action, about social justice. However, none of this has been made law, none of this is enforceable. It is dependent on the policy and the philosophy of the government of the day and its advisers. And when I talk about its advisers I am talking about its departments and its director-generals, et cetera. That is one of

the big problems we have in trying to address the great needs of Aboriginal communities within the structure of the Australian polity as it is.

CHAIR—As Harry Jenkins suggested, these issues are fundamental to the Constitution, not so much to a framework agreement, which is probably a step forward in endeavouring to get the cooperative nature of the thing working better. But the question still arises whether we will achieve what we really want to try and achieve. Can we hear from Betty and then Rosemary?

Mr QUICK—Mr Chairman, can I just add to that first. We had a crazy guy wipe out 35 people in my state. We then had national gun laws, with accompanying state gun laws, and a levy introduced for every Australian to pay for people to hand their guns in. We have got God knows how many—is it 380,000?—indigenous people whose life expectancy is 20 years behind ours, behind mine, and we are arguing the toss about whether it is constitutional or not. Let us get real here! Martin Bryant changed Australian society and constitutional bloody norms. We have got people opposite me who are facing a life 20 years less than mine. If we are going to sort this out once and for all, let us be fair dinkum and stop arguing whether we are going to upset Mr Beattie, or Mr Bacon in my state. We are talking about people's lives here, for goodness sake.

Mr JENKINS—You have set out the model. We are not arguing about that.

Mr QUICK—We are here to say to people, 'You give us the model.' Is it Commonwealth only? If it is Commonwealth only and the states get their knickers in a knot, like they did over gun laws, they will have to wear it.

Mrs McMahon—If you are going to be fair dinkum about indigenous health, you have got to cover education and you have got to cover housing. I have worked on the ground level with the communities for a number of years and I get disgusted when universities—I am not saying anything about these two girls here—have money to train Aboriginal people. If universities do not get the numbers of Aboriginal people up so that they get this money, they say, 'We've got to have 10 Aboriginal people in this class.' They always start with the horse behind the cart. Instead of giving the money to the universities, what they should do is put this money into high schools. QITs are the same: they get money and they do not tell the Aboriginal community that the money is there for training, health and education and things like that.

We did a survey once here in Queensland of how many indigenous people do science and so on in grade 11 and 12. It was nearly zero—because they did not understand the subjects. Maths was another thing that they did not do. If we are going to be fair dinkum and talk about Aboriginal health and how to help the Aboriginal people, we have to start on the ground level with the young people. We have to educate those children in the high schools instead of giving all this money to universities. We have young kids like this coming out of them: a 22-year-old up there on the Sunshine Coast who has been employed by Queensland Health as a mental health worker for the indigenous people. The old people up there just laugh at her. It is ridiculous. If a 22-year old came and told me what to do about my mental health, I would tell her to go jump too.

But this is what they are doing, and I think we have to educate our children in grades 11 and 12. Take this money out of the universities. If you quarantined the money that the universities of Australia get to educate the indigenous people—and how many indigenous students come out of those universities?—the mind would boggle because there is that much money going in and we are not getting that many people out. The same goes for the QITs. We have to get it to our children in the high schools to train these kids to do these subjects, go out and help their people and do the work that we want to do.

I say, ‘Yes, the money should go back to governments.’ Toni is answerable to a white boss. We are all answerable to white bosses. I work for the HACC services. By the time the money comes from the Commonwealth government to the state government, we get only a small percentage of the money we need for the old, and it is dreadful. The Commonwealth government and the state government are not thinking about the young people or the old people. This world’s society has wiped old people out. They are not wanted and neither are the young children. It is only the people in between that they worry about. I think we have got to stop that and start working.

CHAIR—We hope to cover education, training and those issues later on in the morning.

Mrs DE-ANNE KELLY—I want to direct a question to Mr Fatnowna, who is here from the community. Mr Fatnowna, when we have been travelling around it has seemed that a lot of the communities would like to have and would benefit from more control over the funding that comes to them. Apparently, there have been moves to do that but that has not generally been successful. Why do you think it is that the funding does not get to communities to make their own decisions? What is the big impediment there?

Mr Fatnowna—I went to a recent health workers meeting in Cairns. Most of the health workers up there were talking about how they do not get to have a look at how much funding they have. And if they do have a look at how much funding, maybe it is three grand or something. That works out, to me, in my book, at about 40c for every indigenous person that you have got to work for in the area, which is not very much at all. That is not a precise amount. But when it gets to having to work with these people, we are under certain guidelines or something for so many months, and if we need a four-wheel drive vehicle or something and we ask for that, we cannot get it because, ‘No, that’s not in your area.’ Then, if you want to put on certain programs, you may spend your three grand within the first three months and then you are not doing any follow-ups. You cannot follow on through. So that puts a stopper right there. We keep asking for the money, or we need to work out some kind of budget that we need for the whole year round so the health workers can work on something.

Mrs DE-ANNE KELLY—Are you saying that the grants are sort of ad hoc—that they do not continue on? You might get something for 12 months?

Mr Fatnowna—Yes. We do not get enough. We are down at the bottom. If we are looking at working on diabetes this week or something, then somebody might have a chart and say, ‘Oh, we want you to work on mental health.’ It clashes with the everyday lives of the people that you are dealing with. So you have got to go out of what you are supposed to

be doing to do something else, and then there is no funding in that area or there is just not enough funding. You are being pulled both ways. It just cannot work.

Mrs DE-ANNE KELLY—Which agencies do you go to for grants—Commonwealth, state, what?

Mr Fatnowna—I write out letters to a lot of agencies to try and get donations or anything like that. But a lot of the people kind of come in—you probably have about two months in advance to work out and find out where the donations are and then by the time the program comes around, sometimes you do not get that donation. Then it is very late, so you try and fall back on how much money you have in your budget to help out. You can't get a look-in on that so you are back at square one. You are just putting out a false hope to these community people. It is just not happening.

Mrs DE-ANNE KELLY—What sort of model for arranging the funding would overcome that difficulty, in your opinion?

Mr Fatnowna—I thought maybe a consultancy one—maybe a media consultancy or something. I was just looking at that kind of way. It is a long way behind. It is just another lot of changing that needs to be done at the top end.

Mrs DE-ANNE KELLY—Changes at the top end?

Mr Fatnowna—Yes.

Mrs Kirk—With talking about models, I think that we should have more indigenous people involved at that high level where the funding is going through, whether we have a body of indigenous people at different levels to become part of a group of people that can be watchdogs with this indigenous money—and not just people that have been around for years and years, either. We have got a lot of indigenous young people coming up and not so young people that have been in health for many, many years, and health workers and community people who are grassroots women and men—just housewives. We could have them as part of the committee, as watchdogs at that level with these millions and millions of dollars for indigenous health that we keep hearing about, that we have got all this money.

CHAIR—Some states actually isolate the money at the senior level and then distribute it through into Aboriginal health, or they endeavour to, and there is an indigenous body that has oversight of the money.

Mrs Kirk—We have got to be careful with the Aboriginal bodies too, because they do not filter down the money either to the indigenous communities. There is a lot of secrecy out in our communities. We are fed up with all this sort of stuff. Community women and men that I speak to, we know that there is money around, but when we go out looking for it we are told, 'Oh, there's no money here. It has gone.' So where does it all go?

Mrs DE-ANNE KELLY—I want to follow up on Maureen's comments. Are you suggesting an ATSIC type model, then, for having Aboriginal involvement at a higher level. I think you mentioned grassroots people. How would you choose these people?

Mrs Kirk—I am not quite sure what the role of NACCHO is, but I hear a lot of things about NACCHO and they are supposed to be advisory to the ministers or something.

CHAIR—They are Aboriginal controlled health centres, I think.

Mrs Kirk—Yes, they control the AMSs.

CHAIR—Robert comes from another body, I think, from the ministerial advisory group.

Mrs Kirk—I do not know whether they watch all the money that is coming down, or whatever.

CHAIR—My understanding is that they would not. They would have that Commonwealth money that goes into the Aboriginal controlled health centres, but as far as the money coming through to state governments or Aboriginal health, it is difficult, because—

Mrs Kirk—There should be another body.

CHAIR—We are just raising that. There are other models around in other states. It is suggested it might be the ATSIC model but I think the ATSIC model is something that has been consigned to history. It is a matter of, when the Commonwealth money gets to the states, who has oversight of that and how it actually gets spent. We should remember back to that original figure that 80 per cent of health services are provided by the mainstream anyway, let alone specifically to Aboriginal services, whether they be NACCHO or other.

Mr Watson—In 1996, the Commonwealth did an audit of state and territory governments' responsibility to indigenous people. That report said that they failed miserably. Aboriginal and Torres Strait Islander people are citizens of this country. The state and territory governments should actually have a responsibility to us as that, and what the Commonwealth provides should be above and beyond what they are supposed to provide, just to get our health status up to the level of the rest of the community.

CHAIR—Can I be clearer, Edward? There are two streams at least. One is the Aboriginal controlled health services and then there is a second component in the Australian Health Agreements, which is coming from the Commonwealth to the states. Part of those formulae, as I understand it, is a component for Aboriginality, for indigenous people, for aged people, et cetera. So the money, when it is coming from the Commonwealth, is at those two levels.

Mr Watson—I am fully aware of that. What I am leading to is that ideally I would like to see the Commonwealth handle all funds, because these people who are supposed to be distributing the funds—which are getting diverted and all the rest of it, and they are not really putting in the people on the ground floor—are negligent in their duty of care, as far as I am concerned.

We need one single responsible body, whether it be the federal government or not, or even the World Health Organisation. We are not averse to going overseas and complaining

about the situation. As Les says, it has been 25 years. We have got all these figures quoted and all the rest of it, that we are doing it. We are on the ground floor, we see what is going on and the people that are dying and all the rest of it.

I am up at Cherbourg Community Health at the moment. You are talking about warts and all; I am going to tell you. Dr Melanie Bond is very concerned. She spoke to her other colleagues that she knows about that stuff that is resistant to penicillin. What do you call it? They have got a terminology for it in Kentucky Fried Chicken language. It is resistant to antibiotics. You can catch that in the community out there—not in the hospital like in the major cities.

