



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON FAMILY AND
COMMUNITY AFFAIRS

Reference: Indigenous health

WEDNESDAY, 1 DECEMBER 1999

SYDNEY

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS
Wednesday, 1 December 1999

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

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

Terms of reference for the inquiry:

In view of the unacceptably high morbidity and mortality of Aboriginal and Torres Strait Islander people, the House of Representatives Standing Committee on Family and Community Affairs was requested, during the Thirty-Eighth Parliament, to conduct an inquiry into Indigenous Health. The Committee was unable to complete its work due to the dissolution of the House of Representatives on 30 August 1998.

Consequently, the Committee has been asked by the Minister for Health and Aged Care to complete this inquiry in the Thirty-Ninth Parliament, reporting on the same terms of reference as follows:

- (a) ways to achieve effective Commonwealth coordination of the provision of health and related programs to Aboriginal and Torres Strait Islander communities, with particular emphasis on the regulation, planning and delivery of such services;
- (b) barriers to access to mainstream health services, to explore avenues to improve the capacity and quality of mainstream health service delivery to Aboriginal and Torres Strait Islander people and the development of linkages between Aboriginal and Torres Strait Islander and mainstream services;
- (c) the need for improved education of medical practitioners, specialists, nurses and health workers, with respect to the health status of Aboriginal and Torres Strait Islander people and its implications for care;
- (d) the extent to which social and cultural factors and location, influence health, especially maternal and child health, diet, alcohol and tobacco consumption;
- (e) the extent to which Aboriginal and Torres Strait Islander health status is affected by educational and employment opportunities, access to transport services and proximity to other community supports, particularly in rural and remote communities; and
- (f) the extent to which past structures for delivery of health care services have contributed to the poor health status of Aboriginal and Torres Strait Islander people.

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Committee met at 9.09 a.m.

CHAIR—In our last summing up we were saying where we are going with this inquiry. As you would appreciate, we are working in a very complex and difficult area, but we are endeavouring to put down a report that we hope will contribute to government action and government programs over the next decade or so. I will just quickly go through and remind all of you of the terms of reference in a precis form. We are asking questions about Commonwealth coordination and barriers to mainstream health services, remembering that something like 80 per cent of the mainstream health services are delivered by state agencies; the need for improved education; the social and cultural factors, an area of which is a particular interest of mine—to try and understand the cultural factors which impact on good health; the educational and employment opportunities, which is more into the holistic impact on Aboriginal and indigenous people; and of course the past structures which have contributed to health status. They are the terms of reference. If we can bear that in mind when we are talking about this issue.

As many of you would know, this inquiry has lasted 2½ years. We would hope to be writing this report in the next two or three months. Basically what this morning is about, if you were writing the report, is what would be your main focus and what do you think should be in the report. I remind you that the discussion paper was really just to lay down a range of options and it should not be seen as the final report in any shape or form. There are things in that discussion paper which will not be part of the report and there are things there which we have not really focused on in any detail. So this is the clearing house, if you like, this morning.

I will ask you to introduce yourselves and speak for a couple of minutes on your points of interest. We will then go into general discussion. I am a South Australian member and Ninety per cent of the area of South Australia have the Pitjantjatjara and Maralinga Tjarutja people in my electorate. That is basically my background.

[9.10 a.m.]

BRIMER, Mrs Judith Mary, Public Relations Officer, Proprietary Medicines Association of Australia

CROUMBIE-BROWN, Ms Claire, Manager, Policy Unit, Aboriginal Health Branch, New South Wales Department of Health

McNAUGHTON, Ms Lola Jane, Policy Officer, Aboriginal Health and Medical Research Council of New South Wales

PAUL, Mr Kenneth James, Director, Paul Consulting Services Pty Ltd

PHILLIPS, Dr Neil, Chair, Aboriginal and Torres Strait Islander Mental Health Committee, Royal Australian and New Zealand College of Psychiatrists

REID, Professor Wayne, Director of Clinical Psychology, Department of Psychology, Centre for Mental Health Studies, University of Newcastle

WILSON, Ms Geraldine, Senior Project Officer, Aboriginal Health Branch, Aboriginal Health, New South Wales Department of Health

Prof. Reid—I have a particular interest in aged care and also in looking at diseases of the brain and examining how we may be able to help indigenous people with some of the problems associated with ageing and also the effects of substance abuse on brain function.

Mr Paul—I am an architect by profession originally. I moved into master planning of hospitals and then into health planning. After working on major acute hospitals, I have spent the last four or five years working in Aboriginal health at Mornington Island, Palm Island and Woorabinda. I have also worked in psychiatric health in Queensland, which involves Aboriginal people. I am interested generally across health and the means of improving the general health services, health facilities and housing.

Dr Phillips—I am here in my two capacities, one representing the Royal Australian and New Zealand College of Psychiatrists. I am the Chair of the Aboriginal and Torres Strait Islander Mental Health Committee of the college which has existed for the last three years. The college has put in a submission. I am also community psychiatrist for the mid-western area of New South Wales. We probably have one of the better equipped Aboriginal mental health services. We have six Aboriginal mental health workers and I have been very much involved in getting that going. One of the Aboriginal mental health workers, Robert Peckham, and I put in a submission to the inquiry really giving a sort of factual account of how that has been going, because I think the detail is often very important.

Ms McNaughton—I am from the Aboriginal Health and Medical Research Council of New South Wales. We are based in Redfern. I work in a secretariat which represents approximately 20 Aboriginal medical services in the state and we are particularly interested in the Aboriginal community control sector of health and getting viable, workable and practical programs established within our AMSs in the state.

Mrs Brimer—The Proprietary Medicines Association of Australia represents a good many manufacturers of non-prescription medicines, including complementary medicines. I am here because as part of a new direction the association is looking at its responsibilities in this area. I am really here to observe today.

Ms Wilson—I work in the Aboriginal Health Policy Unit. I am a senior project officer in New South Wales Health.

Ms Croumbie-Brown—The areas that I am interested in are I guess reform issues around Commonwealth-state funding. It strikes me that certainly the Aboriginal community controlled health sector is in an invidious situation where it has to apply to a range of government agencies for funding, all of which have different funding program guidelines. The whole problem is about the distribution of Commonwealth-state targeted Aboriginal health funds. Certainly in New South Wales it is fairly inequitably distributed. There is a dearth of a solid planning framework. We are still operating on the basis of submission based funding, which does not necessarily result in an equitable distribution of funds and funds actually going to areas of need.

I am also interested in the whole issue of MBS and PBS funds which are not getting to Aboriginal people which is I think part of your discussion paper. We have recently supported the establishment of a coordinated care trial in one part of the state. It seemed to me that coordinated care trials offer an ideal opportunity for both cashing out and establishing stronger linkages between the Aboriginal community controlled health sector and the public health system. That is my second point.

My third point is that I am concerned that, within the public health system, with the establishment of Aboriginal health workers within the public health system, we are in some respects creating a system whereby we are supporting a segregated model of health service delivery where non-indigenous health workers view Aboriginal health workers as being responsible for the delivery of health services to Aboriginal people. So there are some problems around linkages between Aboriginal health staff and non-indigenous skilled clinicians. They are the three areas.

CHAIR—Does anyone want to lead off? I am interested in all of it but as to the terms of reference certainly the Commonwealth-state coordination is pretty interesting. One question that would immediately spring to mind is: in New South Wales do you have a regional distribution?

Ms Croumbie-Brown—Yes.

CHAIR—How many of those are covered by AMSs? You are then picking up the balance or integrating with the existing AMSs as best you can.

Ms Croumbie-Brown—In New South Wales we have 17 area health services. In most of those area health services there is at least one Aboriginal medical service—not all, but in the majority. For the last four years, the New South Wales Department of Health and the Aboriginal Health Resource Cooperative have been actively promoting the establishment of partnerships between the AMSs and each of those 17 area health services. I guess on the

whole that has worked fairly well but there is an argument for taking it perhaps a bit further. Anecdotal evidence would suggest that there is duplication between the services provided by the area health service and the services provided by the AMS. Obviously both are embedded in different ideological frameworks and it would be difficult probably at this stage in history to really operationalise that relationship. Certainly the coordinated care trial framework—

CHAIR—Where do they operate?

Ms Croumbie-Brown—The coordinated care trials?

CHAIR—In what part of New South Wales? They would be in specific discrete areas, wouldn't they?

Ms Croumbie-Brown—Yes. We have one operating in Wilcannia and if you were going to pick a difficult area for a coordinated care trial to operate, that would be it.

CHAIR—We are aware of Tiwi Island and you would be, too, no doubt.

Ms Croumbie-Brown—Yes, I have heard of it. I am actually not terribly familiar with the details. So whilst there is a partnership in principle, I think there are issues about how to take it further. Just stepping back from what is actually happening on the ground, I think the Commonwealth state coordination is very difficult. The Commonwealth is developing policy frameworks nationally, the states are preparing policy frameworks at a state level and, where possible, we collaborate and it has certainly improved—

CHAIR—You might throw the framework agreements in there somewhere too.

Ms Croumbie-Brown—The framework agreement has helped. It has brought all of the parties to the table and they meet quarterly.

Mr QUICK—But it has not helped the Aboriginals, though, has it?

Ms Croumbie-Brown—Not in terms of meaningful, measurable outcomes, no, it has not.

Mr QUICK—Why not get rid of them? Why not put some sanctions on them and say that, if New South Wales health do not implement national targets and goals, we are going to take a whole bag of money off you or if you are doing well, we will give you an extra bag of money. Commonwealth and state departmental bureaucrats fly to Sydney or Canberra or wherever else they are going to meet—

Ms Croumbie-Brown—There is the state office of the Commonwealth in each of the jurisdictions. We liaise very closely with the state office of Commonwealth health. The state office of Commonwealth health deals with its major organisation down in Canberra, so there is that linkage that also has to occur.

Mr QUICK—Do Commonwealth people ever go to Wilcannia and say—

Ms Croumbie-Brown—State office Commonwealth people and sometimes Canberra based Commonwealth bureaucrats go to Wilcannia, but this is my point. There are a lot of bureaucrats involved in a very small service and it is replicated in the funding. Let us talk targeted Aboriginal health dollars. The Commonwealth puts in in the vicinity—in crude figures—of \$25 million into New South Wales and I think New South Wales Health puts in in the vicinity of \$10 million to \$12 million. You have AMSs stuck in the middle of applying to the New South Wales health department for funding, the Commonwealth for funding—

CHAIR—That is your point about the various programs and various different guidelines and—

Ms Croumbie-Brown—And within that we have targeted Aboriginal health funding in our HIV-AIDS program, in our women's health program, in our Aboriginal non-government organisation program. The Commonwealth has its bucket of funding. You have to be a fairly sophisticated non-government organisation worker—

CHAIR—The submission writers win the day to a degree.

Ms Croumbie-Brown—Absolutely.

Ms HALL—That is one of the points that I have found really quite disturbing. We have looked at the issue, the fact that it is community groups or the non-government organisations who have the skills in preparing submissions and applying for the money who get it all the time, whereas quite often those in the greatest need miss out. When we are talking about funding, if you have had a look at the options that are set out at pages 15 to 17—

Ms Croumbie-Brown—Yes, I did look at that with great interest.

Ms HALL—What are your thoughts and everyone else's thoughts? We will generalise it a little bit.

Ms Croumbie-Brown—I am terribly concerned about 2.72, the notion of establishing a separate agency. If we go back to the days when ATSIC looked after the health dollar there was a very deliberate decision made at Commonwealth level for the Commonwealth department of health to take responsibility, and again if we establish a separate agency to manage that funding, are we not marginalising Aboriginal health further? Are we not further promoting this concept of a segregated model of service delivery, of bureaucratic management's way of establishing a separate agency? I am not talking from the department of health's view with this comment but, as someone who has worked in Aboriginal health for about six years, my personal view is that there would be merit in one agency or the other managing targeted Aboriginal health funds.

Mr QUICK—So if we gave it to the state and said, 'It's your problem' and when people from overseas come and give us a hard time, we can say, 'What's happening in New South Wales is Bob Carr's and the Labor government's fault or the fault of previous governments—Greiner or Fahey. 'Don't blame us, we've given the money to the states.' Can you cope with that if that is our recommendation?

Ms Croumbie-Brown—My view is that it would probably be appropriate for the Commonwealth. Again this is a personal view; I am not speaking as an employee of the department here.

Mr QUICK—Because we are talking about 100,000 indigenous people in New South Wales, and we are talking of tens of millions of dollars being poured into indigenous health for 100,000 people.

Ms Croumbie-Brown—I am talking primary health care, targeted Aboriginal health dollars. I am only talking targeted Aboriginal health funds. That is not the majority of funds that go into the health of Aboriginal people, but the research tells us that the solutions lie in better primary health care provision.

Mr QUICK—What difference would there be in primary health care for people just around the corner at Redfern and the people at Wilcannia and those out Birdsville way?

Ms Croumbie-Brown—If there was one funding body?

Mr QUICK—Yes. How would there be different primary health strategies for those three: the urban, the rural and the remote?

Ms Croumbie-Brown—I would suggest that there would be fewer resources taken up with chasing dollars. Lola, I would really appreciate your comments on this.

Mr QUICK—Yes, butt in.

Ms Croumbie-Brown—Lola is coming from the Aboriginal health community control perspective, and it would just seem to me there would less time spent on pursuing scarce dollars. The Commonwealth has a national view and therefore can put into place some appropriate concepts around appropriate distribution of funds—identifying gaps and so forth—so that we are talking something along the lines of a reasonable distribution formula. Sorry, I am just having a mental blank here.

CHAIR—We have hit you fairly early. We will give you a spell directly.

Mr QUICK—Would the training of Aboriginal health workers be a national responsibility? Then we would not have the stupid situation of Aboriginal health workers in Queensland doing one thing and the ones in the Northern Territory doing something else—and a situation where, if you move backwards and forwards, despite having the same certificate, the nurses will not let you do one thing in one state but they will let you do it in another territory. So you would see the Commonwealth assuming responsibility for primary health care, including the training of Aboriginal health workers?

CHAIR—That was your point about the two systems growing out of that—with the Aboriginal health workers. You mentioned that in your introductory comment.

Ms Croumbie-Brown—Yes, about the issue of segregation. The training of Aboriginal health workers is probably not something I have given sufficient thought to. I think it is

probably more difficult for the Commonwealth to take a lead role in training—I think there is a multitude of training and educational options—but a broad framework, which is clearly an appropriate role for the Commonwealth, would be appropriate. The national health worker training review that is currently under way and was an initiative of the Commonwealth strikes me as terribly appropriate, with the jurisdictions feeding into that process. But the Commonwealth has taken that lead role so the states have a participatory role. But I think we have to be very clear.

Ms HALL—I just wondered if we could finish with the funding issue first, and I know that Lola wanted to come in too.

CHAIR—Yes.

Ms HALL—Could we finish the funding and then go to the training.

Ms McNaughton—If I can just come in about the funding. As you are aware, I have our submission to the inquiry. Most of our AMSs have been in the game for 20 years. They have seen a lot of issues raised over the years and some have been struggling to stay afloat. It is based, as you know, on the community control concept. In New South Wales we have a duplication of services between the state health department and the community controlled organisations at times. I am aware of one section of the state, Dareton, where we have the community health service, the area health service, directly across the road from Coomealla Aboriginal Health Corporation. It is a you-beaut building—we were given a tour when we were doing the New South Wales Aboriginal health plans. Directly across the street is the Coomealla Aboriginal Health Corporation who are struggling to maintain programs within their service.

That is from one extreme to Redfern AMS who are also trying to maintain programs. I worked at Redfern AMS for eight years so I am very much aware of the problems that they have there. They have a good relationship with their area health service, and this is not the case throughout the state; it varies from area to area, I am afraid. But there is duplication of services.

Also, it appears that programs that are more culturally appropriate are being taken on by the state health department. This has been my personal observation. I am not here to say anything against what the state health department is doing, but I believe that there are programs—funded by the New South Wales health department—that would be more appropriately set up within the AMSs, and I am talking in particular about the men's business program, which is only just now in its early stages. So there are differing programs that should be set up within the AMSs, I think.

CHAIR—I will just butt in quickly with a quick one, Alby, and then go to you. In terms of AMS coverage, I get the general geographic of it being across New South Wales—and you made the point about 'across the road' which is the extreme and which I think is the one we have been to—but in a big state you have an AMS here but a community a hundred kilometres away would not have one.

Ms McNaughton—Yes, that is right.

CHAIR—Therefore they would rely on New South Wales Health. That distribution must be an issue in terms of outcomes and needs based funding and that type of thing. It is really something that troubles me. Do you basically agree with what I am saying, that there is a differentiation with the AMSs?

Ms McNaughton—With the distances involved, definitely, and also with the transportation issues—and I note it is in the draft and also in our submission. That is one. Aboriginal people have problems getting to an area—if you saw Dareton and the problems with the border issues that they have: having to go to Mildura Hospital, back to Coomealla and into Balranald. For a turnaround trip you are talking six hours to take someone for specialist care down to Adelaide.

CHAIR—I remember checking the water from Broken Hill or something.

Ms McNaughton—Were you able to go to Namatjira Avenue?

CHAIR—I think we did. Yes, we did.

Ms McNaughton—Yes, they had the water situation there.

Ms HALL—I understand that has been resolved. I was talking to Andrew Refshauge a month ago and he was saying that that program was nearly up and running.

Ms McNaughton—Yes, under the environmental health through the Department of Aboriginal Affairs and the Aboriginal Housing Office that is being looked at.

CHAIR—Yes. But there are strong areas and there are areas that are struggling.

Ms McNaughton—Yes.

CHAIR—Thank you. Alby wanted to come in.

Mr SCHULTZ—Just on the funding, the Commonwealth Grants Commission allowed for increased general revenue to the states and territories, basically on the basis of higher indigenous populations, but unfortunately there is no specific requirement to spend that money on the indigenous population. That indicates to me quite strongly that there needs to be some sort of compulsory reporting mechanism that specifically tells the Commonwealth if in fact the money is being spent on indigenous people. Would you agree with that?

Ms McNaughton—Definitely. If you were to look at our performance indicators with our AMSs, it would clearly show that, because we are being underfunded or our budgets are stretched to the limits—and once again we have made mention of it in our submission—we are prepared to do that. We are the most reported on group in the nation, and reporting back is a requirement. As I said, most CEOs in the AMSs are quite well aware of this and, because we are living on a funded by the government basis—the AMS at Redfern has for over 20 years—we are quite used to doing this sort of thing. I think governments should look at that issue. Everyone is quite prepared to do that within the community controlled sector.

Mr SCHULTZ—Taking up the point Claire made, there appears to me from day one—I am relatively new on the committee; this is my first time on the committee—that there is an enormous sponge of bureaucratic industry absorbing an enormous amount of funds at the expense of the coalface delivery to which it was directed in the first place. Would that be a fair observation?

Ms McNaughton—Yes, it certainly is. Just recently at one of our state meetings it was mentioned that we have to get back to basics, we have to get back to funding of the AMSs within the state, cut out all this bureaucracy at the top. Let's get right back down to basics, back to funding programs that are viable and practical, be they at Walgett, Brewarrina, Redfern or Daruk or in the western suburbs. Let's just get straight back to basics, get the funding up and viable to put on professional staff such as our health workers, nursing staff and also our doctors and dentists.

Mr SCHULTZ—If I were to ask what percentage of a dollar, how many cents in a dollar are actually reaching the health delivery service that it is required to reach, what sort of a figure would you put on it?

Ms McNaughton—I am not sure, but I am aware that New South Wales dollar per head is a lot lower than, say, Northern Territory and Western Australia. The eastern seaboard states are funded—I am not sure—at, say, \$200, where it is \$400 per head Aboriginal population in Western Australia and Northern Territory. They receive, say, \$400 and in New South Wales I believe the figure is \$200. This is John Williams, also a colleague of mine from the Aboriginal Health Medical Research. It is not balanced. As is mentioned here, we have the highest population of Aboriginal people within this state, as has been shown in the 1996 ABS stats. So it is not being balanced out correctly.

I can tell you this from a personal basis. I get quite tired of seeing file tapes of the health of Aboriginals on the media, on TV, that show the deplorable health of Aboriginal people in the Northern Territory and Western Australia, when I know from personal experience that our people in New South Wales are just as vulnerable to being ill. I might also bring in the issue of the mental illness as well as being the first state that was involved in the taking of our children.

CHAIR—Thanks very much.

Ms McNaughton—Thank you.

[9.40 a.m.]

BROWN, Ms Kooncha, AIDS Council of New South Wales

DIMOND, Ms Fiona Maree, Executive Coordinator, International Centre for Eyecare Education

GRAVENER, Brother Michael, Brothers of St John of God

HIRSHMAN, Dr John, President, Australian Health and Development Group

LAWRENCE, Mr Chris, Aboriginal Men's Project Officer, AIDS Council of New South Wales

SCOTT, Mr Clarke Douglas, Aboriginal Community Health Liaison Officer, Wentworth Area Health Service

WILLIAMS, Mr John Dennis Brice, Policy Officer, Aboriginal Health and Medical Research Council

YEOWARD, Mr Kym Andrew, Accountant, Armidale and District Services Inc. (Aboriginal Medical Services)

CHAIR—I welcome the new witnesses. Some of the people who have given evidence earlier will stay on to make further contributions.

Brother Gravener—I am a brother of St John of God. We operate mental health services in New South Wales and we are looking at the moment at the issues of trauma with Aboriginal communities. We are starting to look at this area and trying to work with Aboriginal communities to see what programs we can assist with.

CHAIR—Can you give us a geographic spread?

Brother Gravener—We have two private psychiatric hospitals in New South Wales.

CHAIR—Sydney based?

Brother Gravener—Yes, in Burwood and Richmond. We also have programs in Melbourne specifically for people with intellectual disability. We happen to work with indigenous people. That is one of the briefs that the brothers have sought to go with.

Ms Dimond—We are interested in seeing what we can do for Aboriginal eye health.

Mr Yeoward—I am an accountant with Armidale and District Services, and I am representing Pat Dixon, our Chief Executive Officer. She apologises that she cannot attend today. Pat asked me to speak on a couple of issues impacting on funding. I should add that I have been working with the AHMRC on some of these issues, one of which is the need for further consideration of the impact of the proposed fringe benefits tax changes and the

impact that will have on Aboriginal medical services, the shortfall in funding, the matter of asset replacement and the need for consideration of that issue.

CHAIR—Can you be specific as to what area that shortfall in funding will be?

Mr Yeoward—We are presently funded for \$550,000 per year. That represents 80 per cent of our funding to run our Aboriginal Medical Service. We get 10 per cent from Medicare and the other 10 per cent comes from living by our wits and management service charges for other services that we do. We have to struggle. I was doing some figures in the last few days and we are looking at about \$915,000 to run our service. One thing that the health workers asked me to bring up is that, in common with some other AMS, we are only funded for the town in which our headquarters is located. In this case it is Armidale. We have a medical service based in Armidale which covers a 200- to 250-kilometre radius, so we have a lot of small towns as well and we have to try and work that off the Armidale funding base.

Secondly, as Ms Claire Croumbie-Brown would be aware, we have a state funded Aboriginal Dental Service which is working very well. It operates over a 450-kilometre radius from Armidale right across to the New England, north-west region. We go to Moree, down to Coonabarabran, down to Scone and over to Lismore on the North Coast, so it is a pretty big region. That has a dental caravan which is away 40 weeks of the year. The staff are working in the caravan during the day; they normally live in caravan parks or units of an evening. They are doing it pretty tough, I think. So we get an impact when we have people saying, 'Can the AMS come out and give us some medical service?'

The one thing we are really trying to pick up on now is emotional and social wellbeing, and mental health. Our nurse has actually taken on the role of mental health nurse, and is qualified. We have some funding through now, but we have had to cadge a bit there.

Mr SCHULTZ—Who dictates the level of funding that you get?

Mr Yeoward—We had the Commonwealth rebasing exercise in 1996. We did an honest survey. We did not ask for more than what we thought. We came up with a figure of \$750,000 and we got \$540,000.

Mr SCHULTZ—That is direct from the Commonwealth?

Mr Yeoward—Yes. We do not get any state government funding for our medical service. We have not had any community health funding for a while now, although I believe we have some community health funding coming through the pipeline.

Mr SCHULTZ—What percentage of your funding base is eaten up by your administrative and running costs?

Mr Yeoward—We try and get as much out to the coalface as we can. We are probably talking about between 22 per cent and 25 per cent. It is a constant battle to try and keep it down and, with the GST coming in, we are all planning for that. We have just spent \$1,000 on GST training for our people. We have not had any money for that yet.

CHAIR—That is a pretty comprehensive introduction.

Brother Gravener—Could I make a comment?

CHAIR—Just hold it there. We have these people who are coming in and we are starting to gather. John Williams, could you introduce yourself and give us a few pertinent points.

Mr Williams—I work with Lola in the Aboriginal Health and Medical Research Council. Sandra Bailey apologises for not being here today. We have a few responses overall to some of the criteria that have been put forward for our terms of reference for the meeting. Sandra and the council were quite impressed with the discussion paper that came from the committee. We do not necessarily see some of the emphases in the criteria before us here and that is one of the matters we wish to raise.

CHAIR—Okay, we can do that as we go. That would be your introduction?

Mr Williams—Yes. There has already been a very positive response to the work the committee has done.

CHAIR—Thank you very much.

Mr Lawrence—I am from the AIDS Council of New South Wales. I am the Aboriginal men's project officer. Kooncha Brown is my co-worker. We are here to listen and see perspectives on HIV and AIDS in Aboriginal communities and the kind of structure that exists already and what is happening in the future.

CHAIR—Thank you, Chris.

Dr Phillips—I want to address the funding, where the money goes and whether some of it is not getting to where it is aimed. I am speaking of personal experience here. It is very hard to get any direct accounting for the money that is earmarked for Aboriginal mental health in the community mental health service in the mid-western area of the state. We do not have an AMS, so whatever mental health work is done is being done within the community mental health services. I am sure most of the money has been spent in the right direction, but there has been some concern at the lack of transparency and difficulty in getting the area to give us an account of what money has been spent in the last 12 months. That has been a difficulty. Even if every penny has been spent properly, it gives rise to rumours, resentment and queries and does not help matters at all. I am not addressing the question of AMSs here, but the state areas should provide a clear track for the Aboriginal money which can be examined by people who are using it and who are interested.

CHAIR—Claire, do you want to respond to that? Do we have a path there?

Ms Croumbie-Brown—Yes, that is really an issue. That is one of the roles of any bureaucracy distributing targeted Aboriginal health funds, to ensure those funds are protected. That suggests obviously a strong monitoring role for a government agency and for the bureaucracy within each of the area health services to ensure that those dollars are protected. But over and above the targeted Aboriginal health funds, I think it is very

pertinent here to talk about the structure of funding for Aboriginal health. Obviously I can only do that for New South Wales. There are targeted dollars that go directly from the Commonwealth to AMSs. There are some targeted dollars that go through the New South Wales health department out to area health services and I think mental health is one of those. New South Wales Health has its own targeted dollars which are managed through the Aboriginal health branch and then we have the global budget that is allocated to areas. That is the big bucket of health funding.

Within that is a program for Aboriginal health, but there seems to be more leeway around that program. Again, this is a personal view, as opposed to a departmental view: one of our roles should be to monitor and ensure protection of all of those funds. You cannot ignore the broader context of what is going on in the health system. It is not just New South Wales under pressure; I believe the whole country is under pressure. In New South Wales some of the area health services are quite underfunded relative to other area health services, because funding was distributed on a historical basis and, whilst we have a resource distribution formula in place, a lot of those area health services have not met their RDF target so they are stretched and they are basically trying to survive.

We are talking about political pressures that come from the elderly, that come from larger populations than the Aboriginal population. Then we are talking about the ministerial response and so on. So clearly what happens is that dollars can end up going into acute in-patient services to keep beds open, rather than ensuring the protection. This is an important role for a bureaucracy. This is where I get anxious about talk of scaling down bureaucracies. We have to be clear about what is in the bureaucracy and what its functions are. I note here on 2.12 the question, 'What is the appropriate level of funding?' That is inherent in any discussions, but this committee has not received a consensus view. This is something that bureaucracies need to be carefully examining. What is the appropriate bucket? What is the size of the bucket of funding that needs to be applied to Aboriginal health? Where do we get it from? How do we manage it and how do we protect it?

Mr QUICK—What if we start by giving every Aboriginal health service \$337.77 cash-up MBS as a start? That is a fixed thing. You multiply that per capita grant by however many Kym has in his subgroup, and that is a given. He can then argue the toss about what other top-ups he needs and will at least be able to organise some sort of budget. It would be up to the Aboriginal health service to then organise their own priorities, rather than be dictated to by the Commonwealth or the state and spend probably half of their 20 per cent of their administration in filling out forms applying for funding to God knows how many buckets.

CHAIR—Someone might respond to that. How do you feel, Claire? Does anybody want to respond to that?

Mr Williams—Yes, I would like to respond to that. Regarding the size of appropriate bureaucracies, not to scale them down, I recall the stats in the transition from ATSIC to the department. There were six staff in ATSIC running their health portfolio, which was admittedly deficient, but now we have 170 staff employed in the department of health in Aboriginal affairs alone.

Ms Croumie-Brown—In the Commonwealth.

Mr Williams—In the Commonwealth, yes.

CHAIR—In OATSIH?

Mr Williams—OATSIH, yes. We have another instance we could give you where we have five project officers for recruitment throughout Australia and there are six people, I think, in OATSIH, in that department alone, managing those five people. So when it comes to responsible bureaucratic levels of management, it is a bit of misnomer to use those terms. Also on the state level, whilst there is a partnership in place, there is also a concerted attempt, I think—certainly not officially but in the field in practice—to try and minimise the community controlled sector's direct involvement in Aboriginal health. A case in point is in a large rural community where there is no Aboriginal medical service in the whole of that particular region, no Aboriginal community controlled sector. That happens in two of our regions where there are Aboriginal health services in this state.

Although there are pious platitudes about asserting the rights or supporting the principles of the National Aboriginal Health Strategy which talks about expansion of Aboriginal medical services, we have not seen any in New South Wales at all since OATSIH came into operation and also in the state health department likewise.

In a particular town we could have received funding for an Aboriginal medical service that was promised by ATSIC, where they had a building and dentists' chairs and so forth but no staff. If we accepted it, it was on the basis that we had no doctor. There is a cartel in the town stopping any doctor working in an Aboriginal medical service because of bulk-billing issues. We are talking about access and equity. It has taken some three years to get around that point. We rejected the funds, because we thought a doctor was essential, rather than having two Aboriginal health workers. It all sounds very nice on the surface about bureaucratic levels, but we must look, in terms of direct funding, straight to the Aboriginal community. Its levels of administration, as we have just heard from the Armidale delegate, are quite minimal compared to its counterpart in the government.

Mr QUICK—So if you had 337 times 386,000 indigenous people, you would end up with \$130 million a year. Divide that by 100 AMSs and you have at least \$1.3 million. Would that go part of the way to solving some of the problems and some of the deficiencies?

Mr Williams—Reading the report and also the health report of Mick Dodson, the Social Justice Commissioner on Aboriginal Affairs, where they saw that the role of the community control sector was indispensable in a sensitive, appropriate and efficient conveyance of medical service to Aboriginal people, I would have to agree with you. That would certainly act as a catalyst.