That is because the doctors that go up there are trainee doctors who turn around every three months. The people in the community are of the belief that antibiotics can cure all sorts of things—viral infections as well as antibiotic infections. So these people who are only just there, who have had no cross-cultural training or any skills in communication with our people, are confronted by abusive people who are wanting these pills because they are of the belief in the community that it is going to cure whatever they have got. Then the doctors are not assertive enough to explain to them that that is not what it is for, and all this. They give them the medication so that they can get on with the job and not have to face that abuse, because there is a communication breakdown between them, and there is now a situation in that community where there are various infections that you can pick up, as an ordinary person in the community, that are resistant to the antibiotics.

That is a failure on the part of the education process for those doctors, and the fact is that our people, who are in dire straits in the first place, are actually exposed to trainee doctors, with no permanent doctors and no incentive for permanent doctors to be there and have adequate training to skill up the people. A couple of us have been on the radio—we are going to talk about antibiotics and the proper use of them and things like that.

The leaflets that come out do not in any way reflect the language that is being spoken by the various people around the country. They talk about using all the things—the state Health ones are very good. We asked for funding from state Health to put the same messages in the language that we can understand for each specific area; they do not want to know—no funds available. These sorts of things.

We could go on all day—no doubt you guys have heard it from your travels around Australia. But that is a clear example where the state is trying to provide a service but the fact that it was not adequately resourced and educated has created a health problem in itself, let alone the stuff that we are faced with normally.

CHAIR—That picks up those cultural things very strongly. Lori, you have not had a go this morning. Would you like to say something?

Mrs Salam—I was just thinking about the culture side of it. On most government department documents, it has got the little box where you tick whether you are South Sea Islander or Torres Strait Islander or Aboriginal. What is happening in the Bundaberg region, and I am sure it is happening elsewhere up and down the coast, is that they are not being asked the question when they go in to the outpatient department section and in to the

midwifery clinics. In the 1997-98 research that two health workers did in Bundaberg, they found over 900 people within that year were not accounted for.

What I find is that the Bundaberg hospital, with state government health funding, do not want to recognise that there are this many people actually accessing the system. They do not want to know because it may look like they are failing to show that they are not really doing anything for the people. Between Bundaberg and Cherbourg I think there are close on 3,000 Aboriginal and Torres Strait Islander people within that region, and I think this is where another problem is.

The research that those two health workers did was only weekdays—it was not weekends and public holidays—when they came up with this number over a 12-month period. And I think too that Queensland Health actually hides a lot of the stats. The same year, it came from Queensland Health that there was over a million dollars spent from Bundaberg hospital on indigenous health. When you ask for a breakdown, that is not transport, there is not anything included in that, because it was all supposed to go into that hospital system, which does not work. It is not shown.

CHAIR—It is very difficult, and it really highlights again the suspicion or the wariness of really how the service is—the rhetoric and the reality, I suppose.

Mrs Salam—I am sure Bundaberg is not the only region.

Mr Watson—I am on the state steering committee for the quality of the data and things like that. Where the problem lies overall is that the funding is on a population basis, not on a needs basis. Because the major hospitals have actually concentrated in large cities and people are shipped in from outside, it boosts the figures and stats for that particular area and that district manager. So funds come in there, whereas once those people have had the immediate care taken of them they go back to their community and there are absolutely no resources out there to support those people. Somewhere we have got to have a total mental shift so that rather than a population basis to provide health care and various other government structures we go by a needs basis. It should go to the people on the ground floor, the people who are actually at the coalface, and say, 'There are 5,000 indigenous families in the south-east Queensland area. Overall 10 per cent of the funding for the whole state goes here,' and things like that. You can work it out that way.

CHAIR—Kay Elson has something to say on outcomes. We need to be wary of that. Do you want to come in on it?

Mrs ELSON—The area that I have been most interested in when we have travelled in remote Australia areas is that there are no stats. To me there is no accountability either.

Mrs Salam—That is deliberate.

Mrs ELSON—That is what I said: there is no accountability. I would be 100 per cent happy about giving money directly to all of the remote Aboriginal communities and the urban ones, letting them have full control as long as there are outcomes recorded. That is where you should get your funding from, where the biggest need is. Outcomes is recording

everybody that comes in and uses your services; then the next year, if you showed there was a need to have your funding increased, that is where you could have your full control. You would not need any other body around saying that you are not providing that. There are lot of communities in remote areas that turn away cultures that are not theirs. We see in the Northern Territory over 200 different cultures. You cannot put that many health services in one outback town. If it was based on outcomes, they would be more inclined to invite everybody in to use the centre.

Mrs Salam—I think it breaks down the continuity of care. When you have got to go back for funding every six or 12 months, it is not an ongoing thing.

Mr Fatnowna—We are breeding a new generation of young people now. If you can believe in rites of passage and things like that, you can see that the younger people now are getting to be adults at an earlier age than they are usually supposed to be. That is very frightening, when you can stand up there and look at a seven-year-old kid that is supposed to be at school, and he looks at you as a person and tells you to go where you have to go. How do you react to counteract that situation? You need the provision of funding and things like that to get up these programs, to get it out there, to encourage more health workers and things like that.

CHAIR—We need to break in a couple of minutes. I need to ask you to be very quick. Edward, Rosemary and Jill might like to have a go but I also want to highlight that we have got a number that we have not even touched on and we need to move to when we come back at about 11. But I want to encourage discussion.

Ms O'Grady—I can wait.

CHAIR—So just a quick one, Les.

Mr Collins—On the issue of statistics, one of the big problems is that the way they are collected and reported in state-wide reports they come in district aggregates, and unless you go searching you will not get the stats. I had to do that when I did the stuff on Cherbourg: I had to look in all the Wide Bay statistics. We have a situation here with our frame of agreement action plans where, for instance, Palm Island does not come over as a hot spot in the aggregate statistics for a particular district, and yet we all know it is. That is because those statistics are subsumed in those of the general public and they do not show up properly.

Mr Watson—I have seen a ridiculous situation where organisations working on the ground floor spend half their day doing paperwork and all the rest of it. You talk about outcomes. I worked in this PA district for five years in the area of mental health, and we developed the mental health service at Woolloongabba. The impact we had on readmission rates to the hospital was enormous. In one year there were only three that went in, and 9normally a broad range of people went in three or four times a year. What I am getting at is that the statistics are in other departments all around the place. For five years we were after that perinatal data on why people were going in and what their diagnoses were. The data never came to us as workers on the ground floor and of a non-government service. We tried through our own people at various levels to get it.

As far as outcomes go, enough data has been collected from hospital admissions, births and deaths and various other things rather than the onus and the burden actually being put on the people who are working on the ground floor. We would like to be there 24 hours a day, but that is not a possibility. It gets bogged down with the various logs, filling out car things, monthly statistics, all the weekly statistics, where you are going and all that sort of stuff, to make a paper trail for people who do not even bother to go down to the ground floor to see what the problems are because they want to feel comfortable.

Yet we are frustrated on the ground floor because there are not enough resources. In fact, I work up in the south Burnett district. I have a car for an hour and a half a day in a remote area. That is ridiculous. But when you make approaches to district managers, you get this guff that they are going to cut the fleet and these sorts of things. The outcomes should be the impact any health service has on the ground floor compared to the statistics prior to you actually getting in there, and you can easily sort that out in your own departments.

CHAIR—Thank you, Edward. Everyone wants to have a break but, before we do, I welcome the two people at the back who have arrived. I remind you that, when we come back, we need to cover issues around the social and location factors of health: maternal and child health, diet, alcohol and tobacco. We really are very interested in the educational and training issues, which will no doubt lead us back to Aboriginal health workers as well.

Proceedings suspended from 10.42 a.m. to 11.06 a.m.

CHAIR—I encourage those people that have not had too much to say to come more strongly in. I would like to hear from Robert and John—you might like to jump in a bit more. I know that Rosemary will have some comments to make. Would those that have not had much to say, please come in. Robert, did you have anything in particular that you want to get stuck into?

Mr Holt—Before you addressed us at the council meeting do you remember that one thing I mentioned was that if there were any recommendations they were not achievable?

CHAIR—Yes, I do.

Mr Holt—That is it. Let us hope that it is achievable. There are a number of things that I want to bring up and one is about the health workers and their training and education. We have a national document out which is the national competency standard for the health workers. One of my major concerns is that that is a national document. Just recently we had a workshop up in Cairns on the health worker issue. It is a national thing but I will just talk about Queensland. Some of our health workers go interstate for the training. For example, one of our health workers from Kambu went across to Western Australia and did a maternal health course over there and came back with the qualifications for being able to take blood and give immunisation. In Queensland health workers cannot do that. So here is a young person that went over there, got these qualifications and came back here.

One of my biggest recommendations would be that health worker training, like all other education, becomes a national thing. I just heard recently that the transport system is all going to become a national thing, that we all will be able to turn left at the red lights if

careful, and all that. Also, with health workers, that is a national thing. They should be able to bring home those skills with them and use the skills within the community that they serve. As well, their education then should be recognised interstate. Our health workers cannot apply for the top jobs in New South Wales, South Australia and Victoria and all those other places because they are limited by that education certificate or diploma.

The other thing I addressed at the council was the border issue. One of the things that was brought to my notice when I was out at Goondiwindi and Mungindi was that the aged people that come across from Moree and those places can only afford to get to the specialist, say, on their pension day. They get a discount for their travel but, because the hospital is at Goondiwindi on the Queensland side, they do not get money to get back home—they have got to pay the full rate. They are not compensated because on our side that pension card is not recognised.

The other thing is the patient transport system. We get the doctor to write a certificate and we have to go to the specialist. I will talk about St George. The people there tell me that if they have to go to a specialist on Wednesday or even on Monday, they have to leave on the Friday and they do not come back until the following Thursday, so they spend five days away to see a specialist for 20 minutes. Five days to see one person for 20 minutes! And with that patient transport system, the accommodation is only about $20 to $30. If you can get accommodation in Toowoomba for $20 or $30, please let me know because I will direct them there.

With the cost factor, it is not achievable for these people who go away and stay for five nights. They are only seasonal workers out there. It is the cotton season now and soon it will be the shearing season. So the employment situation is one of the things that everybody has to look at about the rural and remote areas. When I went to the rural and remote conference in Adelaide this year, they called it the 'New horizon'. The transport issue did come up, and they spoke about transport in that particular area and they talked about CDEP, but the funding is not meant to transport people. They are some of the main issues that I would like to see addressed somewhere in this document. I see that transport is there, but as for what is there on patient transport, can I use the words 'token gesture'? It is just a little thing there that says, 'Yes, we give you a hand,' but these people cannot afford it.