CHAIR—John, we have heard this morning already that the AMSs cannot cover and do not cover many areas. We found that in Queensland yesterday and also in New South Wales today. Does that therefore imply a number of new AMSs? Does that imply better liaison

with existing health services? At the moment it is quite patchy on the ground with the AMSs.

Mr Williams—The council has produced its first monograph on this very subject. Its position is that the Aboriginal community itself is the most appropriate forum through which to dispense medical services to its own community. Where there is a lack of an Aboriginal medical service, at least in New South Wales, the council's view is that the Commonwealth and state are providing services by default in the primary health care area. We feel that in the secondary area—that is, the hospital area—and in the area of tertiary services—specialist care—the departments at state and Commonwealth level could be very helpful in improving access and equity to help the Aboriginal community. But in areas of primary health services, primary health care, we find that we are having a duplication of services that is very counterproductive to cost effectiveness. Look at Dareton, that Lola mentioned.

CHAIR—Yes, we have been there.

Mr Williams—Across the road they have opened up a—

Ms McNaughton—I have raised that.

Mr Williams—That is the type of problem we are encountering. If the Commonwealth and the state departments genuinely believe in the underlying principle of the framework agreements between the state and the Commonwealth—that is, in the National Aboriginal Health Strategy that talks about expanding Aboriginal medical services—New South Wales and every state lists in the appendix all the areas that should be receiving an Aboriginal medical services—it is very interesting that the only services that have been introduced since the National Aboriginal Health Strategy was printed, or since OATSIH has come into office, have been 30 remote outposts in areas where there is certainly need but that could have been handled in a satellite way through larger Aboriginal medical services serving the community. I do not know if that answers the question.

CHAIR—No, but it is getting into the field of how you provide the service for everybody, basically.

Mr Williams—Where service is not provided within the state it is by default. It is by default because of the departments not measuring up to the principles of the framework agreement.

CHAIR—That is terrific, thank you. That is the sort of stuff we are looking for.

Mr QUICK—John, where do we find a list of what each of those 100 Aboriginal health services get in the way of funding?

Mr Williams—It is very interesting because we as consultants—the council and Lola, one of the members of the team—have received a consultancy on behalf of NACCHO to do the inquiry on the impact of FBT and GST for the whole of the Aboriginal health services. Kym has also been very helpful in providing stats for that particular matter. We have information on incomes for every Aboriginal medical service in Australia. We think the

effects of the GST and FBT upon those services in many cases could be closing our services down. That report is now just about finished. It will be available for this committee, I think, next week. It has been done by an outside consultant from Brisbane.

CHAIR—Excellent.

Mr Yeoward—Could I comment on that issue, without wanting to in any way speak for AHMRC. We can forget about having doctors and dentists out in western New South Wales if changes to the FBT go through in their present format. It presently costs us just over \$100,000 per year, including the grossed-up value of a car, et cetera, for a doctor to work for us. We presently are funded for \$75,000 per year, so immediately before we start we are \$25,000 short. We have no other alternative at the moment than to use the concession in the Australian taxation legislation. The same applies to our dentist. If we did not have that concession available, we would not have the New England and north-west mobile dentist service operating—period. I do not want to go into an area that the AHMRC has an extensive report on but I could suggest that perhaps when looking at changes, any changes to the present arrangements be deferred for a minimum period of two years beyond July 2000 when the proposed legislation is due to come into force.

We are presently trying to recruit a dentist, and we have a good man who has indicated an interest in coming to us in January of next year. We are in the final stages of negotiations with him and he has been doing a bit of locum work with us. Earlier this year we had a locum up from Sydney and we were trying to encourage that man to consider coming into the mobile dental team. After doing some locum work for two weeks or so with us, he sat down with his accountant and then he said, 'Kym, I can't afford to come up here. I'm on \$130,000 a year in Sydney.' We cannot afford to compete with that. We are not asking to compete with that but we are asking for a bit of concession on tax. Obviously the equity issue is very important but the funding issue is the main one.

CHAIR—I understand we have a report coming next week, so that should give us some further knowledge on that. Neil Phillips, did you want to say any more in terms of mental health? Did you want to get into that in general principle?

Dr Phillips—I would certainly like to get into the mental health issues.

CHAIR—Just before that, we have Mr Scott and Dr Hirshman.

Dr Hirshman—I am John Hirshman from the University of New South Wales School of Community Medicine. I am also the president of a group called the Australian Health and Development Group. We have a strong interest in Aboriginal health. I am also a member of the Aboriginal Reconciliation Committee of New South Wales.

Mr Scott—My name is Clarke Scott. I am the Aboriginal community health liaison officer in Wentworth area, based at Lawson in the Blue Mountains.

CHAIR—Is there any particular issue you want to have a go at?

Mr Scott—No, not really.

CHAIR—All right, thank you. Okay, Neil.

Dr Phillips—As I said before, I am representing the Royal Australian and New Zealand College of Psychiatrists. The college has two indigenous mental health committees, one in New Zealand and one in Australia—obviously, because we are a bi-nation organisation. My particular brief here today is obviously Aboriginal and Torres Strait Islander mental health. The most important thing I want to say is that the problems with Aboriginal mental health are the worst health problems in the country. I cannot think of anything worse. I have asked a few doctor friends and people in the health business, ‘Can you think of anything worse, whether it’s AIDS or whatever?’ The scale is absolutely enormous. The loss of life is massive. If it were the people of Tasmania or perhaps a city of 300,000 people who had this difference in their life expectancy, there would be a terrible row going on. It is an absolutely massive problem and the work of this committee is therefore extremely important.

The other thing is that it is embedded in history. This has been said many times and perhaps repeated so much that it slips past people, but it is embedded in history. It is embedded in dispossession of land, it is embedded in the destruction of communities and culture, particularly in the taking away of children and the breaking up of families. These are obvious issues for a psychiatrist to address. When you get a little further into things you say, ‘Well, how does that work?’ We know that when people are alienated, when they do not know where they belong, where they do not have a sense of connection with things, where they feel deprived, where they are victims of prejudice, their levels of stress are getting very high and the levels of stress lead to a number of things within the body. This is more detailed in the report we originally submitted but there are obviously changes in the immune system and in the glandular systems so that people become more vulnerable to disease from stress within the body. Aboriginal people, in the work I have done with them, often live in terribly stressful conditions and in the face of a lot of grief, tragedy and loss.

These situations lead to breakdown in families. We know that there are many disruptions in Aboriginal family life and that Aboriginal men in particular have been disempowered greatly in the family by these circumstances. So you get problems in the raising of children. I do not mean the sort of problems where the Department of Community Services should dash in and take the children away; I am talking about parents who are in despair, who are depressed and frightened.

We get problems of violence in families, in the communities. I hardly need to add that drug and alcohol problems are massive. In our mid-western area Aboriginal mental health service—this is an estimate, not a study as such—somewhere between 80 and 90 per cent of the mental health clients are affected by a drug and alcohol problem. The other 10 per cent have indirect effects from the violence and disruption that these addictions cause. If we are going to address the health I think various individual programs, particularly tertiary programs, can chip a little off the edges. The eye doctors have done a great deal for trachoma. There is still a lot of work to be done but there has been some success there. There are very many good programs going on but if we do not address some of the underlying issues of land and culture and we do not try and do very much better than Australia has done in the past in this area, then we are not actually going to get at this big block of ill health.

CHAIR—Can you give us a specific on land and culture? What do you mean when you say ‘land and culture’?

Dr Phillips—My direct experience, working with the people I work with, is problems when you get unhappy, rebellious kids playing up, not going to school and whatever. One of the things that struck me with the Aboriginal kids that I have seen is that when they get a chance to go with their parents or with their uncles out into the bush and do something in the bush their whole attitude changes. There is a sense of being on their land, doing things that are especially Aboriginal. I am sure some of the Aboriginal people here could expand on this much better than I could but I will just speak as a white psychiatrist who has observed this. As an Aboriginal mental health service, one of the things we did to address some youth problems in a western New South Wales town was hire an Aboriginal consultant who was an expert on dance and culture, and set up a dance troupe and some various other cultural activities. It had a big impact on the mental health. The things that further alienate Aboriginal communities and people from their sense of belonging are very much attached to land—I think that is very well documented.

Lack of access to land can break down culture very effectively because a lot of the cultural activities are related to land. As we break down culture we will get worse health, not better. We will get worse mental health and we will get worse physical health. With poor mental health you get depression, you do not look after your diabetes, you eat the wrong foods, you have too much salt, you do not care about yourself, your blood pressure goes up and you have a stroke. We go into all these chronic diseases that are taking over from the infectious diseases in injuring and killing Aboriginal people. I think I will leave it at that.

Mr QUICK—The Tiwis are considered to be doing it better than most, and yet their land and their mental health problems are going through the roof. How do we weigh that up? Sixty per cent of the Northern Territory is Aboriginal lands and yet the health problems there are no different to those in Redfern.

Dr Phillips—I think that is a very valid question to ask. Having access to land and contact with your culture is not all that is necessary. There are many other forces coming from the outside. The impact of Western culture—just video cassette machines—has had a very negative effect on health and related things in remote places.

CHAIR—A negative impact in terms of the images portrayed?

Dr Phillips—Just the fascination with the new technology available, and the neglect of children. I am quoting from Ernest Hunter’s research work on this. I am not saying ban video cassette recorders, but the impact—

CHAIR—No, we understand that.

Dr Phillips—of Western society is going into Arnhem Land and into the Tiwi Islands as well. I think there are huge numbers of Aboriginal people who do not have much access to land and much benefit from it. There was an upsurge of confidence in my contacts as part of this—

CHAIR—Let us just deal with that a bit. Here we are in Sydney, the most urbanised part of our country. How do you see the health issues of Sydney versus more rural and remote areas? It is an issue that has engendered some discussion within our committee. You have mentioned the more rural and remote areas. What is the situation in Sydney?

Dr Phillips—Let me start by saying that I think there are many different aspects of Aboriginal cultures in different groups. Here in New South Wales, particularly in Sydney, people are urbanised and they are very familiar with the Western system, whereas in more remote places they are obviously much less urbanised and are quite unfamiliar with Western things in some very remote places, so we cannot generalise immediately from one group to another. My experience has mainly been outside Sydney, but what I have experienced in Sydney is that many people in Sydney come from somewhere—they have a base at Wilcannia, Moree, Condobolin or somewhere like that—and they do have connections back with their families and the town and their traditional lands. They certainly have feelings about that. I think the urban blight in terms of health—drugs and so on—has spread well into country towns as well. You do not have to go very far in a small town to get some heroin.

CHAIR—Thank you.

Mr Lawrence—I am from the AIDS Council of New South Wales. Part of our brief is educating and promoting awareness about HIV and AIDS in Aboriginal communities, recognising that there are already small pockets of HIV which have spread into isolated communities and also urban areas. For our projects we work in the context of colonisation of Christianity and the whole impact of Western influences on Aboriginal people and now Torres Strait Islander people as well. For mental health a whole lot of those issues are also involved, but at the same time in the context of HIV and AIDS sexuality is never a consideration in a lot of strategies on Aboriginal health. When you look at any mental health strategy—suicide reports, and the black deaths in custody is a classic—there was no mention of sexuality, sexual abuse or sexual assault inside or outside prison.

Mr QUICK—Or gender.

Mr Lawrence—Or gender. We know that a lot of those deaths up in Tiwi—young people killing themselves—are from a gay or transgender sister-girl perspective which would not be publicly talked about. Part of our brief is actually breaking that silence. It is about male-to-male sexual abuse, male-to-male sexual assault, and also male-to-male sexual encounters. From my perspective as a gay man, that never gets mentioned or never gets talked about. We have to start looking at that. Most of the youth suicides are male and this is one factor that we are saying is not being addressed appropriately or even being considered. And that is from a black and white health perspective. I do not know if Kooncha wants to say anything.

Ms Brown—Certainly with our transgender or sister-girls, as we are called in our own community, there is nothing focusing on us or anything targeted towards us, no education or whatever. We are always left out. When you consider populations like Palm Island, Yarrabah, Bathurst Island, there are large populations of sister-girls within those communities. On Palm Island alone there are 98. On Bathurst Island I think they have about

67. And we are not considered when it comes to suicide. As Chris said, the majority of people who suicide on Bathurst Island are sister-girls.

Mr Lawrence—Transgender people. ‘Sister-girl’ is a term of endearment, a community kind of perspective. In terms of HIV and AIDS in Aboriginal communities, the high risk of that spreading is male to male homosexual contact and also injecting drug use which is becoming quite popular in Aboriginal and Torres Strait Islander communities, particularly in urban areas. We are saying that sexuality has to be considered and has to be put on the agenda.

CHAIR—We had somebody mention that yesterday, didn’t we, on the AIDS issue?

Mr QUICK—So, Chris, is it just a matter of giving the AMSs—

Mr Lawrence—I think it is a partnership between the AMSs. We have talked about this. John knows me and Lola. We actually have a partnership with the Aboriginal Medical Service in Redfern happening with the AIDS Council here. We also have a partnership happening with Newcastle—Awabakal. We are also going up to Moree. We have also been out to Wilcannia and have recognised lots of issues and lots of barriers for us to actually present HIV and AIDS workshops. We have to come in from a holistic approach and talk about sexual health in general, so HIV might only get this much attention, but we still push the issue that these are the high-risk groups that we need to consider in Aboriginal and Torres Strait Islander communities.

I made a presentation at the Aboriginal Mens Health Conference in Alice Springs with a mix of diverse Aboriginal men from different languages and cultures. I also found myself being media-gagged about that because nobody wanted to talk about HIV and AIDS in Aboriginal communities and nobody particularly wanted to talk about the high-risk groups of activity, which is male-to-male sex.

Ms HALL—What percentage of HIV is there in Aboriginal communities?

Mr Lawrence—I do not have the stats with me. I had them down in Canberra the other day. For the non-indigenous population of heterosexuals it is 8.9 per cent. For Aboriginal heterosexuals it is 34.8 per cent.

Ms HALL—That is quite significant.

Mr Lawrence—That is quite significant, and the people most at risk in heterosexual Aboriginal communities are women, so we need to start looking at that. There is a huge increase of that. And 55 per cent to 79 per cent of Aboriginal homosexual men are infected with HIV or living with AIDS.

CHAIR—Do we have this data?

Ms HALL—That would be really handy, Chris, if you could send that data to the committee.

Mr Lawrence—Yes, I can make sure you get that.

Dr Phillips—I think Chris has brought up something that is very important and something that has been neglected. I look at our mental health efforts, and we have bypassed sexuality and it is something we will have to redress and look at. I am certainly aware of some young homosexual people who have attempted suicide when they have become particularly miserable. It actually applies generally in country areas. It is very difficult for a young, homosexual person to make a go of it socially. It is an enormous stress. The other thing, of course, with the HIV-AIDS epidemic, is that the other sexually transmitted diseases promote the AIDS epidemic and they are also a problem in Aboriginal communities.

Mr Lawrence—I would just like to say that I do not think homosexuality is rampant in Aboriginal communities but it is there. I know that, obviously, coming from that background myself. I think partnerships are a huge thing, particularly in this area. AIDS councils and the white gay community have grown up with the sophistication and elaboration of HIV and AIDS education, but Aboriginal and Torres Strait Islander people have not. We are basically coming from the beginning of HIV in this country, so we are going back to the basics. I think the expertise that the AMSs have in primary health care services will complement the sophistication of treatments and HIV education from the AIDS councils.

I think treatments are going to be a huge issue for Aboriginal people. HIV treatment is very complicated. The processes of responsibility and management of HIV are extraordinarily enormous. Medication has to be kept in fridges. Some medication has to be taken with food. If you are an Aboriginal or a Torres Strait Islander at the point we are talking about now, then HIV treatment is going to be something that will I think devastate Aboriginal communities.

Mr QUICK—My big concern is that there are all these funding streams pouring into individual communities, together with the bureaucracies that support them. We want to clear all the cobwebs away and have perhaps, ideally, one funding stream and then that umbrella organisation which has control of the money—whether it is Kym or whoever—says, ‘Here are the priorities within our community.’ If it is HIV or something to do with eyes or ears, you have a holistic approach and a holistic bag of money, rather than supporting hundreds and hundreds of bureaucrats, either in Canberra or Sydney or Brisbane or wherever.

Mr SCHULTZ—That was quite graphically put on page 35 of the briefing paper under ‘Funding and Service Delivery Issues’, 4.5.5, 4.5.6 and 4.5.7. That is the point that Harry has just basically made.

CHAIR—Chris, you wanted to comment further?

Mr Lawrence—Yes. Because HIV is not so visible, it will be complicated to diagnose in Aboriginal people, given all the other health issues affecting Aboriginal people. If Aboriginal people are not going to the doctors for regular check-ups in the first place, they will not go for symptoms of HIV. I know a couple of examples where Aboriginal people have not been diagnosed with HIV until five years later when AIDS has set in, and now they are living with AIDS. With the prevalence of STD rates in Aboriginal communities there is also the prevalence of HIV. The ABS just came out with those high STD rates, and I think if we are

not addressing STDs with a holistic approach—including HIV—then we are still going to be at the end of the line. Marginalisation and isolation will also play a part in that.

Mr Williams—I think I should say that if Naomi Myers were here, she would question the validity of some of those stats that have come out from the ABS on sexually transmitted diseases. Dr Daniels would. She has come back from addressing the Indigenous Health Conference in Geneva. No doubt in every other respect the council thoroughly supports and agrees with Chris. Some of those stats from the ABS I think need to be carefully checked. I think they would want that said.

I want to come back to Harry if I could. You asked a very relevant question: if the Northern Territory is getting land, why is there still ongoing ill health? I think it ties up with what we just heard from Chris. It is not just sexual health that has been suppressed within the Aboriginal communities in the Western approach to assessing health but Aboriginal men themselves have been suppressed or have suppressed their illnesses. It is only in the last few months or year that the Aboriginal community throughout the country is approaching men's health. The department, I think, is starting a program assessing the communities in this area.

Whilst land has been granted to certain communities, the first land grant on the Commonwealth land grant was at Crescent Head, which was only about two or three years ago, so we cannot immediately seek to find instant results. The dispossession has taken some 200 years, and for what the council has described very poignantly as sociosomatic disease—socosomatic meaning all those social conditions which have resulted in the present ill health of the Aboriginal people—the land and the culture is just the beginning for a pilgrimage back to the roots and back to the equilibrium that existed prior to invasion.

In Tingha, where Lola was taken, when we were doing the inquiry for the stolen generations—the preliminary hearings—a gentleman came up to Lola and asked to go outside and he shared with Lola that he was there when she was taken as a child and all the community could do was to stand and cry. That was repressed for 50 years, with all due respect, Lola!

Ms McNaughton—Fifty-three!

Mr Williams—That has been repressed for decades, and that was the first time that man had vented that repressed psychological trauma. It is not going to be an instant success rate. The patterns of dietary and hygienic values that were imposed upon Aboriginal communities through the rations system and the congregating in virtual concentration camps, as it were, have been redressed, but the implications and results will take probably a generation to overcome. It is all tied up in what Dr Phillips has said: it is a holistic view. Culture, land, dispossession, repression of sexual matters, and especially our women's and men's business and men's issues, are all part of this formula.

It is being addressed, and it can only be addressed appropriately through appropriate, sensitive care, which the report in its wisdom has seen is ideally through Aboriginal community controlled services, yet we see the first point, a), talk about regulation. I notice here that it conflicts with 4.57, which we just read to you. We have this regulation by the services imposing or putting a separate structure upon Aboriginal health services, not merely

for the delivery of those funds but for the actual structure of the programs, the reporting requirements, the onerous tasks for meeting deadlines which are often unethical because it is not timely considered.

We had a letter yesterday received in our office to review the National Aboriginal Health Strategy, the defining document upon which all of our health frame agreements, state and federal, are based. We have a date which we have to answer by—13 December—and if we do not put a submission in, then the draft report will be done in the absence of the state affiliates' contribution.

CHAIR—Can we get the genesis of that?

Ms HALL—That was yesterday you received it?

Mr Williams—Yesterday we received it.

CHAIR—Yes, that was a letter. I am just trying to get where—

Mr Williams—From the department of health, signed by the former CEO of NACCHO, Steven Larkin. They are going to write a new National Aboriginal Health Strategy—quote, 'new'. The word is 'new'.

CHAIR—Let us be clear. This has come from Steven Larkin.

Mr Williams—That is right.

CHAIR—Formerly from NACCHO. Where is he now?

Mr Williams—He is with the department of health. It has been endorsed by the minister. It has been directed by the National Council for Aboriginal Health, on which NACCHO no longer has a predominance of votes. It used to have equal numbers. Now there are only two delegates of a whole council. OATSIH has been asked to initiate and direct this process, involving the state affiliates, involving the community, but as Naomi Myers would say if she were here—

Ms HALL—Excuse me, can I interrupt just for a second. Who has the predominance of votes on there now?

Mr Williams—State health ministers or their representatives, I believe; four Aboriginal health experts chosen by the minister, not recommended by NACCHO, replacing the NACCHO affiliates. There was one representative from each of the states and territories on the council. They have now been replaced by just the chairperson and deputy chairperson, and the minister can now choose four experts in Aboriginal health.

CHAIR—I think we have the general picture.

Mr Williams—Yes. We are talking about timing considerations. In that context, we have not got a chance to even ask the advice of Chris as to what should go into a National

Aboriginal Health Strategy, let alone respond ourselves. I see 5.47 has been read to us by Mr Schultz, and in this here we are talking about the further regulation and planning and delivery of such services. This is the extra layer that is further making counterproductive the services directly into the community.

CHAIR—That is probably an appropriate place to break. We will have a stretch and get a cup of coffee. It is ready to go, I think.

Ms HALL—Barry, I have to leave at 11. Because we are in Sydney today, and Sydney is the place where there is the highest Aboriginal population within the whole of Australia, I think it is very appropriate to address the issue of why Aboriginal people living in Sydney are just as sick as Aboriginal people living in the far west of New South Wales and the Northern Territory and to look at a strategy to address that, and how we as a committee get our head around it. Could I ask someone to address those issues during the discussions this morning. I will probably be back for a couple of minutes after morning tea.

CHAIR—That is excellent, Jill, and I think we hinted at it before. Dr Hirshman, can you wait until after morning tea?

Dr Hirshman—I can certainly wait, yes.

CHAIR—You will be first cab off the rank, I assure you.

Dr Hirshman—Thank you very much.

Ms HALL—You will excuse me if I duck away at 11.

CHAIR—Yes, Kym?

Mr Yeoward—I would like to perhaps, today, make an oral submission to the committee on a number of points.

CHAIR—Yes, certainly.

Proceedings suspended from 10.34 a.m. to 10.54 a.m.

CHAIR—Before Dr Hirshman starts, I would just like to encourage those who have not said much. Wayne Reid, Clarke Scott and Michael would like to come in too. To those who have not said much, we want to get you going as well. Over to you, Dr Hirshman.

Dr Hirshman—Thank you very much. I apologise for coming late, but it just could not be helped.

CHAIR—Glad to have you.

Dr Hirshman—I want to make a few points. The main point I want to make is that I think what is crucial in Aboriginal health, which is multifactorial and has very little to do with doctors and nurses and hospitals, is the question of discrimination. We know that

discrimination, whether overt or subtle, has marked physical effects. As somebody else has said—Dr Phillips I think—discrimination can result in depression. It very often does result in depression and hopelessness, but it can also result in aggression and, medically speaking, technically we have some idea that depression particularly affects some brain hormones, one called serotonin, low levels of which will affect the immune system, and the immune system is crucial to preserving health. That is what I mean by physical effects of depression. Unless discrimination, overt or subtle, is eliminated as far as we can, there will always be health effects, and these health effects will be there whether you are in Sydney, in Armidale, in Wagga Wagga or anywhere else, and that may be part of the answer to you.

The other point I want to make is that the area of Aboriginal health is a very wide area. It is not medical; it is much more than this. It is socially based and culturally based. If we are going to do anything about it, we should start early. By 'early' I mean in quite early childhood. It is the children who have to be given the chance to grow up without feeling depressed, without feeling discrimination, and having some hope.

This is not easy to do, but it is a matter of education and schooling and it has to be done in a very sensitive way. The best example of that, and I think the only example I know where this is done in a way I think is really good, is an Aboriginal kindergarten in Armidale. It takes in white children as well, quite deliberately, but it is largely an Aboriginal kindergarten, run by a remarkable woman called Diane Roberts. In that place they look at language, they involve the parents, they look at literacy, they certainly look at health as well, and immunisation, they look at lifestyle and nutrition, and they particularly look at hearing loss in children. Hearing loss, as we all know, is very important, because it affects, of course, what the child can learn in the educational process. I just emphasise that we should try and have early intervention with Aboriginal children, which has to involve the parents of course too, and to me that is an important part of it. Thank you.

Ms HALL—I am very sorry, I must leave.

CHAIR—Thanks, Jill. Dr Hirshman, thank you very much for that. I have only been involved for 12 months, but other committee members and I are all acutely aware of the long-term nature, really from conception—and even before in terms of the situation and preparation—through all the implications. Thank you very much. I think you put that very concisely.

Dr Hirshman—Thank you.

CHAIR—Wayne Reid, would you like to say something?

Prof. Reid—Yes. I would like to raise the issue of a rather complex problem, but I think it has enormous implications in terms of health care right through the ages, particularly in indigenous peoples, and that is the problem of acquired brain impairment and the effect that acquired brain impairment has on every facet of being in terms of Aboriginal communities. We know that substance abuse is a major problem. We know that there are some problems with nutritional status. There is cardiovascular disease, renal disease, petrol sniffing, alcohol abuse. All these factors impact on brain functioning, and I feel that this is an area in which there has been very little done in health research.

Looking at the impact this has on how information is used in Aboriginal communities, it is all very well if we develop initiatives to look at substance abuse, for instance, and yet when we try and develop educational programs we do not realise that those very people that we are trying to deliver the educational program to about substance abuse may already have acquired brain impairment from their alcohol abuse or their petrol sniffing or whatever, so that they would have difficulties in learning and retaining new information and in being able to take responsibility because of their cognitive functions being affected. In the education of children, babies who have been low birth weight and so forth have problems in learning. All these issues really have long-term effects on health care.

The other area is in looking at acquired brain impairment in the elderly as well. I have done literature searches, and there is very little done on the area of looking at dementia in the elderly. It seems that dementia comes on earlier in Aboriginal communities because of issues relating to alcohol abuse or cerebrovascular disease, so just how do we detect changes in indigenous people in terms of developing techniques for assessing changes in brain function that are culturally appropriate? These are major problems that I see we would have to face in trying to assess the degree of problem in Aboriginal communities of acquired brain impairment. So those are some of the things I would like to raise as discussion issues—and then does anybody know of studies that have been done on ways in which we may be able to develop projects with the Aboriginal Medical Service to have Aboriginal people working on looking at how we may be able to develop techniques of assessing changes in brain function in indigenous peoples?

CHAIR—Professor Reid, thank you. Does anyone particularly to respond to that?

Dr Phillips—I would like to say something very briefly. This also impinges on the incarceration of Aboriginal people, because quite a number of people who are repeatedly incarcerated do have brain injury.

Prof. Reid—Yes.

Dr Phillips—I can think of one gentleman of my acquaintance who had a motorbike accident and acquired a frontal lobe injury. I worked out from looking at his court record that he had stolen about \$300 or \$500 worth of stuff over the years and got 4½ years of gaol, which is probably at least a quarter of a million dollars worth of gaol from the community for his efforts. I think that is quite common.

Prof. Reid—It is. I have actually been involved in very similar cases where people have had a brain injury from motor vehicle accidents or suffered a brain injury from an assault or whatever, and their behaviour goes haywire and they commit criminal offences. Quite often it is due to their brain impairment rather than due to them just being an offender, and repeated offending. The courts have not been taking this into consideration.

CHAIR—Is anyone aware of the National Aboriginal and Torres Strait Islander health clearing house? Some are? Good. I think it is Neil Thompson in the west in charge—we were quite impressed. It is a database on the whole range of Aboriginal health issues, so with the new technology it is quite a remarkable tool.

Mr QUICK—We often talk about what is happening in New Zealand and also in North America. Are they able to put in place any remedial—

Prof. Reid—They are struggling. For instance, I have just come back from South Africa, and the issue there again is this very problem and what we do about it, how we identify these problems. There are also lots of taboos about mental health issues in different cultures, so how do we address this issue and how do we develop assessment procedures which are very culturally appropriate? The sorts of methods that we use in Western societies are probably quite inappropriate to address these issues in indigenous culture.

Mr QUICK—So you would be about 4,000th in the pecking order for research money through the NHMRC.

Prof. Reid—You see, it is an area that has not received much research at all. In fact in doing a medline research there is hardly anything that has been done in this area, particularly in Australia.

Mr QUICK—So in our recommendations you would like to see us put something about the need for research funding—apart from altering whatever funding strategies there are to solve it? But there needs to be a bag of money for research in that particular area and any other area—for example, what Chris is on about as well.

Prof. Reid—Yes, and very much involving the Aboriginal community in this whole research process because that is the way we are going to be able to look at what are going to be appropriate methods of doing this sort of research.

Mr QUICK—Do we put it in, say, Sydney with everyone works through Sydney rather than having the scatter-gun approach of having it in Darwin, also in Brisbane, Perth and Adelaide?

Prof. Reid—I think there would be a need for consultation with the Aboriginal Health Service to actually look at what might be an appropriate strategy. It might be best to actually start it in one centre and do it as a nationwide study because it is a new area. So there needs to be some sort of integrated process.

CHAIR—The principle is right, isn't it? We have to plan for the integration to maximise the effort. That is what you are saying?

Prof. Reid—Yes.

CHAIR—I know John wants to say something.

Mr Williams—Yes, just taking that specific matter, and with such an august psychiatrist present, we need counsel in this area of acquired brain impairment. I am sure Alcoholics Anonymous in general would also be very interested in such a program. When we come to research into Aboriginal health one of the criteria is that it is essential research to benefit the Aboriginal community. I am sure something along these lines would be beneficial to analyse

the impact this would have on people within the community but I think it should be seen in context.

We were asked a question by Jill Hall earlier as to why there is such a homogeneity of ill health within the Aboriginal community, whether it is New South Wales or the Territory and so forth, and in that context it could be inferred that you are suggesting that there is some magic solution to the ill health that seems to be consistent throughout the whole of our communities. I think it would be a minuscule area. To suggest that an acquired brain impairment is any higher in the Aboriginal community than the non-Aboriginal community I think itself would be a cultural slight.

I do not know of any statistics at this stage, and if you are saying that we should do a study to ascertain whether that is actually one of the problems of Aboriginal health, I would like to see the criteria in the research before we go any further in giving an endorsement for this program. As a scientific program, fine, but as a panacea to solve the Aboriginal health problems I think we would should put it in context.