Mr QUICK—So what is your solution, Robert? What if you were the minister, Michael Wooldridge?

Mr Holt—Give it to Kambu and we will sort it out. That is the medical service in Ipswich.

Mr QUICK—Do we get the optometrist to fly out to the areas once a month on a regular basis, so you do not have to go into town?

Mr Holt—Yes. With those specialist services, a specialist goes out to Dalby. He comes out once a fortnight. That is starting to achieve something. Once a month is a bit too long. For example, the Goolburri dental service has to service a wide area—it covers the Goolburri district, which is a vast area. Some of these people go to the dentist when the dentist comes to their specific town, but that dentist does not come back for another three or four months.

In the meantime, a number of things can happen—the filling can fall out, or the dentist has only addressed half of whatever process is being done in their mouth.

Mr QUICK—Why aren't Aboriginal health workers trained as dental technicians? My understanding is that there is only one Aboriginal dentist in the whole of Australia. Why aren't Aboriginal health workers dental workers as well so that you do not need the specialist to be out there as often because there is a dental technician?

Mr Holt—It was mentioned by Naomi Myers at that meeting. Everybody's biggest focus is on the doctors and nurses—those people delivering primary health care. We seem to get away from oral health and the other major ones. We are channelled down that alley and we have to branch out. Everybody knows that one part affects the other part of the body, so we have to look at it in a holistic way and not just think about how we are to get the doctors to the rural areas and all these incentives. How do we get the dentist? It is hard. It has taken Kambu two years to get a dentist, and we are in an urban situation.

Mr JENKINS—Isn't that what you are asking for, that Kambu make those decisions; that you be given the pot of money, whether it be cashing out MBS and PBS, plus some of the Queensland Health money, and you have control of it and make the decisions about what it is that you buy in or get in or train up or whatever?

Mr Watson—If those organisations can hire and fire, sure, but when we put in a submission saying, 'We want a doctor for this service,' we have to wait for all the infrastructure to happen. If it is on the ground floor, where indigenous organisations can say, 'Okay, this is the amount of money, we are prepared to retain you to work for us,' that would be a lot better. It gives more control to the people, they know what the needs are and they will make the demand for the particular specialist to come into that service. You were talking about dental stuff before. Well, gingivitis causes kidney problems later on, so you are going to be backing up with the machines again. But if we had that sort of thing, then if we needed a psychologist somewhere we could just put out the tender like everyone else in the public sector and get it. The money is not available. We have been going cap in hand for the last 25 years to governments of various forms and to various departments. It is degrading, it is demeaning and it is an absolute failure so far.

Mr SCHULTZ—That is compounded too by the fact that we have seen a number of wonderful medical clinics doing outstanding work in some of the isolated communities, and there is a fully fitted out, state-of-the-art dental facility there and they cannot get the dentists.

Mrs McMahon—The trouble in Queensland—I do not know about the rest of the states—is that primary health care is worked out between the hospitals and the general practitioners. People go into hospitals and have an operation, say, a gall bladder out, and they are sent home. They could have that at 9 o'clock in the morning, they are sent home and it is left to the health workers on the ground to make sure that those people get to the general practitioners to have the necessary medical assistance to help them over the next couple of weeks. At one time, when you had your gall bladder out you spent five or six days in hospital.

It is putting a lot of pressure on our health workers, and our health workers are not getting recognised for it. The general practitioners are being paid by the Commonwealth government for Aboriginal health. The Aboriginal health workers are educating the general practitioners with no fee at all, but if you want the general practitioners to educate you they want a fee for it. It is about time things were really turned around so that the health workers get the proper recognition that they need and the pay that they need. It will make it a lot easier because the stress that our health workers are getting themselves into is utterly ridiculous. In the mainstream, it would not even be thought of.

For mental health patients who should be in hospitals, they have not got enough beds, even in Nambour, so it is the Murri ones who are thrown out. They are then left to the health workers and you have a 24-hour call for this person who needs mental health training. The mainstream mental health will not touch them if they have had a few drugs or had a few drinks, so it is left to the health workers to work out this person until 9 o'clock in the morning before they can get some help. I think that is our biggest problem.

As I said before, I think it is better if the Commonwealth take our money back and give it to some of the community organisations, not to ATSIC. The Commonwealth should handle it and let it come to the community organisations where they are made accountable by the government. We have to have our statistics in to get the money, whereas hospitals and that do not.

They do not have to have any statistics, but they are the first ones to come to me for stats. Their planning committee came to me and said, 'Betty, how many Aboriginal people do you think would access the Nambour hospital?' I said, 'I wouldn't have a clue. You should have your own stats. What do you want to know for?' They said, 'So we can put in for funding. We get our funding by bed numbers.' If they put down that they get 1,000 Aboriginal and Torres Strait Islander people a year in the Nambour hospital, that is boosting their funds up, plus all the other funding they get. But they are only keeping those people in there for one or two days, which is not right. The services are falling back onto the health workers, and I think a lot of these AMSs, even the remote controlled ones, are saving the federal government millions and millions of dollars with Medicare, because the AMSs are doing the work of doctors out in those communities and they cannot claim Medicare. With a doctor, you have just got to go and get a prick on your finger and your Medicare card has gone through.

Ms HALL—Would I be correct in assuming, or taking from the discussions today, that there is a general feeling that a global health budget to Aboriginal health services would be supported by most of the people within the room? If so, how can we be guaranteed that some of the services that have got the greatest need but are probably the least able to prepare submissions and come up with those outcomes actually get their share of the budget? Whereas you have put up a very strong case for global funding of Aboriginal health services, how can we make sure that quite often the most disadvantaged groups in the community, and disadvantaged with their stats collection, their data collection and their ability to complete those submissions, actually get their share?

CHAIR—Do you have anyone in mind you can direct that question to?

Ms HALL—No, it is open.

CHAIR—Robert would like to say something, then Les and Betty.

Mr Holt—First of all I would like to say something about the funding of the ones with the greatest need. My perception always was that what should be funded first is those established AMSs to fully equip them, meet the needs they have already. They are three-parts way there, and you should fully establish those first before you go on to the ones with the greatest needs. We keep seeing that for the year 2000-01 there is one point something million for this, and then we go on from $2 million to $3 million, and then it is $2.3 million, and it increases over five years. In the first year, you should fully equip those ones that are established.

CHAIR—Now Les wants to contribute, and then Betty, Edward and Maureen. Just keep your statements concise and quick to the point, and we will just keep rolling.

Mr Collins—In terms of that global budget issue, the National Aboriginal Health Strategy recommended yonks ago that there be single-source funding for Aboriginal community controlled primary health care services. I guess the issue is how much the global budget is going to be. In terms of directing it to those areas that are of greatest need, you would need some way of establishing that. Some of the issues that need to come into account are things like: what is the real cost of care, what data is there to support or to enable directing money to those in greatest need?

Invariably, you will find that, when an Aboriginal community controlled health service gets established, in its first 12 months the data will show that there are a hell of a lot of problems. The reality is that no-one knew in the first place, and it was not until the Aboriginal community controlled health services got set up that this information was able to be forthcoming.

If you are talking about global budgets, that has been recommended a long time ago. Clearly the big issue is how much and how you estimate that. We had one of the most eminent health economists in the country get up at the rural health get-together in Mount Beauty a few years ago and recommend that the best way the Australian government could spend a billion dollars would be to spend it on Aboriginal health. That is a notional figure but in my estimation of things it is going to cost a bit more than that, and over an extended period of time. These are the issues involved in how to get to that point.

Mrs McMahon—That is what I think. It has to be global. The money that comes to the states we are losing. We used to have a policy unit within Queensland Health, and we used to get our money through there for our health, but now the state government have wiped that out. That policy unit is just a figure. They have got a director in there that has no funding. To all of us Murris, it is a real joke. He does not even have a budget. He is the Director of Aboriginal and Torres Strait Islander Health in Queensland and does not even have a budget.

I have had the beauty of working with both sides—with QAIFH and with Queensland Health. Lori and I were on the advisory council last year. We put up some darn good

recommendations but they did not get past the bureaucrats within the state government. That is why I think we have to have a global budget and it has to be split in a certain way—

CHAIR—Jill, if I can just interrupt: when you say 'global', can you define that? Are you talking about the pooling of Commonwealth-state or what do you—

Ms HALL—By global I mean that an Aboriginal medical service, or whatever community health service it would be, would be given a lump sum. It could then determine its priorities and the programs it needs to run. You would be accountable, of course. Say you were funded for a three-year period, at the end of that period you would have to supply the outcomes to prove that the money had been spent. But if one community had a special issue—diabetes is a big issue—then you would obviously have a lot of programs that were structured towards that. You would be able to identify, say, 10 or so key programs that you wanted to work towards, rather than your programs having—

CHAIR—What I was hoping to get to, Jill, was in terms of the state programs that Betty was defining there. If the state is applying for federal programs—

Ms HALL—No, it would be directly funded to the organisations rather than going from Commonwealth to state. It would be a pot of money that went to a community, for the community to determine how they wanted to spend that money.

Mrs McMahon—At the moment what we have, even with the AMSs—and Queensland Health also—is that you only have that 12 months funding. It is a long story about the way we work, but we had some money left over. We had to put in to have that money used for drug and alcohol. We can only use that for 12 months. We just get the program set up—

CHAIR—Was that state or federal money?

Mrs McMahon—Federal money. We are only just getting that program set up in 12 months, and no more money. The community just asks us, 'You had that there last year. So why can't you help us this year?'

CHAIR—It is about the sustainability of programs.

Mrs Kirk—I am not quite sure whether we should give it all to community health. They have to be accountable too to the community. There is a rift and a division between community health and state health workers and state, but not all the Aboriginal community use community health. So I have a concern about all the money going towards community health.

There has got to be something set up to watch where this money is going, and not just people who are involved in community health being accountable for that money. They have got to start putting some community people in who are not involved. The Aboriginal medical centres have to have some sort of outsiders. I am just not in agreeance that they should get all the money.

Mr Watson—I wanted to talk about AMSs. I was in a situation where one AMS is actually a company under the Aboriginal associations act. When that particular company was taken to task as to its accountability as far as funding goes, it was outside of the CJC's jurisdiction and it was outside of the Australian Securities Commission, and you had to go to three different departments in the state to bring those people to task.

If Aboriginal organisations were formed under the Commonwealth Aboriginal associations act from 1986, at least you can ring up the registrar or you can ring up someone and there is accountability for misappropriation of funds in that area. But there are some services that were set up prior to that legislation and there is no act of parliament that allows the various watchdog committees or departments to actually look at them. That is because precedent has been set in Queensland, in the Supreme Court, in regard to associations and various companies. So, if you are going to pour big heaps of money into certain organisations that are clearly shown not to be responsible for that period of time when the people are in charge, then you are going to have a barney on your hands and you are going to have all sorts of problems.

CHAIR—That is an excellent comment because it raises the sort of thing we are here to tease out and understand.

Mr Watson—What happens is that you have these structures that we have to operate through, through various legislation and companies acts, but some boards of trustees are on top of, say, a large pool of money. Let me go just for a little bit and I will keep quiet after that. New South Wales had a situation where six per cent, I think, or two per cent, of all land sales went into the coffers purely for Aboriginal people. In 1986, $54 million of that money was not spent. It did not go back into consolidated revenue.

So they went and collected people from out of the community who went around and said, 'This is your area that you had the trouble.' This bloke went around Dubbo and all that and looked at aged care facilities. He did not go anywhere near the organisations and the various people that are around; he went out to the community and talked to the people themselves. They said, 'The priority we want is aged care housing.' So he went back to the government, who had that money, and said, 'This is where it is at.' So they spent that $54 million the following year on housing. That was a good model that could possibly operate with a group of people over the top that haven't got affiliations to one particular organisation or whatever.

CHAIR—But it would create some pretty interesting conversations between the established organisations as well. The tensions between organisations would be fairly significant, wouldn't they? There would be significant political pressure on the existing organisations if it was not being spent, if it was spent in a coming-in-over-the-top model. I am just being the devil's advocate. Those existing organisations would have had different priorities, I would presume.

Mr Watson—Yes. But if there is any excess—say, the whole budget globally might have $200 million or $300 million left over at the end of the year—instead of that going back into consolidated revenue, then you say, 'Okay, this year you operated—

CHAIR—Understood.

Mr Watson—You go out and find out what the need is on the ground floor and just bang it straight in there.

CHAIR—Rudy, do you want to come in?

Mr Sandy—I just want to answer Mr Quick's question about why not so many indigenous professionals are coming back into the community. When they are going through university, the problem that happens is that they get picked up with scholarships through agencies or departments or whatever and none of them ever get back to the community. It is a big problem with the competency standard in communities falling rather than rising through education or whatever, because state and Commonwealth governments are picking them up and we are not getting the chance for them to be promoted within their own communities or whatever else.

The other thing I want to pick up on is the mention of disparity of funds, whether they go to regions, states or wherever. To look at the disparity in funds: the NACCHO stats show that Queensland, with one of the biggest populations of indigenous people, from its OATSIH funds gets $103,000. This is from the figures for 1995-96, and I do not think there is much change in that time. Then we leap over into funding from all services per capita. From OATSIH it is $103; when we go to all funding per capita, it is $185. That is saying that the state government has put in about $82.

Then we go to a state like Victoria or Tasmania. The OATSIH figure there is $155 per capita, with funding from all sources per capita at $813. Also in South Australia—I guess you might have something to do with it—it is $498 from OATSIH per capita and from all sources it is $698. That is great for South Australia and great for Victoria.

The point I am trying to make is that you can see from these figures that it is the states who are not contributing to the health funds for indigenous people. Maybe in the future when you look at funding for specific states these figures should be taken into account. In Queensland we need to look at whether the funding that comes into the state should go straight to the Queensland Health or, as Ms Hall has said, to indigenous organisations.

I want to pick up on that in relation to people on the boards of the community controlled health services. The vast majority of people on these boards are very honest, hardworking people who are trying to give a service to their community. The unfortunate thing is the amount of funds that actually come to them. They have to be responsible for the funds that come to them and it is not their fault if funds do not become available for health workers and so on. We fight hard for our health workers and for whatever they get. The unfortunate thing, as I say, is that it is the state government that you have to fight hard to try to get those funds out for specifics, whether they are health workers or whatever else.

I come back once again to this: if people feel that they need to contribute to the community controlled health services, they should come along to the meetings—the AGMs or whatever else—and come onto the boards. We do not knock back anyone in our area and I am sure if people in other areas would like to go onto those boards, they should see fit to attempt to get onto these boards and then be able to control any funds that are coming down.

CHAIR—So it is very open and available to people to participate?

Mr Watson—Yes.

Mrs McMahon—Getting back to that: our problems started with nepotism. That caused the breakdown between our medical service and that is why we are in the position we are in now. We have changed our constitution so that only one family member can be on the committee at any one time and no employees can be on the committee. We had the same thing in our HACC service, which has been going for three years. I have had arguments with ATSIC because ATSIC will not change the guidelines in the constitution at all. Even if they changed their guidelines that only two family members could sit on a board, it would make it a lot easier for the people in the communities, but they will not take the steps to do that, to try and wipe out nepotism. A lot of these families do work hard, but you have the odd one and then everybody gets tarred with the same brush.

The people at the top have to protect the ones that are working hard at the ground roots by taking this stand, to help us in the community situations with our funding. We are fighting hard, but we are not getting the help from up the top.

Mr QUICK—Harry mentioned models. I have just been having a yarn to Robert. On page 13 it says that the per capita MBS payments vary from, in the Northern Territory, $169 to $337.70 nationally. If we cashed that up for indigenous people—there are 368,000—and if you multiply that by 37, it comes to about $1.3 million. If you put a weighting, for example, of 0.6 for urban services, because their needs are not as great and they can access a whole lot of other things, 0.8 for rural, a full weighting for remote areas and gave five-year funding per head of population, you would provide the 100 AMSs in Australia with a hell of a lot more money than they are getting now. There is transparency. They have the five-year funding, so they can plan and they do not have to worry about filling in Commonwealth and state forms and have this section by section thing. They can have a holistic approach, much like what is done in the Tiwi Islands. I am not even talking about PBS. That, at least, would be a start. For a community of 1,000—as a schoolteacher, I have been doing sums—it is $337,000; for a community of 2,000, $674,000; for a community of 3,000, over $1 million. If you multiply it by five, there is guaranteed funding there. You can decide what you want to do. If you want to buy in optometry services, speech therapists or whatever it is, there are no excuses. No-one is going to duckshove. That is my contribution.

CHAIR—To me, there is a lot of merit in having some kind of equity. My secretary was showing me a quote from the Health Insurance Commission which essentially reminded us that—and I quote:

> . . . the Medicare system cannot of itself be expected to serve as an adequate funding mechanism for health care for Aboriginal and Torres Strait Islander peoples unless Medicare were to be radically altered.

It is there in our discussion paper; we think it is that important. With respect to those basic numbers that Harry alluded to, you do not have to be Einstein to work out the sort of dollars that might be available. There are some trade-offs; nevertheless, the statement is here very clearly from a fairly authoritative source. They are the sort of things that we want to hear

about. We have some balancing arguments, if you like, in terms of the more holistic approach.

Mr QUICK—Hopefully, someone in the Commonwealth could tell us what each of the AMSs in Australia gets in the way of funding. If they cannot, it is a crying shame.

CHAIR—It would not be that hard. OATSIH would be able to tell us in about two minutes, I would imagine.

Mrs McMahon—We know how much we get.

Mr QUICK—You get something but then there is all of this other stuff. It is like a Petty cartoon of how you link in to all the other bits and pieces and no-one can quantify that. That is why the system is stuffed, in my mind. You cannot unravel the Gordian knot with Queensland Health or New South Wales Health or Northern Territory Health.

Mrs McMahon—Queensland Health is mainstream in all Aboriginal health. Everything will be mainstream—even with the HACC services. Once upon a time, we used to have an Aboriginal HACC coordinator for the whole of Queensland. We would have meetings on how our people needed help and how to get access for our old people. That has gone. We have not even got that any more. We are left with a mainstream project officer. It makes it very difficult because all the meetings I go to are mainstream. Our people do have a difficulty in accessing mainstream. The only question they ask me in mainstream is: why don't we have any Aboriginals in nursing homes? I said, 'Because of the extended family.' This is what governments have to look at.

Mr QUICK—You would not need to have all these meetings and Commonwealth and state bureaucrats flying all over the place to work out framework agreements with no sanctions. If you have the money, you can decide that the HACC service is a priority, nursing homes for aged indigenous people are a priority. You have your bag of money, you have it for five years, you can work out your strategy with John Spink, who can put all the numbers in the computer and work it all out. You can then say to the community, 'Here it is, sit down and work out your priorities. You only have that amount of money, there is no more, end of story.' I am sure that the disparity between us and you is going to come down, and there will be no excuses.

Mrs McMahon—That is true.

CHAIR—Lori, would you like to come in?

Mrs Salam—I was thinking about how you were saying earlier that everybody goes off and gets trained and does not come back to the community. What happened in my instance was that I am a registered midwife, and off I go and work for Queensland Health. I want to run the programs for the indigenous women and families, but my idea was to go out to them. What happened was that they said, 'No, they have to come in to see you,' and I am a hospital based person. You are not going to get them, therefore my programs are going to look as though they failed, and that is the way it works.

CHAIR—Such an important part of the work you could have done was going out to these places.

Mrs Salam—If I had gone out it would have worked but because I am staying in, it has not.

Mr QUICK—If Betty has got the funding she can say to you, Lori, 'I want you and your team to come out.'

Mrs Salam—Not if we are under Queensland Health.

Mr QUICK—No, but under this new system: Betty has her bag of money—X millions of dollars—so she can then say to you, 'Where are all these people that you have trained,' indigenous people, culturally aware and sensitive, 'come out and do it.' The community does not have to go out, you can come in.

Mr Collins—A notion that NACCHO has been talking about with the Health Insurance Commission for a while to cap funding is to have cashing out.

Mr QUICK—Cashing up?

Mr Collins—Yes. Health services across the country have identified a couple of problems with it; they are still working it through. One of the keys ones with cap funding is whether it will have some basis per units of care and the real cost of care. For instance, you might have a significant part of the patient load at Kambu which requires a lot more intervention than, say, patients at some other place. Therefore, the cost of care is going to be affected.

CHAIR—It is very wise to bring that point out.

Mr QUICK—My cashing up is $130 million a year. People are bandying about the fact that indigenous health needs $1 billion. I am talking about $130 million.