Prof. Reid—I am not implying that this is a problem that is necessarily going to be greater in the Aboriginal community at all. If we look at what are some of the main health concerns in Aboriginal communities, it is alcohol, diabetes, cardiovascular disorders, renal disease. In some communities there may be nutritional problems. If we look at these sorts of disorders, we look at the target areas of the body which these disorders actually affect, and they affect the brain. We know very well in any society that alcohol abuse causes brain impairment. The effects that alcohol abuse have on brain function are to do with memory, to do with what we call executive adaptive abilities—that is, our thinking capacities, to be able to plan, to organise and to be able to conduct our lives in an appropriate way, and deal with complex problems.

That is what we see in alcohol. That is not restricted to any particular group of people. Diabetes causes small vessel disease, and what happens when we get small vessel disease is that because our brains are very much full of small vessels as well as larger vessels we have little strokes and little areas of the brain are damaged because of those strokes. When areas of the brain are damaged they cause changes in a person's thinking capacity. We see this in any society.

In non-Aboriginal communities we have facilities in our hospitals to actually assess these problems and to look at ways of helping people overcome those problems. In any rehabilitation unit there are people that look at assessing what effect a stroke or what effect brain injury from a motor vehicle accident has on that person's capacity. So to deliver a good health service we need to be cognisant of those sorts of problems and how we can do something about helping people who have those problems to compensate for their deficits or else learn other ways of assimilating and learning new information. If a person has a stroke in a particular area of their brain that affects their verbal abilities, the other side of their brain that actually uses their visual skills may be used to compensate for their verbal disabilities.

So what I am saying is: whether it be an Aboriginal community or any other community, if we are aware that these issues disturb cognition and may impair a person's ability to learn

and to adapt and to benefit from moneys that are being poured in to actually improve their health status, I think it is a very positive step. After all it is the people who have these problems, and they are not even being addressed. In brain damage, for instance, the example that was given here by Dr Phillips is that it can affect behaviour. Unless a person is aware that there is a brain injury and just sees the behaviour they will be incarcerated without consideration.

Ms Croumbie-Brown—Could I just comment? I think there are a large range of health problems impacting dreadfully on Aboriginal communities throughout Australia, and we could probably pick any disease group or illness and say, ‘That is a problem for Aboriginal people and Aboriginal people aren’t accessing the appropriate services.’ I think it is difficult if we start getting bogged down in competing health issues, because I think at one level that has to be determined at the local level. Really, from where I sit, where your point takes me is that we need models of service delivery that are flexible, responsive, skilled and linked to secondary and tertiary and other specialist services.

Within that we also need the spectrum of prevention, screening, early intervention and so forth. In some respects the Western model of health service delivery has been a reactive health model. So if I am a GP or a nurse in some type of health delivery setting, I wait for a person to come to see me before I do anything. It does not work in Aboriginal health. We need a more proactive and a community development approach where you establish relationships with the community, where you have presence with the community. So I think it is unfortunate if we pick on particular illnesses without looking at models of service delivery, because I think those specialist issues can be captured by appropriate models that have appropriate linkages.

Mr QUICK—So, for example, if the infrastructure is so hopeless that the roads are virtually unusable and you can only fly into the airport during the day, you have this whiz-bang health system working for example at Docker River or Oak Valley or out in the middle of bloody nowhere—

CHAIR—That is my electorate, Harry.

Mr QUICK—And the local government and state government education system is absolutely abysmal and the provision of infrastructure for teachers and for nurses is a shipping container at Ernabella. You have the health thing but you do not have all the other agencies putting their hand up to say, ‘We’ll tip some money into the bag so that you have this holistic thing.’ There has been no evidence anywhere in Australia that this interagency thing is happening. We have enough subcommittees and framework agreements and all these things happening in health—let alone trying to think of how you are going to have it in education—and you have the Northern Territory government saying, ‘Bilingual education is useless and we’ll get rid of that.’ Is it hopeless?

Mr Williams—I am a bit concerned. If what Claire from state health is saying is that she is affirming the model that the community itself has chosen, I think her comments would be very praiseworthy. If it is an open-ended cheque where they are seeking more models or additional models of care, I would be saying we are going back to the drawing board again and we have already spent 20 years doing this. It is the community itself which has spoken

and are speaking. Coordinated care programs in the non-Aboriginal community have proven to be a failure, from what I read in the paper recently. They are being taken up quite enthusiastically within the Aboriginal community and at tremendous expense. There is a review of that being carried out right now and it will be interesting to see the results.

I heard of one thing in Wilcannia where the coordinated care program meant that it had increased the number of flights of the Flying Doctor Service but then it turned out that the majority of people who availed themselves of the doctor's visit were non-Aboriginal people and the population is 80 per cent Aboriginal. So I think coordinated care is what Aboriginal medical services do instinctively. They have done it for 20 or 30 years and probably 40,000 years prior to Western medicine. So let us not go over old ground again. If we are going to suggest an open examination for modelling I think our contribution to this inquiry would be very limited because we are coming from a position where we have been instructed by all the community on a very democratic basis. This is what works in the community. What is lacking, as Harry said, is the direct funding to make it work.

Ms Croumbie-Brown—John, I will just clarify the comment I made.

Mr Williams—I made a provisional comment.

Ms Croumbie-Brown—I am not actually proposing new models. I guess I am proposing an investment in existing models and buildings and further skilling—

Mr Williams—It is the plurality of models that worried me. You mentioned models and I am afraid the Aboriginal community has one model and that is that which works in conjunction with state health, like yourself, as a catalyst to bring about the provision of services that have real and genuine relief to Aboriginal people, which include—we have just heard from the professor—matters pertaining to brain damage as well, as part of the overall scheme serving the community, which has ill health which is unmatched, unfortunately, anywhere in Australia.

CHAIR—Professor Reid, maybe we can move on from there. I just make the point that we were in Darwin a fortnight ago with the CRC. Some of the board members, who were from the Aboriginal community and from the AMSs, were very clear that Aboriginal people had great emphasis on a whole lot of research which was not finally perceived to be delivering the results. Other committee members will correct me if I am—

Mr QUICK—Researched-out, I think was the phrase.

CHAIR—Thanks, Harry. Going around the country in the years that I have been a member of parliament, it seems that the Aboriginal people have been poked, prodded and researched. It gets to a point that the natural response is let us just do it. It does not in any way say that we do not have to do the research, because we have to. There is no doubt about that. But these are specialised areas. I do not know whether anyone wants to add to that. I was going to move quickly to Clarke Scott to ask him to say a few words and then perhaps to Michael.

Mr JENKINS—Just before we leave that, I note in this monograph the ethical guidelines for research into Aboriginal health. Is that also going to go to matters pertaining to building up the submission, the proposal?

Mr Williams—The Commonwealth government provided the funds for our recruitment program. Melinda Bell runs that section in New South Wales. The three first publications of the monograph will be directly for the doctors in the wider community and all people in the health field, to help expose the non-Aboriginal community to the actual issues. Ethics would be one and it is to provide an outline that is consistent with the national ethics committee approach—Professor Chalmers—so that it is culturally adapted to the Aboriginal community.

Mr QUICK—We heard yesterday from two graduate speech pathologists and they were four year graduates. They had been trained for four years and I think they one hour of cultural sensitivity and they were out into the boondocks of Queensland to deal with Aboriginal health. What are the training institutions doing, for goodness sake.

Mr Williams—Lola would probably know this better than I. There was a motion unanimously moved at the Aboriginal mental health conference that all tertiary training institutions in health be given appropriate cultural awareness training in Aboriginal culture and so forth.

CHAIR—There are at least two levels we have in mind, I think, in the training itself: the professional development of the professional people and also orientation into communities themselves. There have to be at least two stages and so I think we have taken that on board. Your comments will be appreciated.

Dr Phillips—If I could just address that. We have been looking at that within the college of psychiatrists and we do have an existing ad hoc sort of training program and it is quite small really—over five years of specialist training. We are hoping to expand that. The college of GPs has taken a considerable lead in this area and the stuff they are doing is very interesting. We will follow on that.

CHAIR—I will ask Clarke Scott to say a couple of words—just liaison in terms of the health service and those sorts of things. It would be great to hear from you.

Mr Scott—Originally I was a liaison officer at the Nepean Hospital for four years. During that four or five years I was asked to do community consultations in the Blue Mountains which probably is a very isolated community up there. It is a distance from Dharruk AMS and the community virtually all over the Blue Mountains—not in one area—and it is very difficult for those people to get to Dharruk and that sort of thing. So I did the community consultation. One of the things the community cited was the need for a liaison officer working in community health centre, accessing the hospital to guide the community through the medical system, through the hospital system. That is what I am doing. I am also doing cultural awareness. My statement of duties or job description was written by the community through the consultations. So I am doing the cultural awareness stuff you are talking about. We were pretty lucky to be put onto the staff development calendar for Wentworth area health, with the involvement of Dharruk AMS. So that sort of thing is happening in our area.

CHAIR—You are on the board, aren't you?

Mr Scott—I am on the board of Dharruk AMS. That is what we are looking at. In the future, I am trying to make the services more culturally sensitive, until we can arrange some outreach services and things like that to happen from Dharruk, to go up into the Blue Mountains. That is what we are trying to get going. It gives the people a choice, too—whether they want to use the community health centre or the AMS, if they can get there. The other thing, too, is that Dharruk has been involved in all consultations with the area health. Not all things are working, of course, but everyone is trying.

If people are accessing the services actually at the hospital, I was thinking that, if we can give people access to some of these services, it will stop them from getting to hospital. It becomes a major problem when Aboriginal people sit at home and wait until they are very ill before they will go to the hospital. The hospital is seen as a government department and Aboriginal people usually only go to hospital to either die or have their children taken from them. That is still a thing that is in the Aboriginal community. That is the sort of thing I am trying to do and I came down just to get a bit more education from you fellas.

CHAIR—That is great, Clarke.

Ms McNaughton—In speaking of cultural awareness, it is not a part of putting it into the curriculum of all graduating med students. You are talking about the history of a people. When the national inquiry into the stolen generation was released, tabled in federal parliament, I saw the shock on the rest of Australia's face that this could have happened in Australia. I gave a lot of talks around the state on it. I was on the advisory committee for it with the commissioners. We are talking about trying to understand Aboriginal people, why we think the way we do and why our health is so bad. It cannot happen in a cultural awareness part of the curriculum. I will bring it back to the community level.

We have a doctor who works at the Aboriginal Medical Service in Redfern and part of her training at the time was to work up at Biripi AMS at Taree. She has been at the Redfern medical service for something like 15 years now. She spoke to me, when I was personnel officer at AMS Redfern. She said, 'The best thing that I ever did in trying to understand getting to the mind of an Aboriginal person, as well as look at their physical make-up, was to work at Taree.' That doctor—who is my doctor, all these years later—is still there. It is going to take more than just have a panel of Aboriginal people speak on the Aboriginal culture because it varies almost from region to region, as you are aware, in New South Wales. Then you have to contend with the different factions within the regions—so there are all different areas.

I once gave a paper at the mental health conference and I said, 'We're invisible people in our own land,'—and it is true. The majority of non-Aboriginal people in this country have never seen an Aboriginal person. We are all aware of this. The task that you have before you is quite mountainous, it really is. There are all these different issues that have to come into play here. The bottom line of one of them is the cultural awareness issue; that there are reasons why an Aboriginal person walks out of a GP's surgery or clinic out in Tingha or wherever, and there are a multitude of problems there. We have to look at the whole big picture for all of this.

CHAIR—Yes, that is a good comment, Lola. Thank you.

Mr QUICK—We have one Aboriginal dentist in Australia. We only have a handful of Aboriginal doctors. When we get to the stage of improving the education system and we have a heap of people that people can choose from, that will improve things.

Mr Lawrence—I would like to reiterate what Lola is saying, but I also think it is fair to say that a lot of Aboriginal people are still understanding themselves: the impact of colonisation on us, and being removed from our families, and trying to trace those linkages back to where we come from, and we have only had access to the resources to do that in the last 30-odd years. I was not born a citizen in this country. I was born in 1966. I think we have to remember that Aboriginal people can articulate—and we might get degrees and whatever—but when you look at the number of Aboriginal people coming through the university institutions, there are only about two or three in each, when so many other Australians are graduating on a much larger scale.

That mental health stuff, coming back to what Neil said, is also part of that whole issue about colonisation, and where Aboriginal people fit in the bigger picture. There was no counselling given to my mother who was taken away, and there was no counselling given to her children to deal with that impact, because we had to grow up with all the issues of what happened to my mother and my father in the missions. When I was going to school, we had a welfare officer at the school. We had to get our names ticked off the roll, and then go to our classes, and then get our names ticked off again. That is still happening in a lot of schools. You still have the welfare system. You still have DOCS following Aboriginal kids around the place. There is no incentive to study, there is no incentive to learn, because you just feel like you are a number and you feel like you are still being researched and still following along this path of institutions and whatever.

CHAIR—The history is just walking with you.

Mr Lawrence—The history is walking with us. And we have to remember that it has only been 30-odd years that we have had access to these resources.

CHAIR—Yes, that is true.

Mr Lawrence—So you have to give the AMSs credit for where they have come from. They started off with nothing but volunteers like Fred Hollows and Andrew Refshauge and others who volunteered their time and services, particularly here in Sydney, to set up the first AMS have to be given credit for what they have taken on board, and for what they have achieved and where they are going. I think all that has to be considered in this whole process of what is happening here.

CHAIR—I acknowledge that.

Mr Yeoward—We were in Brewarrina High School just last week. They had their first Aboriginal HSC graduate in 11 years. It is really hard to get people coming through the system.

Dr Phillips—Could I go back to a point Lola made about the need for health professionals to have real contact, not just a day or two here and there in a four-year course. A few days ago there was a meeting set up by a committee of medical college presidents here in Sydney to try and do some coordination amongst the colleges with regard to Aboriginal health. Puggy Hunter came along and told us some stuff that I had not even thought about. The point he made is that NACCHO and related organisations were welcoming to health professionals coming to have some real contact, but it also proved a burden financially, and they often did not have the money to actually service that so they had to say no. So there is another financing point that is probably very important in improving overall relations and skills of mainstream health professionals, and also making them, as health professionals, more accessible to Aboriginal medical services. That needs some financial support and input.

Brother Gravener—What Chris said to us made a lot of sense to me. As a Brother of St John of God, part of a Catholic religious order, we recently sat down at a table and said, ‘Who are we actually helping in our society?’ Our brief as a religious order is to help the most disadvantaged groups. It was not very difficult to come up with Aboriginal people. It was pretty simple, actually. The brief was then given to me, because of my own experiences. As a pilot I used to fly up in Julia Creek in Queensland. I went to Doomadgee Mission in Burketown and Normanton and all those sorts of areas and, as a young fellow, I saw a lot of incredible health situations—drug and alcohol issues—and exploitation by white people. Normanton itself was apartheid. It was very much a segregated town in the way it delivered services, be it pubs or shops or whatever.

Then as a tourist I visited Katherine one day, and the attitude of my fellow brothers and sisters was that the black people there were very lazy. It was the typical stereotypical view of Aboriginal communities that a lot of Australians still hold. All I could see was absolute misery on the streets. There was absolute misery: at 10 o’clock in the morning 50 people might have been lying around the place. Then listening to Chris’s story about their generational history and the history of the Aboriginal people, it reminded me of when I became involved in working with Vietnam veterans in post-trauma studies. What we are finding more and more is that there is a generational change, a generational movement of that trauma to the children of Vietnam veterans.

That said to me, ‘Whoa, what’s going on here?’ Imagine if you were an Aboriginal person and you have been dispossessed from your land; you have been taken away from your family. Of course you are going to develop areas like drug and alcohol areas. You have been exploited. You do not know who you are. You are still struggling to identify who you are. You are going to display an ongoing learned behaviour which builds up in tremendous anxiety, tremendous paranoias. I can remember an Aboriginal woman walking into the post office in Katherine. I was before her, and the woman was wonderful to me, and immediately there was a change in attitude from me walking away from that desk and this woman wanting one stamp. Her head was down, her whole body language was hunched over—‘Can I have a stamp, please?’ and the woman said, ‘Here’ with no, ‘Hello, how are you?’ which was what she gave to me. I imagine that if you have such a low self-esteem of who you really are, if you have problems every day walking into the post office just to get a stamp, you are really suffering.

CHAIR—Yes, that is right.

Brother Gravener—So as a group of brothers we started thinking, ‘This trauma issue is something we really need to have a look at.’ For us, it is an issue not of us actually going out and doing the stuff but us somehow resourcing Aboriginal workers to learn about trauma so they can put that into their cultural circumstances. That is why I am here, to listen to what is going on in the scene, realising that we may have something to offer. There are courses that St John of God psych hospitals run for health workers, social workers, doctors, nurses, all those sorts of things, that address the issue of trauma. I suspect there are a lot of issues there, listening to Chris’s story. I work two days a week at the Come in Centre in Paddington. We have young men who—

CHAIR—Forgive my southern origins, the what at Paddington?

Brother Gravener—The Come in Youth Resource Centre, which is a youth centre mainly for male prostitutes. We have some Aboriginal men there who are HIV-positive gay prostitutes suffering trauma. We have some really very difficult people who are going to struggle to survive to the age of 35, if they are lucky. There is a double disadvantage just to being an Aboriginal in this community. I see the issue of trauma as being one avenue that we can explore.

CHAIR—Can I ask this for Jill Hall in her absence, because as committee members we get to know each other pretty well, and what each other’s particular issue is. You were just suggesting to me that the issues for urban indigenous people are very much similar—because you have that experience—across the rural and remote as well. I am just trying to get that understanding as to the health issues of rural and remote versus urban. You are suggesting, I think, that it is coming from the same base, and parts of the health issues are not dissimilar. Are you able to make a comment on that.

Brother Gravener—I think that if a generation of people have been growing up with parents that have been taken away from their parents, there is the trauma of that and the trauma of that woman raising a child, not knowing what is going to happen to her child, because she is anxious herself, all those sorts of things—

CHAIR—But with respect to urban life versus rural and remote, is there anything that strikes you as different?

Brother Gravener—I really cannot speak on that. As a non-Aboriginal person you cannot really suggest that. But an issue for white Australia is that quite often we sit and pontificate and it is very much, ‘We are superior and we will look after you’ and quite often we are not hearing the stories of the land and we are not understanding the concept of the spirituality of this land which would be of huge benefit, not only to us as people, but to our whole economic system, the works.

CHAIR—Thank you very much for that. You obviously demonstrate that breadth of knowledge and experience from your own life experience. That is quite valuable. Good luck in whatever you are endeavouring to do.

Brother Gravener—Thank you.

CHAIR—You might wish us the same in what we are endeavouring to do.

Brother Gravener—Yes.

Mr JENKINS—Barry, from just this little discussion that we have had, one of the great challenges that we have as a committee is to play a role in trying to get that national awareness of the whole community, to get the wherewithal to keep achieving, and build on the achievements, but recognise that there is a lot of work to be done. In the last two days when we have introduced ourselves I have indicated that in my electorate, out of a population of 120,000, 500 people identified themselves as indigenous at the last census. I am typical. I am one of the ones where, in my community, it is just not an issue. But what I have learned over the last couple of years is that just because of numbers we do not see it, but in a lot of other communities where there are higher numbers people still do not see it. I did not quite, at the start, really understand that.

Today, Lola has helped me, when we were talking about cultural awareness, with the story about the doctor. Like Jill, I have been concerned that a lot of times we tend to talk about the remote examples and anecdotes, because they are easy; they confront us; They are there. But I have been concerned that they do not then have some relevance when we get back to where the majority of indigenous people live, and that will be here in Sydney or wherever. I just want to put on the record that today I have been helped in understanding that it all is interlinked and it is relevant, because if we are to achieve something we have to try to explain to the wider community what it means to have this type of dispossession, what it means to emphasise the cultural wellbeing as being part of the wellbeing of the community and its individuals. What I do not know is how we actually do that in a way that we bring people with us.

CHAIR—Yes, that is the great challenge.

Mr JENKINS—I am open to suggestions, because it is one of those important things. Chris was able to put it in a generational time frame that is quite clear. I can always remember one of the stories from the Stolen Generation report that brought it home to me. It gave the instance of a fellow who is the same age as my sister who was taken from his family in Victoria. I thought, 'Here I am, I have grown up, that has been part of my generation.' Chris has shared with us the same sort of thing. Unfortunately, we immediately fail to get people to understand that, but I think we have to do that. I did not mean to lecture. Sorry about that.

CHAIR—No, I think that puts into great context, Harry. Thank you for that. I think the same things struck me with Chris reminding us that he was born actually an 'unperson'. It strikes you, doesn't it. It was post the 1967 referendum.

Mr Williams—Mr Chairman, on the matter of Jill's question, which has just been answered to some extent, I am not a doctor but I have heard doctors comment that whilst there may be some parochial diseases like trachoma that are more pronounced in certain areas, by and large the people who are visited through the Aboriginal Medical Service are

very typical across the whole of the country, are very similar. They might come for one ostensible medical complaint which might be fairly trivial, but there is a whole list of serious matters. They end up finding out they have cardiovascular problems and goodness knows what. That is consistent right throughout the whole of the Aboriginal Medical Service, whether they are in the city or whether they are in the rural or remote areas. As someone has said earlier, so many of the Aboriginal people within our metropolitan areas have come from or have relatives living in these communities anyway and they have come into the cities for work.

On the matter of transgenerational trauma, at the recent mental health conference run by the Aboriginal people themselves that was one of the discussion papers. One of Lola's colleagues was in Cootamundra Girls Home and has written a very definitive work on counselling transgenerational trauma. That will be published in our fourth monograph, which will be out later this year. From an Aboriginal perspective alone it will be a very helpful and positive document.

CHAIR—Thank you.

Dr Phillips—You mentioned transgenerational trauma. There has been a lot of evidence coming in that these effects do pass from generation to generation. It is commonsense anyway; if your parents are very distressed and disturbed you are not going to have a wonderful childhood. It is not just from studies on Aboriginal people but also Holocaust survivors and so on. There is quite a lot of significant literature on this and it is a very strong effect. It is not a marginal thing.

There is one thing I would like to add. Back in 1993 there was an Aboriginal mental health conference, which I think was the first national one. I went there still pretty green in the area. I did not know a lot about it but I was interested. What struck me, as a white doctor coming into this, was the 800 Aboriginal people there who were working their guts out to get things right. There were an enormous number of Aboriginal people working terribly hard in the communities, putting things right and struggling with things. What is very important is that they get adequate respect and support, particularly from government organisations and government. This is where the flavour of a government, the relationship a government has with the Aboriginal community, is very important.

I know, just from my personal contacts, that when something goes wrong in a relationship between the government and the Aboriginal community generally, a lot of people get very distressed and despondent. The attitudes of governments are very important. I am just speaking as an outsider and I would be very interested to hear from Aboriginal members of this forum their response to what I am saying about that. Governments can really hurt the community badly, just from an attitudinal thing.

CHAIR—Does anyone want to comment?

Ms McNaughton—When the *Bringing them home* report was released, I had a big hand in going around New South Wales and on some occasions John travelled with us. We went to 22 Aboriginal communities in New South Wales to tell them about the national inquiry that was coming up on the stolen generation. We had meetings say at 6.30 and sometimes

they would go through till 11.30 at night. What came out of there was people agreeing in their own minds that, 'Yes, I would like to speak to this inquiry.' A lot did, that I am aware of, in New South Wales. They had private hearings with the commissioners as well. Upon the tabling of that document in parliament I can tell you that there were just so many traumatised people afterwards. You are talking about people who had never spoken to their children about being taken from their families, had never even told them that they were in the homes or anything, and all of a sudden it is there; it is national. Everyone knows about it.

Requests were coming in for people who were taken from their families, the stolen generations, or who were taken from their families under other circumstances. All of a sudden they were in the spotlight and they have had to deal with that. A lot of them, to this day, are still not dealing with it, as was experienced at the state mental health conference that we held in the first week of September. I have been counselling transgenerational children of those who were in the homes. The issue is now that really, once the lid is off, you cannot put back what is in—they never spoke of their lives to anybody but they spoke to the Australian government.

One thing I did find out when we travelled around: all walls were down with respect to all the different factions in the different towns we went to, on this one issue. There was no factional fighting at the forums that we held.

CHAIR—Unifying them.

Ms McNaughton—Unified as one, you see, and so it is really a big issue. I think it is the biggest issue with Aboriginal people and will continue for a while.

CHAIR—Thank you, Lola. That is wonderful.

Mr Lawrence—Another example of that post-trauma stuff happening is in respect to Rob Riley. He is dead now but people know Rob because he headed up the Aboriginal Legal Service in Western Australia in Perth.

CHAIR—Yes.

Mr Lawrence—When the stolen generation inquiry went to WA, Rob publicly announced what had happened to him: being taken away, institutionalised and the sexual abuse that he encountered along his way. Two weeks after that, Rob committed suicide and, to us in WA and across the whole nation, that was a huge devastation because of the leadership he undertook for Aboriginal people and the way that he was leading Aboriginal people in WA, particularly my people, the Nungar people. It left a void feeling of despair and disillusion, because we were angry with him because he was our leader. He was a leader and a prominent person who would have continued on the struggle for Aboriginal people, particularly in WA. So that was one clear example of what Lola was talking about. Somebody at that level can still be affected.

Obviously these things do not leave you and they leave a horrible scar—to publicly come out with that. Like you say, they have never spoken about this with their families before. It

is the same for a lot of Aboriginal parents out there in generations. They have never talked about this and all of a sudden there is this national inquiry and they are telling governments and the families are standing back saying, 'Well, hello, you didn't tell us about this. How do we deal with this?' There are no mechanisms there for pre- or post-counselling after these inquiries, and that is a real consideration that has to be taken on board as well.

CHAIR—Thank you, Chris.

Ms Brown—Can I just say something?

CHAIR—Yes.

Ms Brown—I am not taking anything away from the stolen generation but within Aboriginal communities you certainly have a lot of other people with mental health problems. They have never been taken away but have actually grown up in those communities. I will give you a personal experience. When I first came to Sydney I faced so much discrimination, I was wondering how I actually came through it. When you are a pre-op transgender, when you are Aboriginal, you get so much discrimination thrown at you. I remember hopping on the bus going to uni every morning: nobody would sit next to me, even when I was going home. They would sooner sit next to someone who was white, who was drunk, who was abusive—rather than sit next to me. It really affected me to the extent where I actually got agoraphobia out of that. The only way I felt safe was to pack up and go back to my own community. You are talking about mental health. It is a huge problem in Aboriginal communities. Like I said, not taking anything away from the stolen generation, it is still there.

CHAIR—But you draw out an excellent point. You bring them together.

Ms Brown—I think it goes back to what Dr Hirshman was saying. Discrimination certainly plays a big part in this. I am tired of being discriminated against. I am tired of going out there having people looking at me and saying, 'Oh, you black slut this and you black slut that.' How do you think I felt growing up as a child, when I was going to school, being told that I was not a part of this society? I was told that I was dirty, I was black, my parents were alcoholics, my mother was a slut. How do you think I feel about that? That had a huge impact on me growing up. The only way I dealt with it was being in my own community. That was the acceptance I had. You are talking about why we do not access non-indigenous services. Why should we, if that is how we are going to be treated? I will leave it at that.

CHAIR—Thank you. Ken, did you want to say a couple of things?

Mr Paul—Yes, just a couple of things I would like to pick up on. There are obvious differences. You have all been on this committee and travelling around different states and will have seen them. I was just noticing the difference in New South Wales with the Aboriginal Health Service and how it works in conjunction with the acute health service. On the three projects I worked on at Mornington Island, Palm Island and Woorabinda, the Aboriginal health services up there had been separated for many years and operated in the primary health area and preventative health. When we went through the process of

consultation with the communities and worked out what they wanted in the way of health services and how they saw them being implemented, the three different groups there all asked that the Aboriginal health services be co-located with the community health services and the acute hospital.

That was for a number of reasons. First of all, there was a question of language because of use of tribal language—for instance the Lardil language up on Mornington Island. It was felt that people could interpret for the non-indigenous staff and that would be most helpful. Also, in the remote areas, when specialist people are flown in, like a paediatrician and a baby health nurse, the nurse would go down to the Aboriginal Health and the paediatrician would go to the hospital, yet the paediatrician would want to see the mother and child and vice versa.

So those three different groups opted to be co-located and I thought that was significant because they had been through the process of separating the services and then coming together. But in each case they also opted for having a liaison person, a distinct person role, at the interface between those services for the Aboriginal health, the community health and the acute hospital. That person would float backwards and forwards between there. I think that also was intended to extend. What Lola was talking about, the cross-cultural things, cannot be dealt with in one lecture and there is obviously a constant change of a lot of people in the acute health area. Unfortunately a lot of people are recruited overseas or from agencies and they think they are going for a nice holiday on one of our islands, or something like that. They have no idea of what they are coming into so it takes time to educate them.

On the cross-cultural issues we found there were quite diverse requirements. Mr Chairman, we spoke about external waiting areas, the need for more waiting areas for people coming in their family groups, et cetera, and having external toilets, drinking fountains, and possibly even a kiosk outside for them to get their needs attended to. There was the co-location of the clinics that I mentioned. The affinity of the land was also brought up.

We went through the whole discussion on birthing or birthing. That varies again, obviously, with the cities and the remote areas, et cetera. In Sydney there was publication entitled *Women's Talk* by Dianne Gosden, August 1992, which dealt with how things are handled at the RPA Hospital and the King George V Hospital. There was discussion on prenatal talk, birthing, and post-natal, and the Aboriginal women gave detailed accounts. When we tried to raise those issues up in Mornington Island and some of the other areas, the members of the committees said to us, 'Well, that's women's business and we shouldn't talk about that.' And yet once we finally won their confidence we were able to discuss that, and we ended up making sure that the rooms in the hospitals could accommodate carers to help with the birthing process.

With their affinity with the land too, there were problems with the mothers being flown from say Mornington Island to the regional hospital in Mount Isa to give birth. There were advantages in the mother going there in trying to get the birth weight of the baby up and to overcome some of the problems that are inherent in low birth weight rates, but another problem was the fact that the child would have on their birth certificate, 'Born Mount Isa' rather than Mornington Island, for example. That happens in quite a number of the remote areas around Australia. There was even a suggestion in one of the reports by one of the

human rights commissioners that there should be an additional column on the birth certificates, 'Place of birth, place of origin.' Simply having an extra column would mean a tremendous amount and could be done very easily. With birthing you have tribal differences for remote areas. In Alice Springs they have a completely different method of setting up their birthing areas to follow the traditions of the tribes in that area.

We also found that the whole question of grieving was an important one, with the viewing room and the mortuary, and we had a very extensive external grieving area for the families and the community to come together, plus a lot of landscaped areas for visitors. They are only fairly superficial cultural considerations, but it does mean that if there is a process of communication during the development of the services and the facilities a lot of these things can be attended to quite easily.

CHAIR—The document from which you have obviously prepared a significant document, is that your own work?

Mr Paul—The document was actually the functional plan and the master plan that was put out for Queensland health, the capital works section. Those documents would, I think, have to come through the capital works section of Queensland health. They would have those documents for Mornington Island, Woorabinda, Palm Island, et cetera.