Mr Collins—One of the other problems was that if somebody from Cairns came down to Rockhampton and got treated at Bidgerdii, for instance, how would that get paid for? Would that be taken out of Bidgerdii's budget and then reimbursed? Who would do all that sort of stuff? The other very important thing is that there needs to be a fundamental shift in the way that Medicare funds are provided and what they are provided for. At the moment they are only for GP consultations, they are not for primary health care.

Mr Watson—What international treaty obligations have been ratified with respect to human rights, our health status and all the rest of it? We are pretty much in the dark unless we probe through the Internet and find out what is going on. There has been a lot of talk over the last 25 years. I was fully aware of Gough Whitlam's statement in the General Assembly. What do you guys carry in your minds for us as a group with regard to health status? We are looking at the stuff on the ground floor here, but there are obligations under those various treaties. I know Australia is a signatory, but there are some that they have

actually ratified in this country that they should be operating under. I am just curious about whether you can share some information about this. Could you indulge us?

Mr QUICK—We can ratify heaps and heaps of treaties—and we have a special House committee on treaties—but they have no effect, in my understanding, until legislation is passed in Australia.

Mr Watson—Just focus on our health status then, because this is what we are on at the moment. Has anything been ratified? What about the Ottawa agreement or whatever on indigenous health?

CHAIR—I am not an expert on it, but I think the general principle is as Harry Quick has said. We might come back to that if we have time. Give us a bit of time to think about that. Harry Jenkins would like to comment.

Mr QUICK—Yesterday we heard Professor Ian Ring mention that the reason North American Indians and New Zealand Maoris have managed to cut down the disparity is that they have the treaties with the American federal government and the Treaty of Waitangi. His suggestion was that we will never get a treaty in Australia at the moment, that it is politically incorrect to even think about it.

CHAIR—The Treaty of Waitangi was in 1844, wasn't it?

Mr QUICK—Perhaps one of our recommendations should be that we have an agreement.

CHAIR—I am going to have to cut you off, Harry, because Harry Jenkins is very patiently waiting for an opportunity to speak.

Mr Watson—Is this gagging the debate?

Mr JENKINS—I think the point that Harry raises is the more important question for a committee like this to come to grips with. I do understand where you are coming from about international treaties and the health status of indigenous people, or first nation people. Whilst Australia, as a country, has been involved in things that give a guiding principle, I think there is a growing understanding that a lot of the issues this committee has been looking at result from social influences and from past history. We have to recognise that. How the committee actually comes to grips with that, I cannot tell you today. One thing is that this is a multiparty committee, and there has been a desire to try to achieve things that each of us, as members of different political parties, will sign off on. As I say, perhaps these issues will have to be tossed around.

I am not running away from that question, we appreciate that that was put on the table, but I want to go to a another matter. If we are talking about this cashing out, I am conscious of the fact that we are really talking about just AMSs. I get the feeling that a large proportion of the indigenous population of Queensland is directly served by Queensland Health. I wonder how we can encourage Queensland Health to be involved in a greater

degree of community consultation and to take responsibility for being involved in capacity building for the communities themselves?

Northern Territory Health say that they are involved in capacity building. I am not in a position to judge whether or not that is the case, but at least where they directly provide the services they have some understanding that the next step they should be aspiring to is that type of thing. I do not know who I am asking, but could somebody make a comment? I think that gets to a bit of our frustration, because we understand we will still have to deal with state departments because they provide the services.

Mrs McMahon—I think Queensland Health have to educate their district managers. On the Sunshine Coast we have been trying to get our district manager to do exactly that, to communicate with the community, but it has always been overlooked; it has never been taken up. I think we made Queensland Health sit up when our model to buy in the services was put up. We had to set up a partnership with Queensland Health and the general practitioners, and I think Queensland Health thought, 'Gee, they have all this money, about $400,000 or $500,000. We will get this, because we are in the partnership.' We knew exactly what Queensland Health wanted to do, so we had a talk amongst ourselves and decided to tender it out, and neither Queensland Health nor the general practitioners won any of the tenders.

We did it all in the proper way. We had politicians, local mayors and people from the university sit on those interviewing panels. We even had Les there. When you compared the Queensland Health's submission with the submission put in by the Aboriginal community organisation, it appeared as though the Aboriginal community health one had been put in by a professor and the Queensland Health one had been put in by a two-year-old child. Everybody who sat on that board was absolutely disgusted by what Queensland Health put in. All that money went to a community organisation which is working quite well. We now have seven workers in that organisation who are getting down to the community. That organisation buys the services for those things. It has actually broken the partnership with Queensland Health.

Mr Collins—Queensland Health will probably argue that they do that sort of stuff, like consultation and capacity building, whereas the communities would argue differently, I suppose. One of the things that Queensland Health need to do is to take serious note of the achievements of community controlled organisations and community controlled health services.

The VAHS in Fitzroy, since its inception in 1972, has been largely responsible for increasing the life expectancy of males in the inner suburbs of Melbourne from the low 30s to around 57-58 at this point in time. The way in which the Nganampa Health Service has provided services has reduced the STD incidence by 80 per cent. If we had the computerised information systems in place, we would be able to get this sort of data out. In the Brisbane ATSIC regional council area the efforts of health services like Brisbane and Kambu can be directly attributed to the increase in life expectancy of Aboriginal people in this particular region, and the story goes on. Where Aboriginal community controlled health services have been up and running for 10 years or more, you can see a real, marked improvements.

The other thing with Queensland Health is that they have an opportunity by way of the health act to provide health services within the context of affirmative action and social justice. When they go about implementing it and providing a service they need to maximise the legislative opportunity they have. They need, in my view, to ensure that the service agreements they have with the district managers and people like that embody targets and things like that which are clearly about focusing on and improving Aboriginal health outcomes. We do not know if they do that, because we never get to see that sort of information.

CHAIR—Betty, can you enlarge on your service, the purchaser provider model. Is that within the normal AMS structure?

Mrs McMahon—No.

CHAIR—I did not think it was, and I wanted to try to draw that out. Could you explain a little about that?

Mrs McMahon—I will let John do that.

Mr Spink—The model in which we work includes a partnership with Queensland Health, the Division of General Practice, the North Coast Aboriginal Corporation for Community Health and now the Queensland Public Health Unit. Our geographical area covers Caloundra to Gympie and up into the hinterland to Kilcoy. It is a big area. The needs are determined and then services are developed and tendered out in the community. Queensland Health tendered for a couple of those services. They were unsuccessful.

As far as accountability for the funding goes, those services now being developed and delivered will be monitored by that partnership, and OATSIH will sit in on that particular partnership in an observer role as well. So accountability should be pretty well of a high standard. I think the model we are working under, the purchaser provider model, is 12 months young—or old—and it is probably due for some sort of review in the next six months or so by the minister's department.

CHAIR—And if you were changing it a little, in which direction would you go? Is there something emerging?

Mr Spink—No. I spent many years in Central Australia working with a similar model. I worked with a drug and alcohol agency there which was directly funded by the Northern Territory government to deliver the Remote Area Aboriginal Alcohol and Other Substance strategy. We got about $150,000. It was all about addressing alcohol in the first place and then, of course, when petrol sniffing came on deck, it was all about that. We employed a cross-cultural facilitator to visit the remote areas—over 35, I think, over the six or seven years it was operable, and it still is, I think. She spent time in the community with people, and then the community would send in a submission. Those submissions ranged between $500 and $20,000. We funded all the remote area night patrols that began many years ago and now the diversionary strategies. By doing it that way, it was creating ownership, autonomy and that sort of stuff for Aboriginal communities to be able to have a bit of money to purchase whatever service they wanted and however they wanted to deliver a

particular program to address the issue. Thereby, the productivity level was a lot higher than normal. I think the purchaser provider stuff has got a bit going for it.

Mr QUICK—What is your budget, John?

CHAIR—On the issue of Queensland Health or encouraging the state—whatever terminology you want to use—I want to ask Maureen whether she has some comments on the general state in response to Harry and whether Harry would like to have another bite of that in terms of how we would bring the state health services with us.

Mrs Kirk—I can speak only from the area I am working in and from what I have heard. We do have an agreement—a partnership. Queensland Health is looking more into having partnerships with different organisations within the community—working with OATSIH and private companies as well. There are pluses working with the Aboriginal medical services. We are looking at partnerships in the area that I work in with the cancer stuff.

Mr JENKINS—The only comment I would make is that the flavour of the discussion paper indicates the committee has great confidence in the community-controlled sector and has some attraction to ensuring that that is bolstered up. I think it is safe to say that we have learnt in the consultations that there are varying views about how far we can push that. One of the reasons is that people have quite rightly indicated that there are some communities where there would be a lot of work required to enable them to have the ability to take over the community control. We are now very conscious of that as an aspect. The only reason I floated the question was to get some feedback in a Queensland context.

CHAIR—Thank you for that. I think there are 39 districts in Queensland, and there are some areas where the AMSs are not represented—and would not offer a service, of course. So it is the only available service. How we do that is very important. I am acutely conscious—and the statistics, et cetera, may not always be helpful—that we do have a strong reliance on the state health service. How that works better, whether it is through liaison staff, whether it is through cleaning up the Aboriginal health worker issue or whatever, seems to me to be an essential component in terms of working with the state system as best we can and the Aboriginal controlled sector as well. I keep coming back to that.

Mr Holt—I think mine is probably a bit of a success story. I have been on the board of Kambu for nearly 10 years now. One of the things with Queensland Health—or State Health as it was—is that I was one of those arrogant property people who closed the door on them. But in the last three or four years, I reopened the door so that we could sit around the table. That way, you read and hear how much funding they have for indigenous health. Thanks to the coordinator that we have in our West Moreton district, we are able to sit down and form a reference group.

We invited a number of Aboriginal organisations within our community to sit around the table, and we have achieved so much in the last three or four years. Queensland Health funds us for a nutritionist, and we get services through them. All it took was for me, I suppose, as the chairperson, to open the curtain. Not only that, I think it is do with communication. It is like a happy marriage: if you do not have a good communication, you do not have a relationship, do you?

Mr Sandy—Whilst we do not have a level playing field in relation to funding, the community controlled health services cannot have a partnership with Queensland Health, because there is no level playing field. The money comes straight from the Commonwealth government. There is no indigenous signatory there to say that X amount of dollars has to be spent on indigenous health in this state, and that is where the problem lies. It also lies in the housing, and you can go on.

It is the way the system works between funding from the Commonwealth to the states and how much control indigenous people may have over the funding that comes in. The only way you are going to have some type of control over it is to maybe have a peak indigenous health body within the state, or within regions of the state that can sign off on specific moneys that are supposed to go to indigenous health. Until that happens, we do not have a hope in hell of coming to any agreement with the Queensland state government in relation to health, because we are not partners, so to speak. We are just sitting on the sidelines clapping.

Ms HALL—What you are saying is that you need an equal partnership to be able to work together rather than the unequal system that exists at the moment?

Mr Spink—Yes.

Mr Holt—Earlier on, Betty talked about our state director. He could take recommendations up, but it all stops with the DG. That is it—no-where else. There are a number of things we do not have to which we could go to achieve something, instead of it being just one man or one person making a decision.

CHAIR—It is very clear to me that you have got to have access at the top level and be represented in meaningful decisions that you can respect, which basically means an equal partnership. There is a blockage. You have got a way to go. You get so far, and you open a door or two to get a few things, but you want the 'Full Monty' sort of thing.

Mr QUICK—We have got the Commonwealth here: can we get their side of the story? What are they putting in place to ensure that the field is being levelled off with the bulldozer?

CHAIR—They would be restricted once again by the Constitution. I think that might be their answer, but it is not for me to speak for them. I was going to ask Toni because I know there was something she did want to say about a new alliance. Maybe it is an appropriate time for the Commonwealth officers to just say a couple of words about it after listening to the discussion we have had for the last hour and after listening to those issues you mentioned to me. What opportunities are there for that partnership to develop at the state level and how therefore is the framework agreement, et cetera, having some influence on it? I am not asking for miracles; I am just asking for an assessment and where we might go.

Ms Malamoo—I know there has been discussion in terms of Robert's concern about the actual ability to coordinate services at a regional level. It is based around a personality—the coordinator, in terms of Ipswich. In terms of the framework agreement, it has to come down from a state level to a more regional focus. These are probably some of the issues that both Betty and John have raised around the model that has actually been set up at the north coast

and the players that are involved in partnership there to bring about services to Aboriginal and Torres Strait Islander people in that area. It is not necessarily a model that is supported by the community controlled health sector in full but it is something that sends a clear message that regional partnerships can work.

I guess the transparency issue from Queensland Health is still a major issue for Aboriginal and Torres Strait Islander people in terms of knowing what sorts of dollars have been rolling out. Maybe that is a way to ensure that that information will be available. In terms of a state based alliance, there is the Aboriginal and Torres Strait Islander Health Alliance, which is an agreement, a memorandum of understanding, that has been signed off outside of the framework. It has been signed off by the ministers but it has come down one level. It has been signed off by state based organisations such as the QRMSA, which is the Queensland Remote Medical Support Agency; QDGP—Queensland Division of General Practice; the AMAQ, Australian Medical Association of Queensland; and QAIHF, Queensland Aboriginal and Torres Strait Islander Health Forum. Queensland Health, as far I understand, had an issue with the legalities that would bind them to that memorandum of understanding. I understand that has been worked through. I think they have actually signed the agreement. That alliance has actually sorted out a protocol, if you like, at the state level, between state based organisations and their contribution to Aboriginal and Torres Strait Islander health in Queensland.

So that is a level across but I think we need to take that alliance down to the level of community controlled health services, community health centres and hospitals involving dons and medical supervisors. I do not know whether district managers would sign off at that level. I think possibly the Aboriginal coordinators would sign off with Aboriginal community controlled health services. But I would have to say that the community control would have to push district managers to actually agree to some type of regional partnership model.

CHAIR—Thanks for that. That is a pretty good overview. How long has that state alliance been going—12 months?

Ms Malamoo—We signed off in July this year.

CHAIR—So it is very recent—just coming to six months?

Ms Malamoo—Yes, that is right. It is an issue. QAIHF clearly recognised its role in primary health care services and as a primary health care provider. I would have to say the community controlled health sector, from where I sit, leads in primary health care. You have got the hospital environment, the community health centres which Queensland Health is trying to combine in a primary health care model and the general practice sector which we are trying to move to addressing population health issues so that it becomes more of a primary health care model, whereas the community controlled health sector is a primary health care model. It operates a clinical, preventive, promotional, educational and training role. It actually rolls out the whole box and dice, if you like. It should be a model that everybody looks at as something that, in terms of primary health care, can be used across the board by all providers who want to get involved in primary health care.

CHAIR—While Toni is discussing this general issue of Queensland, can I draw you out on the 39 districts?

Ms Mulherin—In respect of the community controlled health services in the 39 districts, community health centres attach to those 39 districts.

CHAIR—How many would have AMSs?

Ms Mulherin—Les, out of the 39 districts, how many would have community controlled health services?

Mr Collins—There are fourteen community controlled health services that provide primary health care. There are a couple of variations to that model that have been imposed by the minister for health.

CHAIR—It just highlights that there are significant areas where there is no AMS and where Queensland Health is the only service.

Ms Mulherin—Yes, that is right in terms of the deed of grant in trust communities, and there are 29 of those in Queensland. The majority are in Cape York and Torres Strait.

CHAIR—Could you repeat that last bit?

Ms Mulherin—The deed of grant in trust communities or DOGIT is legislated under the Department of Aboriginal and Torres Strait Islander development.

CHAIR—Okay. The last point is in terms of the geography of Queensland. We realise how far it is from Cape York to the New South Wales border. I flew from Cairns yesterday. That creates its own issues, more decentralised in some ways, but nevertheless, it is a huge task in terms of delivering services and in terms of the population spread. In the Northern Territory, you have got up the track and then a range of isolated communities. But Queensland presents its own challenges. I just wanted to put that on the record in terms of inviting comment about how that is different from the rest of Australia and to remind all of us, as committee members, how Queensland does have significant problems. Western Australia might claim to have some similarities; I just put that on the table. Does anyone want to continue with the Commonwealth officers?

Mr Watson—I have got an area that I would like to talk about.

CHAIR—Is it related?

Mr Watson—Yes. They are a separate entity because they have to go through the local council, but there is no equity in the land and those councils have to go to state government, or whatever, to seek funding to put up what they feel is necessary for that community, and that is one of the crazy things about Queensland. There is no equity in the land that the council owns, in a sense, because it is under specific legislation, and there are all sorts of rules involved in that.

For them to get money up there, they are leasing properties belonging in that DOGIT area to farmers so that they can have some sort of income to build infrastructure to try and support that community. Those councils and those people who are operating there, looking after social services within the DOGIT areas and providing the adequate services, are hamstrung. They go cap in hand to state government.

I do not know how the federal government can go directly to fund those sorts of things because there is a quasi sort of a situation that sits in Queensland. There is a real dilemma there. In fact, they are talking about competing with state health medical services in Cherbourg. They are building another medical service not 50 yards away. You can guarantee that, because of the movement that way, people are going to move out of there and you will have something that has been wasted for that period.

It mainly comes down to that land having no things. If the council says that they have got X amount of millions of dollars in equity in the area which is regarded as Cherbourg, let us say, then they can invest in industries and various other ways to be independent of direct funding from government to support that community and bring about better health outcomes. But it is not possible under the legislation that is available in Queensland.

Ms O'Grady—I am speaking partly as a person who has lived in the bush for a long time but mainly as a lawyer. I do not mean to be critical here; I am just trying to be analytical. All the time, we are talking principally about money—and this is understandable—and then there is a degree of confusion about power. That is not surprising because of the nature of the federal system and the shire and council structures within states. Perhaps to oversimplify the equation, a huge percentage or concentration of the energy of this entire problem solving exercise of this whole health policy area of government activity is focused on how to identify, amass, quarantine and manage government moneys. Those moneys must inevitably derive from the central government, the central funding power. As a consequence of that, who holds the power? The people who control the money are the people who ultimately hold the power.

It seems to me that there is an elision: the crucial issues slide past one another. At the same time as they are the real issues—money and power, as they always are—we are talking as if, in the best of all possible worlds, this power can be devolved to local communities. As an ideal, that may well be exactly what people want. But there is a downside to that, too. I will tell a little story and then refer back to what some of the speakers have been saying about enforceability of agreements and potential entitlements under international instruments.

I remember Gough Whitlam telling us stories. This was some time after the dismissal when he was travelling around Australia as a guest speaker at various functions, one of which was my university's centennial. The situation arose in Darwin where a young woman had run away from a community and sought refuge with a woman in Darwin who used to provide shelter for women who were victims of violence. This young woman was objecting to the fact that she was to be married off to a promised husband. Some of you might remember this story. There was a great deal of argument, discussion, scandal and uninformed ignorant comment about it in the media, of course, but also generally. Gough Whitlam himself came down on the side of the Northern Territory authorities who said the girl should be returned to her community.

My own opinion is the opposite one, but it is not my opinion which is important here. And my opinion is the opposite one not for emotional reasons but because we are talking here about individuals. In all this discussion about devolution of power to communities, I think you need to decide how to deliver what is best for the people, et cetera. I am not arguing with any of those objectives. Because of the limited amount of funds that are always going to be available under our federal system of government, you do not want to lose sight of the rights of the individuals.

You should not trade off fundamental human rights for community rights, for corporate power or for money and power. The reason you should not do that is not because one weighs more heavily, greatly or more importantly than the other but because one is the essence and is the grassroots of the other. The minute an organisation, community or political entity starts to trade off individual human rights, as has happened in the story of the girl who ran away to Nightcliff, you start to undermine the whole basis of your own democracy. You start to eat away at your own democracy and your own power structure. Although it might take a very long time—it is certainly not a long time in Aboriginal terms—it is an inevitable weakening of your civic entity.

That is what worries me about this. When these issues focus on just money and power, as they must do, we must not lose sight of the fact that always what we are talking about are individual human rights. The reason the Treaty of Waitangi works is that it was an agreement, a treaty entered into by nations. As the representatives of nations those sovereigns were able to hold one another to account. That then is an enforceable instrument. It not only sets up the international law obligation between the two nations but also enshrines the rights and duties which exist between the sovereign and the subject.

Very often when we talk about these issues of funding to indigenous people and others, we are talking only about the rights which exist between the corporate bodies and government bodies. That is why you complain about unenforceability of agreements because we have not insisted upon the civic right of each person, not as an indigenous person but as an Australian citizen.

That girl who ran away to Nightcliff was running away from certain outdated indigenous obligations which she chose to avoid and had the right to choose to avoid as an Australian citizen. Of course, the price for that was that she lost status or had to make a payment in Aboriginal society, but she was entitled to make that choice by reason of her status as a citizen of a modern democratic nation.