Mr Williams—Mr Chairman, could we respond from a New South Wales perspective. Regarding the particular parochial dynamics of working in Mornington Island and Queensland we cannot comment, but from a New South Wales perspective there are two points. Firstly, recently every attempt to try and co-locate Aboriginal Medical Services with Department of Health community health centres, even with the threat of non-funding if compliance is not met, has been resisted heavily by Aboriginal communities in New South Wales. And, secondly, recently the New South Wales health department did their own survey on why administration staff in hospitals are unwilling to properly identify Aboriginal people as they are required to on admission, and ask the ABS questions on identification. The reason for this is that New South Wales is the only state whose statistics cannot be used by ABS because they are so unreliable because of this very factor of non-identification.

The two workers, one Aboriginal and one non-Aboriginal person, who went around had to actually close one of their sessions or actually not proceed with others planned because of the absolute racism in the hospital by the white administration staff. One of the problems we do have in New South Wales—and I am sure it would be comparable in other states but maybe not on Mornington Island where it is a much closer knit community—is that there has been a reluctance to use the mainstream health services because of this racism that we just heard from Kooncha. That is still as late as this year, current in New South Wales hospitals. Therefore the indispensability of the Aboriginal community controlled health services is paramount. If we are talking about New South Wales here we should try and respond accordingly from a New South Wales perspective. I am very pleased to hear that there have been mutual relationships at Mornington Island. I do not know the parochial situation, but it is not the situation here in New South Wales. There has been a good relationship with the department but the Aboriginal community want to go their own way in this area.

CHAIR—John, I think that is quite valuable. It is saddening; nevertheless, it is quite important to put it on the record.

Mr QUICK—Is it just with the country hospitals, John?

Mr Williams—It is any hospital outside of Hornsby, pretty well.

Ms Croumbie-Brown—I think there is significant variation across the state. I think we probably encounter racism in some of our metropolitan hospitals. I certainly would not try to suggest that there is no racism within the New South Wales public health system. It would be a foolhardy person who would suggest otherwise.

CHAIR—Are there little seeds; are there good examples? Clarke has commented on some effort being taken. I do not want to go away from here believing that New South Wales is not making some genuine effort in these areas which seem quite critical.

Ms Croumbie-Brown—I think it is making some genuine effort in terms of input around training packages and training programs. The cultural awareness initiative is being further progressed in New South Wales. There is currently an examination of complaints mechanisms which can be instituted so that Aboriginal people can actually make complaints to senior Aboriginal people within the public health system, so there is the encouragement to behave appropriately.

CHAIR—If Aboriginal people have to go to hospital, there is only one place that they are going to get a hospital from, and that is from New South Wales Health. It would be relatively unusual to access a private hospital.

Ms Croumbie-Brown—Absolutely.

Mr Williams—There are some very good success stories where small country hospitals have a good relationship with Aboriginal people, and where Aboriginal people are on the board. Members of our council are actually on the board of the hospital, the area health service, and the board is very pro-Aboriginal. So it is very scattered. Racism is not as noticeable or it is very seldom experienced within the larger metropolitan areas.

CHAIR—I think that is a fair comment.

Mr Phillips—Could I comment on the business of hospitals and mainstream health services. Where I work there is no AMS, so we have an Aboriginal mental health service operating within the community mental health service. It has been an interesting experience for me in being involved in its development and seeing the difficulties, some of which surprise me. Basically we really got the money to do this by an informal coalition of two or three mental health workers and people from the Aboriginal community who were interested. We used to have meetings once a month, a feed and a chat. We ran a two-day conference and I took it upon myself to regularly pester the Director of Mental Health regularly—Noel Wilton at that stage in New South Wales—about getting some Aboriginal mental health workers on the staff. We had none. When some Burdekin money came through, some of it

came our way to establish the services. There was no AMS. It had to be mainstream. What surprised me in this process was how much obstruction there was of a quiet, informal sort.

CHAIR—In a white-anting kind of way?

Mr Phillips—I will give you examples.

CHAIR—You did not say white-anting but I did.

Mr Phillips—White-anting would be a good term actually. For example, before we actually had funding for an Aboriginal mental health worker, we had the opportunity of recruiting an Aboriginal registered nurse into the community mental health service, and the only way of doing that within the bureaucracy, because our positions were full, was via the local psych hospital. It was knocked back and we lost a very valuable person who had worked with us in training and was excellent, on the grounds of equity in that she would have had to go in front and get a position ahead of some non-Aboriginal people. Yet what we needed from her was her professional expertise in Aboriginal matters and her knowledge of the community which no non-Aboriginal could possibly provide. We got this pseudo thing: ‘Equal opportunity—we can’t let an Aboriginal person go ahead of a white person,’ so we lost a very valuable person.

More recently there has been quite a debate on whether the members of the various mental teams should be just that, and there should be no Aboriginal mental health team, no cohesive team, which the team itself has opposed very strongly—and rightly, I think—because they do need to meet together. Yes, they have to be scattered over a 500-kilometre range to provide a service but they need a monthly meeting. There are very many issues and they need their mutual support, they need input from myself and other non-Aboriginal health professionals, that sort of technical support. I think we have won that one. But there is a great deal of pressure, just through cars not being made available when the mobility is terribly important for the Aboriginal mental health workers; little pinpricks of them not being regarded as proper professionals. Some of them have qualifications, some of them do not have paper qualifications, but they have this professional level knowledge of their own communities which we must have if we are going to provide an effective service.

I think it is working. Our new Aboriginal clientele came up from about three people who walked in the door in 1990, before we had any Aboriginal mental health workers, to the last figures 1997 or 1998 where there were I think something close to 400 new contacts. This is from having the Aboriginal mental health workers on deck. It has made an enormous difference to me, as the consulting psychiatrist, that I now have a lot of people who walk into the office perfectly happy to see me, whereas previously there were enormous obstacles. It is not always even having an Aboriginal person present, it is just that I have been vouched for, and that makes a great difference to my work.

CHAIR—Yes, they have given the good word. Yes, that is great.

Mr Scott—I just wanted to say something in regard to Aboriginal workers. I think a lot of them in area health services do not think that knowing the community and being in the community is a qualification. They are looking for that piece of paper, but sometimes those

people with that piece of paper are not in the community, and people with those qualifications are getting into positions where this person who is right in the community, knows what is going on in the community, lives with the community, identifies with it all the time, is missing out on the position. Someone gets the position because of certain qualifications but they are not mixing in the community, are not identifying in the community. Then there are major problems because the community does not go to that worker. It is not helping anything.

CHAIR—It is not the ticket but it is the acceptance of it.

Mr Scott—Yes.

Dr Phillips—And the mainstream health service needs to recognise this community connection and qualification and knowledge as a professional qualification, even if there is no ticket for it. I think if we can recognise that, then that is the way to go.

Mr Yeoward—I would like to beg five minutes of the committee's time to make an oral submission on a number of points. I would like to introduce myself first of all. I am a chartered secretary and a certified practising accountant. I am the accountant with the Armidale Aboriginal Medical Service. I have had around 15 years in Aboriginal health in Bougainville, Alice Springs, Wagga and Armidale. I would like to make a few points, and I have some good news also to point to. Firstly, on the matter of health staffing structure, unfortunately it is a bit of a pyramid nature there. Certain services of a medical, dental and other professional nature cannot be provided if we do not have the professionals. What I am particularly concerned about is the real threat from 1 July next year when the government's proposed changes to the fringe benefits tax come in, the impact those changes will have on not-for-profit organisations, in particular Aboriginal medical services. I will not go into it at great length. I have circulated a copy of a letter I have sent to a number of members recently and of course Mr Williams has indicated there is a report coming from the AHMRC.

Mr Williams—From NACCHO.

Mr Yeoward—From NACCHO. I believe it would be the biggest single threat to primary health care services in the outback and, indeed, Aboriginal medical services in general over the last generation. If this change as it is proposed comes in we can largely forget about having doctors working out in the west of the state. Please let us see if we can look at this issue. We would like to have a two-year moratorium. I will not go further on that matter, but open it up for thought.

On the issue of foreign qualifications for doctors we recently had a crazy situation in Ashford, New South Wales, whereby a doctor in private practice who had a lot of Aboriginal patients was required to leave the country because his two-year visa had expired. Surely to goodness we can have some sort of special visa category for doctors working for Aboriginal medical services or doctors who are in private practice where the private practice has a lot of Aboriginal clients on board, whereby there can be some dispensation allowing foreign trained doctors to come here.

CHAIR—How long ago was that, Kym?

Mr Yeoward—The one I am talking about was as late as April this year.

CHAIR—Yes. I think from about June-July there was that change.

Mr Yeoward—Yes. In fact it was so serious that the New South Wales Farmers Federation ran a television commercial campaign during the state election.

CHAIR—Can I just intervene. I understand there has been a Commonwealth initiative and they are now dependent on state governments. I think New South Wales has accepted the challenge in terms of basically accepting the qualifications of overseas trained doctors.

Mr Yeoward—It is an issue that we need to be aware of and keep an eye on, if you can, because a lot of doctors for Aboriginal medical services are overseas trained.

CHAIR—Do not let me interrupt you, but I just wanted to get that in. It is a bit of good news.

Mr Yeoward—Okay. I am putting on my bean counter's hat here. I am sorry, I am a bean counter! Regarding the issue of asset replacement in AMSs, around 10 per cent of our expenditure each year on paper is for depreciation, wear and tear. We are required to put it in our accounts because Australian government standards, which are legally enforceable, require us to note that. The problem is that we cannot. We are not allowed by the Office of Aboriginal Health to budget for capital replacement. I was actually told this year, 'Do not include any budget items for capital items. You'll have to go off on a cap in hand basis and replace it.' This is a crazy situation. We have a dental caravan now that is nearly 10 years old. It has been a good caravan, it has done great service, but we do not have any money to fund a replacement of it.

What I would like to suggest is a simple straightforward solution. On 1 July next year the new GST system comes into place. The tax office is handling tax credits. Why not allow the AMSs to take their audited accounts to the tax office, say, 'There's the depreciation figure for last year. It's \$45,000' or \$50,000, \$100,000'—whatever it is—and give them a tax credit voucher straight off it, the same way child-care placements are presently funded. Subsidies are funded by the Commonwealth through Medicare bulk-billing, so that the mechanism of the tax office is going to be there for that.

In 1996 the former minister, Carmen Lawrence, introduced a very innovative scheme called the Staff Training Relief Staff Scheme. That enabled AMSs to get a little bit of money—\$25,000 or something like that—per year. It varied according to the size of the service. They could then hire relief staff to replace health workers whilst health workers went on their block release courses of four weeks or so four times per year down in, say, Sydney. That was stopped in the 1997 horror budget. I am sorry I have to say it, but it was a horror budget for Aboriginal people. That has meant that releasing staff to go on training has come to a grinding stop. We do not do it. We cannot afford it. We cannot afford to hire the replacement people and we cannot afford to let those people go because the patient need is there. So, please, can we have that scheme reinstated?

I have a bit of good news for you on women's health, amongst all this doom and gloom today. We do not have funding for our women's health program but we do have a women's health program. We have managed to cadge it a bit. A doctor comes in two days a week—a young lass who does it on bulk-billing—and, with a couple of CDEP health workers, she has built up the breast cancer screening rates in New England and the north-west region. We go up to Armidale, Walcha, Inverell, Tingha, and Glen Innes. They can get over almost as far as Moree some of the time. They have a statistically proven breast cancer screening rate of 71 per cent now of Aboriginal women in that area. So it can work—you only have to get a little bit of money—but, please, can we have it?

Ms Croumbie-Brown is tied up with the state health department. I have to say we have not had any community health money from the state health department for the last three years—not a cent—bar one bit of funding for a dental therapist.

CHAIR—You have put that on the record.

Mr Yeoward—The point was made before about the Minimbah service and we are working closely in Armidale with Minimbah on child hearing. This is a pilot program funded by OATSIH. OATSIH in their great wisdom chose not to fund us for a motor vehicle for that worker, so how is the worker expected to get across the whole north-west region of New South Wales? What we did is what any AMS would do there: we nipped and tucked a bit and we spent some money that should have gone to on insurance premiums—we found that out later on—and we got a little car for her, the cheapest possible one. So we try and make it happen, but it is a battle.

Regarding community health, the diabetes side of it, the health workers are out there on the ground, and I should mention it is not just the paid health workers. We have a shadow work force out there, and those shadow health workers are called the Community Development Employment Program people—the Work for the Dole scheme. There are 32,000 Australians who work for the dole in Aboriginal Australia. I have to say that in our part of the state most of them work darned hard for it. In our office, for example, we have a data entry operator. She works three days a week which is paid for from our budget. We are not funded for the full five days a week. We have a need for a five-day funding. She is on CDEP for the other two days per week, but she is getting a qualification now coming through. Our new child hearing health worker is a CDEP worker who has now gone up and done the hard yards for it.

I hear a lot of criticism of CDEP around the place, but some CDEPs are good. We have 190 people in Armidale on CDEP and we are trying like hell to get training for them in skills to enable them to get into regular jobs, but we are finding problems with the changes to the TAP program. The old Training for Aboriginals Program worked well. The new one from Minister Reith is trying to come back, trying to do a bit more, but we are still being asked to meet two-thirds of the bill on that, and for us to put on 10 health workers per year that is going to be around \$55,000 or \$60,000. It is going to have to come off something, and we will be nipping and tucking.

Community health involves a lot of diabetes and drug and alcohol. There are some great programs under way there but we do not have any money. We are not getting much money

from the partnerships. Partnerships with state health is really an issue that needs a lot more work. Nurse practitioners in New South Wales now have an approved category of work. In the far west of the state they will be important in assisting doctors, and I suggest we could have that through. Regarding telemedicine, if each AMS in Australia could be funded for a telemedicine centre it would be a heck of a lot off our patient transport budget. For example, just this week we have paid \$1,000 for two health workers to accompany one disabled person to come down to Sydney for a check-up. I am not talking about the real nitty-gritty of where a patient needs to travel and a doctor certifies that is necessary—great, yes—but where it is just a check-up, maybe we could have telemedicine there.

Could you also keep in mind the training of staff. For training of CEOs perhaps the Australian College of Graduate School of Management at the University of New South Wales or another institution could arrange training, because they are often very hard-working people who do not have a lot of education and need to—

CHAIR—They need some administrative strength. Can I just say on the administrative strength that this is very important. I could not agree more.

Mr Yeoward—I am a CPA, but out in the remote parts of this nation it is very difficult to get qualified and trained people on board. There are ways that we can resolve some of that with video training and so forth.

CHAIR—Yes.

Mr Yeoward—Last but not least, with respect to environmental health and home carer support, a little area that does not get much of a mention which I would like to put it in is the issue of mental disease, in particular schizophrenia as it affects Aboriginal people and communities. We have a couple of people up our way in communities with their people and they get next to nothing in the way of support. We need to have some support in mental health development. Regarding environmental health—and this has been said before—the role of local government is perhaps not appreciated very much. Where you have local government wanting to be cooperative, they are partners who should be brought into the exercise. We have been lucky in Armidale because we had a good involvement.

CHAIR—We would be encouraging local government to the maximum. We have found it to be patchy on the ground.

Mr Yeoward—Yes. They do not have the resources, I guess.

CHAIR—It is also a matter of will, too—their own will.

Mr Yeoward—That is about all I had to say.

CHAIR—That is great. Thank you for that. It was very comprehensive.

Mr Yeoward—I will put that down in writing a bit later on.

CHAIR—Thank you.

Mr JENKINS—I want to clarify a point. The 190 CDEP people are not with the medical service, are they?

Mr Yeoward—We have 10 people assigned to the CDEP. The way the CDEP scheme works is that each CDEP in the town has a certain number of teams or crews allocated to them—

CHAIR—But they are not assigned to health. I think that was Harry's question. You mentioned you had one in the office, but you had a team of mental health—

Mr Yeoward—Yes, nine CDEP. For example, my assistant is on our payroll three days a week and she is on CDEP for two days. Some people might say that is doubling up, but what I am trying to say is that we have never been funded for the level of support that is necessary.

CHAIR—No, I think that is the accepted model. I think that is a model that is all around the country. I do not think that is an issue.

Mr JENKINS—You mentioned a funding level of about \$500,000.

Mr Yeoward—Yes, \$550,000, and we will probably need just on \$900,000. The CDEP is putting in the equivalent of about \$115,000 a year.

Mr JENKINS—So the \$115,000 is not in the \$500,000?

Mr Yeoward—Because of all of those people, they work their 14 hours a week there, no two ways about it—

CHAIR—But would you agree with Harry's question, though, that the \$115,000 is on top of the \$550,000?

Mr Yeoward—What I am trying to say is that it is a shadow because we do not actually touch that money at all. That is actually paid through, but it is the time and the training of the workers. It is often an opportunity for the Aboriginal people who have not gone to school. They come through the CDEP, and if the CDEP has the right training, let us not leave them on the side. CDEPs have a very important social responsibility. They keep people off drugs and alcohol in other regions. They might not seem to be doing a lot but often for many people it is their first step into employment.

CHAIR—I think there is general bipartisanship on the CDEP.

Mr Williams—I have just two comments on Kym's comments which I think need to be made as points of clarification. Regarding training of CEOs, the council has a very successful program with ACHSE. We have already had 15 of our CEOs trained professionally, equivalent to those qualifications for a mainstream hospital. That is an ongoing program, a very positive thing for New South Wales. The second thing is, regarding otitis media: where you have no car, the council objected when it was allocated the money for otitis media. They first of all refused to accept the money without vehicles and then they

relented. Some services rejected the program altogether, because they could not provide that support. They only had bicycles to take round the audiometry gear.

Mr Yeoward—Yes. This is a classic case of a program devised in Canberra when a person has not thought about the practical issues.

CHAIR—Thank you. Does anyone want to particularly draw anything out of those comments? If not, I want to quickly move on.

Mr Paul—Mr Chairman, just quickly, the comment was made about telemedicine. I think it is one thing that has to be pushed for the remote areas and the Aboriginal communities and so on. For education of staff, for emergency consultation, communication with family members, particularly in remote and removed locations and even when some of the people might be in prison, for instance, they are coming along to the hospital where the thing is actually set up there and the family can talk to them and give them some support and back-up, which is very important for them. As for the psychiatric areas, I know that there are suggestions being made that even diagnosis may be made in certain circumstances if the psychiatrists can agree to that.

Dr Phillips—It is actually surprising how well it works in psychiatry. You would think that if you put a paranoid person in front of a television camera where they are talking head-on and asking questions it would fit into quite a lot of delusional ideas, but it works. People can distinguish very well that this is real and some of the other stuff is not.

CHAIR—They are quite comfortable with it?

Dr Phillips—Yes, it works. But there is a proviso there. There is something that is important about telemedicine, that the talking head on the box—the psychiatrist's head or the specialist's head—really needs to belong to someone who also goes to the area. You do not have much credibility in country areas if you never turn up and you do not understand who you are dealing with in the environment if you do not go. So if we are going to fund telemedicine, we need also to fund visits by the people who get on the box, otherwise the governments may be tempted to take it as a cheap option.

CHAIR—Yes, that has come out through discussions, I think—not just substituting.

Dr Phillips—Yes. It is not a substitute for visits.

CHAIR—Can we just understand where the Aboriginal Health and Medical Research Council fits in to the national picture. Jim and I have been chatting about it this week and we feel we have a bit of a picture of linkage across to the CRC. I should have said cooperative research centre rather than get into the acronym. And can we get a bit of a picture of the Menzies School? Are they slightly different creatures throughout each state?

Mr Williams—The correct nomenclature is the Aboriginal Health and Medical Research Council of New South Wales. I think that explains the abbreviation. The acronym is due to the length of the words, not the actual meaning. NACCHO is the National Aboriginal Community Controlled Health Organisation. Each state and territory has a state affiliated

equivalent. NACCHO is made up of member organisations that have the Aboriginal medical services, state affiliates like ourselves, and the comparable situation would be QUAHF in Queensland and WAACHO in Western Australia, AMSANT in the Northern Territory and so forth, none of which is a constituent member of NACCHO. Only the members of NACCHO are their AMSs. So it is a state duplicate of what happens at the national level.

But because health is administered through state and territory health departments, the role of the state affiliates is crucial and in many cases is more hands-on than the national body in taking on national issues and so forth. That is basically where we stand. We recently have moved into the area of health and research. We have our own college about to be opened up, training in Aboriginal health, our own health workers in mental health and various components. We have our own ethics committee. There are comparable situations in other states but we are totally separate from the government. We are in partnership with the state government, which is working out very well.

There is one thing I think I should say, and I will be brief. I was told to say this if I say nothing else. NACCHO and our state affiliate in New South Wales—and I think others are following—have been recognised by the Australian Taxation Office as public benevolent bodies and institutions, not just the AMSs. That is crucial. It came to a head recently where a surgeon in northern New South Wales retired and offered his services to the Aboriginal community in lung and cardiovascular matters. He wrote to Senator Herron, and Senator Herron referred him to us. We accepted his offer, and arranged a schedule to fly him all over the northern part of the state. When we wrote to the Department of Health and Aged Care through OATSIH, we were informed they could not help us. We were only after \$5,000 for air fares. This man gave his services free, and they said they could not help us because they did not see us as a service-providing body, that we were only a coordinating organisation.

We think the only way to solve the lack of services we have mentioned—and Dr Phillips has mentioned the need to have a presence, be visibly seen in communities—and to address this ill health in our Aboriginal communities is provision of tertiary services. By that we mean specialist services. And we are going to solicit funds from the public and the corporate sector to specifically provide specialist services to the community. We are a service provider and we take umbrage with the department's attitude. That is counterproductive. It is working against the need to provide services in the community, and I have been asked, if I say nothing else, to let this committee know that we and NACCHO and other state affiliates possibly down the track are going to be soliciting public money to provide services for help to address Aboriginal health.

CHAIR—I think the committee members will know what I mean by 'alternative delivery models'. The phrase 'alternative delivery models' comes to mind. I think that would fit. Would you agree with that sort of approach there? Lola, do you have something you wanted to add to any of the discussion?

Ms McNaughton—I think I probably said it earlier in the opening: the concept, the whole phrase 'Aboriginal community control' encompasses a whole lot of issues, because we are the ones who need to be in control of our lives, our destiny and our very health. That is how I see it personally as an Aboriginal woman. I realise that we have to work with governments on this. A lot of my colleagues at work, too, and a lot of the Aboriginal people

who are my friends, my family and community members feel the same way as well. We are not all what they used to call back in the 1960s the black power movement, or Aboriginal activists. We are all not of that calibre. We sit back in our lounges and say, 'Oh, no, here they go again.' The media particularly have a tendency to bung us all together, but we are not, and that is really important. There are Aboriginal people I do not particularly like, but I am here for the long haul, as long as I am capable of doing this.

I know there are a lot of Aboriginal people who are in this state, exactly like me. There are Aboriginal people from the early days of the Aboriginal Health Resource Cooperative Committee who are now CEOs of very successfully run AMSs in the state. I remember we used to sit there with the old infamous whiteboard and see how much money was going to this AMS or this whatever, which is what used to be done in the early days through Peter Collins's office, because we were the direct link at the time to AMSs; it was AMS reps from around the state all together at state meetings deciding where the dollar was going to. I have seen people who have now gone on from that and are now and have been continuing to fight for the dollar for Aboriginal community controlled health services, which are very successful.

As someone mentioned earlier, when you come to the LGAs, there can be problems with having a building, a shop front or something like that. So there are all these issues that are involved, and they are quite capable of handling all of this, with good sports, with non-Aboriginal people like Kym and like John, who are quite capable of doing these things. I think we should at all times be in control of our own destiny and health. Thank you.

CHAIR—Thank you very much. I am obviously intending to wind it up, so do people want to jump in and just make a couple of comments. Neil.

Dr Phillips—I would just like to provide a little bit of feedback from the college presidents meeting. A point that was made very strongly by Puggy Hunter, and also by the Northern Territory people, is that there is a problem with communities and health services being bombed by well-intentioned mainstream services who want to come in, and they all fly in for a day and actually put quite a load on the communities and the services. I am just really passing this on, but it struck me as a very important point. The message we got very strongly in that meeting from NACCHO was that we white guys had better get together and decide what it is we want to do before we come and offer something in communities. I think that is an important point that needs to be made.

CHAIR—Yes. Thank you.

Mr SCHULTZ—Assuming that the final outcome of the committee's report centres on the Aboriginal community handling the funds directly, and considering the long historical exercise of federal, state and local government involvement in Commonwealth funding to indigenous health, would you think that the way in which that new system—assuming it was there—would be to introduce it very slowly; in other words, introduce it on, say, a community by community basis? I know logistically there is going to be an enormous problem if we go down that path in terms of changing the culture that has been long established in the health funding delivery service to the indigenous people over the years. That is just a general question to ask to stimulate a bit of thought.

Mr Williams—I will respond this way. When the New South Wales Land Council was introduced in 1983, it came in without a manual. When Telecom have one slight module change they have two years' training. Suddenly with New South Wales land rights, there were 117 councils in New South Wales—117 secretaries, treasurers and so forth, and no ground rules as to how to spend money. We have had some unfortunate convictions over the years because of that stupid scenario.

Of course, something like this would have to be done accountable to the government; it is government funds. We have no problems, as Lola has mentioned earlier, about accounting for money. Probably we would be the most arduous in making sure that is carried out. But it should be done on a basis where the communities themselves individually can cope. We do the same thing with our PBI. There are certain communities which, at this stage, we know do not have the expertise or experience to live up to the responsibilities of a public company or a public benevolent institution, and there is a learning process to go through. I think it should be approached with a proper training program, working closely with NACCHO but probably, more importantly, at the state level, where there is a closer relationship with the state funding bodies, and working in tandem on a scaled program, reporting back to the committee or to your parliament to ensure that we get some outcomes that are positive and moving in the right direction.

Mr Yeoward—I have a little bit of good news, if I might pass it on. The University of New England has just had the first five, I think it is, Aboriginal graduates of their graduate diploma in health management course. This has been arranged by the Australian College of Health Service Executives, the ACHSE. The basic intention of that is not just to train Aboriginal people in Aboriginal medical services—that is a bit of a sideline—but more particularly it is about training Aboriginal people in health management in the mainstream health sector, so that we can go into the mainstream health institutions and find a representative number of people in there. For example, one of our health workers has just been appointed to the position of Aboriginal health services manager for Western Sydney. He is only a young bloke of about 30 or so and he does not know quite what has hit him yet, I think. But we have to have Aboriginal people and Aboriginal managers coming into mainstream health institutions. If the community can see some way to support that little program, it would be helpful.

Mr QUICK—Can I follow on from Alby's question to John. If we came up with five-year funding, linked targets and goals and outcomes, is that a realistic sort of reasoning?

Mr Williams—Well, apart from the camaraderie context of a five-year plan, I think it is a very realistic five-year program, geared to outcomes. It would have to be geared to outcomes. For example, we are very anxious for the community itself to start working on statistics for health. We have held back in getting all the health statistics deliberately, because the community wants to do it. It is saying, 'We want this responsibility.' I think, comparably, it is the same with the financing side of our services. The expertise is there. It is coming increasingly. All our services, as far as Aboriginal organisations go, I think it would be fair to say, are the *creme de la creme*. They have very highly skilled personnel. All their accounts are audited. It is a rare exception where there is any aberration from acceptable accounting practice. I think what you have suggested would be a practical,

pragmatic way to introduce funding so that the bulk of the money is going into services to address Aboriginal health.

Mr QUICK—One other question: how are we going to get over the areas of Australia that are across borders, where they play silly buggers with cost shifting between states?

Mr Williams—There is a need to address that matter right now. NACCHO itself wanted to do it at its own instigation with the state affiliates but, naturally, they have to work with the state governments. They have now taken the ball to some extent, so it is being done in tandem. Right now in New South Wales, for example—and it is going across this country—there are negotiations going on with Victoria and Queensland, with Canberra shortly to come on board, where they are involving departmental senior executives and an Aboriginal community controlled executive to address reciprocity in funding on the borders. It is being addressed but there is nothing tangible coming forth yet.

Mr Yeoward—Can I comment there. There are sometimes some crazy situations. The Commonwealth used to have this rural dental program subsidy. It got the axe in the 1997 budget, but our colleagues over at Kempsey had their funding under the Commonwealth program. We are funded for our dental services under the state program. We still have a state dental service running, but the people on the North Coast do not have any dental service coming through. I think that the Commonwealth OATSIH people are trying to address some of that there now, but you do get those issues.

The biggest challenge that a lot of AMSs I think are facing in 1999-2000 is this issue of accreditation. The Australian Hospitals Association and other groups are trying to move to have health bodies accredited, and that means having all the staff being trained in occupational health and safety, and patient relations, you name it. It is quite a big challenge.

Mr Williams—The council has addressed that, Mr Chairman. We know of the CHASP and others, and there is a medical lobby also seeking accreditation of AMSs. They are all jumping on the bandwagon. What our chairperson and our council board have decided is that those services who want those sorts of services are fine—they are very costly—but as our college develops we will have our accounting section, and one of its duties will be a self-regulatory accreditation process within the community itself.

CHAIR—Yes, that is encouraging.

Mr QUICK—It is like jumping through six hoops and paying for it.

CHAIR—The debate about accreditation is the constant self-improvement.

Mr Williams—Lola's colleague Dulcie is a trained educator from ITAB, and our college is very much geared towards addressing that issue, so there is no worry about that.

CHAIR—While on data and statistics, from a national perspective we constantly run into the reliability or otherwise of data. You commented about doing work with your data and your statistics and you have made some warnings about relying on certain statistics. Do you have a general comment, Lola or John, about statistics and data?

Mr Williams—The problem with statistics in New South Wales is that the state health statistics are faulty. I am on the committee, actually, so I am pretty au fait with what is going on. They are trying to address that matter. The Births, Deaths and Marriages Registry, the ABS, the department itself and we are working together to try and address that. We have got round the computer problems, and identification is being resolved, and that is basically coming from non-identification of hospitals and of funeral directors. That is being addressed, but the data that we are referring to is the health data, where the AMSs held back from complying because they tried to enforce it by inducement. One week before the next year's budget is required, up comes a 35-page questionnaire and, if you do not sign, you do not get funded next year. It is totally unscientific and it crossed all the decent levels of ethical propriety.

We are in the process of seeking funds to have all our AMSs trained, to try and get an epidemiologist working in each AMS and to do our own recruitment and our own collection of data to be channelled through and then passed on to AHIW and the NHMRC, so it is in hand. The only problem again is what Harry has mentioned: that when we go looking for funds for it, there are no funds for us to proceed. If we could have the carriage of that process, we would be getting those data back directly to the scientists here today and other people, but it has been stifled. If you do not work with the community and you try and impose a system that forces it out of the community by stealth or other means—by inducement or coercion—it is not going to work. We want to provide that data so that the medical people in this country can assess and address Aboriginal health.

Dr Phillips—Could I just comment from within the health department, as a person who works for them. Both in community health, and particularly for our Aboriginal mental health workers, community mental health, the statistics that are collected reflect purely face-to-face contact which would be, at the most, 50 per cent of what a good community mental health service does and probably even less in the Aboriginal mental health service, and I do not know why the health department restricts it to that, but it is quite nonsensical. You can spend all day working extremely hard and appear to have been in the pub all day! From a statistical point of view, they are utterly unreliable.

CHAIR—It just highlights a concern to us. Thanks for that. Ladies and gentlemen, I think we will wrap it up, unless anyone feels that there is something they want to add? Thank you for your time. Given your busy schedules, it is much appreciated.

Committee adjourned at 12.55 p.m.