Your rights, powers and money are derived from that modern, democratic, federal relationship. Therefore, it is important to keep coming back to it in the problem solving. Perhaps you feel you have gone beyond it because we do not talk about body derived or body generated issues, but if you do not come back to body generated issues it is no good setting up several of these programs that you have been describing which are admirable. I think you said that your committee that you have served on over the years is now working very well. Now you have good communication going and now you have a dietitian.

If you look at this analogously, the circumstances which give rise to inequalities and the acute condition of indigenous health in Australia have parallels in other parts of the world.

They will not be the same but they have parallels. Always this comes down to, in the end, issues of money and power. This is about poverty. When you say we did this work and we got communicating and now we have a dietitian, that is a definite achievement but it ought to be commonplace. It ought to be that any citizen of Australia has access to that kind of information, knowledge, expertise and service delivery if they need it.

Indeed, that is the focus and the direction of the kinds of instruments of international law that you have been talking about. The international covenant on civil and political rights, instruments against torture, instruments on the rights of the child are all directed against the inequalities of poverty—the inequalities of lack of power and lack of money. How does international law build up those rights, duties, entitlements and enforcabilities? It does so by creating what it calls an international human rights norm. Although they are obligations which exist between nations, these are rights which adhere to the individual.

I would be far more optimistic about outcomes if we were not so much still confined to talking about money—which of course we must—and accountability, audits and transparency, which are very important. But when we confine ourselves to talking about money and the federal structure, we are confining ourselves to concepts which fail to take into account the two most dominant constraints on anything which happens in Australia, which are time and space. If we are tied into 12-month contracts and three-year budgetary divisions, we are immediately limiting our potential to obtain results and a solution to these chronic, acute, long-term problems.

The other thing is space. The huge defining obstacle in Australia for the delivery of any service which is funded by government is area and the fact that we spend so much of our centrally generated funds on setting up structures, paying for transport and simply getting into place those organisations which are going to do the delivery. As you all know—as everyone in government knows—by the time you actually get to getting it onto the ground, there is no money left for the actual service. In order to change that, you have to move outside the existing parameters and come at the problem from a different angle.

The power exists under section 51(xxvi) of the Constitution, the race power, and 51(xxxix), the incidental power. The overall requirement of section 51 is for the government to be able to act for the peace, order and good government of the nation. Anything which is done in this direction—if you want it strongly enough, if you can analyse it acutely enough and present it—can be done under the general power of section 51(xxi) of the Constitution. Do not worry about the power; it is there. Into that, you can attract all those criteria and standards that you want from those international instruments—the treaties.

Mr SCHULTZ—That was a longwinded way of telling us we have got power under the Constitution. You could have told us that in the first three or four minutes.

Ms O'Grady—With that, could I excuse myself, then? Because I actually believe that that is an attack on free speech.

Mr Sandy—Before Ms O'Grady leaves, could I reply to that?

CHAIR—Yes.

Mr Sandy—She talks about power and money. Money is a side issue. It is the power that is the issue. Bureaucrats are the ones who have the power. They do not have the money. Governments have the money. Bureaucracy has the power to be able to implement things, which they have been doing.

In relation to the people and section 51 and so on, if it was so easy to drag section 51 out of us, Les and Ted, we should have carried section 51 with us in our street marches when we got our heads kicked in and things like that—when we spilt our blood on the streets.

Ms O'Grady—I did that, too.

Mr Sandy—Yes, but if section 51 was so great, why didn't it work for us then?

Ms O'Grady—Because we did not know.

Mr Sandy—We didn't know? I thought you said it was in the Constitution.

Ms O'Grady—It is. But you can only make it work when you know how to make it work.

Mr Sandy—The Constitution has been there for over 100 years or so.

CHAIR—Do you need to leave us, Rosemary?

Ms O'Grady—I do not like being spoken to like that, so thank you.

CHAIR—Thank you for your contribution. We are obviously getting towards the end of our time. We have given it a fairly good flogging, I think. We are very much open for business. We are back to anything we have left out.

Ms HALL—I would like to go in a different direction for a moment. I always get a feeling that we tend to concentrate a little bit on remote and rural. If nothing else, I am probably predictable, like all of us. I would like to move to the front of the report where it talks about where people live. Brisbane is the area of Australia that has the second highest indigenous population; it follows Sydney, and the next highest area is the strip basically from Brisbane to Sydney with a few variations. The thing that I always find overwhelming is that, no matter where indigenous Australians live, they have similar health problems. In the cities and the large regional centres like Ipswich, you still have Aboriginal people who are sick and who have the same mortality and morbidity rates, yet where they live and their access to services is very different. I ask whether or not it goes back to that emotional wellbeing aspect, and whether you can divorce health from all those cultural, land and other issues that relate to where Aboriginal people are. I want to throw that into the discussion and hear what people have to say.

Mr Watson—I have a handle on that because I am in the mental health area and I have done a fair bit of study on it. I have also studied Aboriginal logic versus Western logic. To get down to the point, our people are suffering from post-traumatic stress disorder in that

sense. Transgenerational trauma is one of the things that is now recognised in psychiatric fields and in most sociology. A lot of people do not know the real history of this country, but we, each individual group of family, have got those old traditions. Our grandparents and uncles and aunts have told us what actually went down in this country. They go on from time to time. In some circumstances, in the reserves and various other such places, I am conscious and aware that some people have never been off those places.

The situation in Australia until just recently has created very dysfunctional families, and those kids that have witnessed that dysfunctionality have carried it on and on and on. That constant stress and trauma has been suppressed because we have to put on a front to participate and actually survive in this society out here. It does not mean to say that that trauma has gone away, it has not been resolved. The drug use that you see is masking a very serious emotional and spiritual hurt—we call it trauma—and then it breaks through and goes on to other things. Every single human being from the indigenous perspective is under constant stress daily because of institutionalised racism and those sorts of things.

How I figure we can get around that is that we acknowledge each other. We say, ‘Hey, brother or sister, we know that you exist.’ That anchors us in reality. That also says that you are conscious and aware that someone is there, you are getting positive strokes. But when the majority of the people walking on our land here at this point in time do not want to know you, do not acknowledge you, it is like someone is sending you to Coventry; it is like they are ignoring that you exist. That has a traumatic effect, and the body response is to tense up and say, ‘Hang on, am I wrong?’ and things like that. It does not matter what environment you are living in, in this society you will always carry the stress and the trauma and those things from past generations, but also from the interaction with other human beings. We acknowledge each other. I have just moved up to Cherbourg and I am like the Queen—I am waving all the time because we acknowledge each other. Down in the city here we give a nod, but up there it is different matter. It is a wonder I am not built like a soldier crab!

We are constantly under stress living in this environment. We have to justify ourselves everywhere we go—funding, work, the whole lot. Even at home we have enough problems within our own families because it does not go away. We are under stress as human beings. As far as health status, any organism under stress creates body responses and things like that which affect longevity, the lifespan of people.

Ms HALL—What about the relationship to poverty and being able to access work? That question is open to everyone.

Mr Watson—Yes, I was just going to say that. We have been denied an economic base as a race of people in this country. That is the truth of the matter. Every time we have to go and put up a proposal to do something, you can guarantee—and I will be blunt—that white consultants get paid almost the amount of money that you ask for and then we get knocked back by the various funding bodies. You have to be honest—it was lawyers who made a heap of money off us in the last 20-odd years; now it is ecotourism consultants and various other consultants. That is what I am saying, but I leave it open now for someone else.

Mrs McMahon—To get back to the universities and the QUTs, they have all this training for the Aboriginal younger people. They now have the CDEP, which is helping a lot of our people. They educate them for, say, three months and then say, 'We'll get you a job.' But what they do not do is educate the employer on the cultural problems that these young people might have, then that causes confusion with the younger people, the employees. I think we have to educate the employers a little bit more when they take these Murri people into their workshops. I know it sounds funny but that is a big problem because some of them just cannot relate, they have never been into that environment and it is very hard for them to be in that environment.

CHAIR—Thank you. There are a couple of things I am trying to come to grips with. In terms of the ownership of the issue, what is realistic? When I talk about health I accept the broad holistic nature of it and the discussion that we have just had. Some would say we are making gradual improvements, gradual steps forward, in terms of the bigger picture, without entering into the partisan political debate on it. We hear about control, we hear about power. I am interested in individual ownership. How do individual people understand about it, whether it is diet or whether it is exercise, with the impact on life with vehicles, with Toyotas in much of this country now—and I am as guilty as anyone; I need to get out and jog a bit more. Can we talk about individual people in terms of what things can happen that might help them improve their own health? Is there any simple little thing that you might like to comment on?

Mrs McMahon—Yes, there is a simple little thing.

Mr Sandy—Jobs.

CHAIR—A job.

Mrs McMahon—Yes, a job, and to have our grassroots people trained. There is nothing better that an Aboriginal or a Torres Strait Islander person likes than when the health worker can walk into their house or meet them at the hospital with a few Aboriginal words. That makes the whole difference. That is what I call ownership. I do not know about anybody else. That, to me, is what we need.

CHAIR—That is a good clue. Just those things that make the difference.

Mr Sandy—When I talk about jobs, I do not mean jobs in some government department. I mean jobs originated by the people themselves, some industry. We talk about the Olympic Games here at the present time. I bet half of the stuff that is coming here to be sold as Aboriginal artefacts or whatever is coming from Taiwan or somewhere.

CHAIR—I bet, yes.

Mr Sandy—These are the issues, that we need to put higher penalties on copyright and so on in relation to indigenous people. In the past it has not happened. I see we have the certificate of authenticity now. How well that will work in the future I do not know, but I would hope that governments take a stronger stand in that area. But, as I said before, I also

hope that they look at trying to give some sort of incentive to businesses maybe starting up in some of these communities that we talk about.

You can go to DOGIT communities right throughout the state and I do not think you will find many industries at all. It is about time the government started to go into these communities and see what sort of industry may become available. Why ship off some cheap product from some Third World country when we are talking about Fourth World country here? People have made that statement. Surely to goodness there must be some way for governments to be able to start up industries in these indigenous communities.

Mrs McMahon—It is the same with the bush tucker. An Aboriginal corporation can put in money to the government to try to get the bush tucker program up and they do not have a hope in hell. But a white bloke puts in the money for it, then he comes to the Aboriginal and says, 'Can you teach me the bush tucker?' We say, 'No, we don't do that.' He might pay them about $5 an hour and the Aboriginal thinks, 'That's great, I'm getting a bit of money', but the white bloke is making millions. I think the trademark is what we have got to do.

Mr QUICK—We have not mentioned infrastructure in the rural and remote areas of Queensland. We need to sort the money out for health but you do not have a decent airfield, you do not have decent accommodation for the teachers. It is giving to the community with one hand and taking away with the other. How do we get a total community package together so that you have got lighting so the Flying Doctor Service can fly in 24 hours a day, you have got decent roads that are the responsibility of the local government, you have got accommodation for the nurses and the other professionals that are out there? Why in the hell would you want to go out there if you have got to live, as we have seen, in shipping containers?

Mrs McMahon—It really is a joke. As I said, I work on the ground level with everybody. We have ASSPA committees set up in our schools. Those ASSPA committees get money and they can employ Aboriginal teacher's aides, who get no training whatsoever. But if they bring on a white teacher's aide, she gets all the training in the world. This goes on in many, many places.

It is the same with everything. If it is good enough to train a white teacher's aide, why is it not good enough to train an Aboriginal teacher's aide? They are going in there to help our kids to read, write and understand the mainstream culture. The Aboriginals lost all their culture back 200 years ago; it was taken away when they were put into different homes and the cultures were mixed, so we lost it. Very seldom do you hear a person talk Aboriginal in the way you can go to New Guinea you can hear people talk pidgin English. You have to go out into the far country to hear it, because it has never been taught to our children.

Governments do not take the time to listen to the simple ways of life that we would like. Even if they got a few of our elders together and put up a history book so it can be taught in the schools, it would help our children in lots of ways to understand their language, their past ways of life. But this is what the problem is. If they want to train those teachers, they have got money. It is the same with health. They can train them in those positions, on-the-job training, if they wish to do it. They do it with mainstream. Why can't they do it with us?

Mr QUICK—One final question: the Maoris have got their total immersion schools, and you have got the situation in the Northern Territory where bilingual education has been cut and so you are on your own, English is the only way to go.

Mrs McMahon—That is right.

Mr QUICK—Have any of the communities said, ‘Stuff it, the Queensland education system just doesn’t work’?

Mrs McMahon—Yes.

Mr QUICK—For example, you are running your own at Aurukun. Is it working anywhere else?

Mr Collins—There are a few.

Mrs McMahon—There is one at Salisbury, Coorparoo.

Mr Collins—Throughout the Territory there are lots.

Mr QUICK—So who is funding them, ATSIC?

Mrs McMahon—I do not know.

Mr Sandy—I do not think ATSIC funds anybody these days. Just getting back to your question in relation to the infrastructure and all that sort of thing: a few years back when the moneys for the infrastructure were supposed to go into the communities, all that was supposed to supply employment, training, apprenticeships and so on for the indigenous people. I used to be heavily involved in the housing and that, and go around.

I went to Canberra to have a meeting with all the people from around Australia. It was supposed to be an indigenous housing and infrastructure meeting. I got there and I looked around, and I thought I was in the wrong place, because they were all non-indigenous people who were part of that. So I went into the meeting, got up and said my piece. I said, ‘It’s about time we started to train and give apprenticeships to the indigenous people within these communities.’ One non-indigenous person got up and he said, ‘What’s going to happen to the rest of our town, our people? They’ll have nothing.’ So it is all right for our people to have nothing, but it is not all right for others.

This is the problem that we are having in relation to indigenous moneys. People talk about indigenous moneys, but by the time it gets down there it is swallowed up by non-indigenous people before it actually gets to where it is supposed to be going.

Mr QUICK—My brother worked on Mornington Island for about 10 years as the construction manager, but he made a point of training the indigenous workers there so that, if he wanted to go and have a holiday and the roof blew off in a cyclone, they knew what to do. Are any of the communities saying, ‘Stuff it, we’ll put in place training regimes, even if DETYA doesn’t fund us’?

Mr Sandy—Most of the contractors are taking their own people in there.

Mrs McMahon—Going back a few years, I went to Cherbourg when they were building the new bridge there. They had the CDEP set up there. I was at a health conference up there and I said to one of the councillors, 'Why aren't any of the indigenous people working on the bridge?' He said, 'They're all specialised jobs.' I said, 'What about pouring the concrete?' He said, 'Yes, they're specialised jobs too.' I said, 'What a lot of garbage.' They had brought up a contractor from Sydney and he had used all his own men. They built new roads out there and not one of those Murri people in Cherbourg got put on there to do the kerbing and guttering, or to do anything like that. They let them out to mainstream and that is out.

Mr Collins—People like your brother are not commonplace.

Mrs McMahon—Not commonplace. It is like his coordinator. If we had coordinators like he has up there, we would not have any problems whatsoever. Stella Johnson is one in a million. She worked for Queensland Health, she had federal government input, and if every Queensland district had a coordinator like Stella Johnson and Toni Malamoo here, we would not have any problems whatsoever. But Toni has to answer to a mainstream boss, and that is our problem. They are one in a million.

Mr QUICK—One last question we have not raised is about nutrition and store managers. I have yet to see any that know what they are doing and have got the interests of indigenous people at heart—there must be some out there—and a lot of us are of the mind that there ought to be a national registration of storekeepers so that they do not come in and rip you off, then disappear and start up somewhere else under an assumed name. It is the same with some of the town clerks that wander around. So what are your feelings about a person having to do a registered diploma or a TAFE course to be a store manager, with an automatic police check, so you are getting nothing but the best in your community?

Mr Watson—In the tendering process, there should be a clause that says you can operate a business only if you employ a certain number of indigenous people. Comalco in Weipa is a good example. There are two indigenous people working in that place, and they are security guards outside the fence. The abattoirs at Cherbourg employ two cleaners who are indigenous people. That is ridiculous. When they went to private prisons here, there were certain clauses which, if breached, meant that they lost their contract. There are penalties attached to it.

The same should apply if there are shopkeepers or various other businesses operating. If you put those clauses into their operating contracts, so that X amount of Aboriginal people get trained per year, if they fail to do that, they should lose the contract, with no compensation. Those sorts of provisos should be in the contracts.

CHAIR—This is pretty serious stuff. We had a story the other day about a police check.

Mr QUICK—There were six applications for a store manager job. When they were told there was going to be an automatic police check, they all disappeared.

Mr Collins—Whilst it might be a noble sort of suggestion, I think we need to face the reality that it is not simply the store manager who controls the prices and what is going to be on the shelves. We live in a market driven economy. With respect to getting the food to those remote communities, the people who deliver it clearly have freight charges. I do not know if there are any controls over that sort of stuff. If you are going to have a store, one of the driving factors is to be profitable. So we need to take all those sorts of things into account.

Mr QUICK—We have been to places where the store makes a huge profit and subsidises the local football team and a whole lot of other things. In the meantime the junk they sell is contributing to the illness of the community. The community have got to take responsibility. I come from Tasmania and all the freight is subsidised. Why can't we put in place a subsidy on fresh fruit and vegetables to remote communities as an incentive for people not to buy only fish and chips?

Mr Collins—I understand that fresh fruit and vegetables that go to Weipa, which is predominantly a white town—Napranum is a reserve which is next to it—are subsidised. Yet if you go up to the Torres Strait and buy a watermelon, you are paying $15 or $16 a kilo.

CHAIR—Ladies and gentlemen, I would like to bring this to a close, but I do not want to exclude anything that anyone would like to say. We could go on forever, but we cannot. We all realise the seriousness of the issue. There is a determination to try to come to grips with it. It is 20 years since the last parliamentary inquiry, so we hope that we will be able to do credit to what you have contributed to us here today in the report that we bring down. Having made that closing statement, in thanking you, is there anything that anyone would like to conclude with? Are there any concluding statements?

Mr Watson—There was a fundamental shift in government with the Aboriginal affairs ministers. In the past, until Tickner, a senior member of cabinet reported to the Senate on a yearly basis on our status as a people. It went to a junior minister. There was no consultation with us. If you could explore getting the Aboriginal affairs minister of the day reporting directly to the Senate, as they used to in the past, and give an update on a yearly basis, you will probably see results from these sorts of discussions and inquiries, and maybe a change.

At the moment, nobody is accountable. I would assume that the Senate was the watchdog on the government of the day for legislation and various other things. That status changed without any consultation with the people. It is not that we want to have an Aboriginal affairs department on top of us as a people, having regard to all the bureaucracy. But if you can explore that, maybe we can bring about some changes in the whole system.

CHAIR—As a member of the House of Representatives, far be it for me to comment on the Senate; nevertheless I think that accountability at the senior level and at the executive level will need to be part of our report.

Mr Collins—In closing, I want to reiterate probably one of the most important statements in the *National Aboriginal Health Strategy* of 1989, which was that if governments fail to recognise the rights of Aboriginal people, our health rights, only a

marginal gain, if any, will be the order of the day. If you do not deal with the real issues, the approach is always going to be that of trying to fix Hiroshima with an aspirin.

Mrs McMahon—I hope that something does come out of this. I have sat on so many boards and workshops. We spent a week here in Brisbane doing a workshop to put forward a policy for Aboriginal and Torres Strait Islanders. It went through parliament here in Queensland; it was never implemented. I have gone through four health ministers here in Queensland. Each time we have a new election, our policy agreement has to go before that government, it has to be signed off. Nothing has been done. And that was done in 1994.

Now they are setting up a new structure and it will probably take us until the year 2010 to get that set up. I think we need to have a committee that is going to do something for us. We can give out a lot of information. We have sat on boards with the health advisory councils, we have travelled all over Queensland so that we can get to the outback communities. We put forward a lot of policies, but it went as far as the D-G and nothing was ever done. None of the policies were changed. I hope that this time you blokes can do something for us, and I will take my hat off to you if you do it.

Mrs Kirk—With respect to all that we have spoken about today, we have heard it over and over for many years. Aboriginal health workers and our leaders in health have sat around in conferences. We have put forward recommendations. All these recommendations that we have heard about today we have heard over and over. When is the government going to start listening to us? We have to heal ourselves. We are doing the best job that we can in our community. But when is the government going to start walking the walk with us instead of doing the talk all the time? We need them to talk with us now and do the walk as well.

CHAIR—I can assure you that we do not sit here not hoping to achieve something. We want to see it go forward, but we do not underestimate the difficulty. I am reminded of Robert Holt who said, 'Be achievable to be achievable'. Thank you very much.

Committee adjourned at 1.03 p.m.