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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

FRIDAY, 10 DECEMBER 1999

CANBERRA

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Friday, 10 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: Mr Edwards, Ms Ellis, Mrs Elson, Ms Hall, Mr Jenkins, Mr Nugent and Mr Wakelin

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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

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

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

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

WITNESSES

Committee met at 9.09 a.m.

CHAIR—I declare open this public hearing of the House of Representatives Standing Committee on Family and Community Affairs, which is coming towards the end of its inquiry into indigenous health. I will just ask people to introduce themselves and pick out a couple of main issues that they would like to focus on or bring to our attention. The issues we are grappling with are fairly widespread and profound. Nevertheless, the discussion paper forms the basis of where we have got to in our process.

People from the department, from OATSIH and a number of other interested community people are coming. I think an Aboriginal medical service person, Julie Tongs, is also coming. Generally, we hope to gain some enlightenment from your views this morning about the old hoary chestnut of Commonwealth coordination. With a federation, there are issues between the Commonwealth and the states. We are very interested in how we might improve the capacity of mainstream health services, which are predominantly delivered by the states. I am hoping Dr Robert Cooter might help us with that.

As you will recall, our terms of reference are reasonably specific about the sorts of issues we are attempting to address, so I ask you to address yourselves to the terms of reference. We will have a reasonably informal discussion about your points of view and what you would want in this report if you were writing it.

[9.12 a.m.]

BAXENDELL, Mr Noel, Health Policy Officer, Aboriginal and Torres Strait Islander Commission

BLUNDEN, Mr Stephen Vincent, CEO/Public Officer, Durri Aboriginal Corporation Medical Service

BUCKSKIN Ms Mary Joan, Board Member, Winnunga Nimmityjah Aboriginal Health Service

BUCKSKIN, Mr Peter, Assistant Secretary, Department of Education, Training and Youth Affairs

COOTER, Dr Robert Benjamin, Past Chairman, Residential Task Force Aboriginal Health, Royal Australian College of General Practitioners; Royal Flying Doctor Service

DARGAVEL, Ms Ricki, Convenor, Implementation Task Force, Canberra Journey of Healing Network

DEEBLE, Professor John Stewart (Private capacity)

FIELD, Ms Patricia, National Program Manager, Rural, Remote Aboriginal and Torres Strait Islander Programs, National Heart Foundation

McCARTHY, Mr Chris, Acting Assistant General Manager, Housing, Infrastructure, Health and Heritage, Aboriginal and Torres Strait Islander Commission

McDONALD, Ms Mary Therese, Acting First Assistant Secretary, Department of Health and Aged Care

PRICE, Mr Andrew Robert, Assistant Director, Executive Policy Unit, Department of Health and Aged Care, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Aged Care

SIBTHORPE, Dr Beverly Margaret, Fellow, National Centre for Epidemiology and Population Health, Australian National University

STRASSER, Dr Sarah Elizabeth, Director of Rural Training, Royal Australian College of General Practitioners

TONGS, Ms Julie Anne, Chief Executive Officer, Winnunga Nimmityjah Aboriginal Health Service

WILSON, Mr William Thomas (Private capacity)

CHAIR—Welcome. Thank you for appearing before the committee today. I advise you that this is a public hearing of the committee and all the normal rules of the parliament apply. Does anyone have any comments to make on the capacity in which they appear?

Mr Wilson—I am retired now, but I had something like 35 years in public health services in Papua New Guinea, New South Wales and also with the Commonwealth department of health, the Aboriginal health branch, DAA and ATSIC. I still have a very strong interest in the health area.

CHAIR—I want to try to pick out particular areas of interest. Can I start with you, Ricki. In your perception of indigenous health, how do you see your organisation contributing to a better outcome?

Ms Dargavel—What the Implementation Task Force has done in following up the *Bringing them home* recommendations is talk to a range of indigenous workers in the ACT region about how services are working on the ground. Amongst those, obviously, are health and other services. We have come up with a couple of discussion documents, so we are contributing to the debate in that way. One is a report on those consultations with workers and some of the issues they raised—their proposals, really, for overcoming the problems that are arising. The other one is going through the *Bringing them home* recommendations, reducing the recommendations to actions and reporting against those. Health was obviously an important part of all those issues that were covered.

I was pleased to see your discussion paper coinciding with the issues that we have come across in our work. The main ones were, firstly, the need for indigenous control of health services, which is an issue you have brought out and, secondly, the need for culturally sensitive mainstream services. That is a fundamental issue that we have not addressed. If we are in the business of providing culturally sensitive services, why is it that cultural awareness training for people—that is, for people who are making policy, providing funding decisions, planning services, providing services—is optional? How can we provide culturally sensitive services without that? That is a major problem that we are pleased to see that you have brought out in your report.

CHAIR—Professor Deeble, since we last met, is there anything you would like to add? Basically, if my recall is reasonable, it is to debunk the old-fashioned idea that there is a lot of money going into Aboriginal health and it has been wasted. Essentially, what we had established is that there is a similar amount of money going to Aboriginal people when they have an issue that is at least three times more serious than that of your average Australian. I guess in issues of the states and their delivery of those services, have we added to that and have I got the rough summary near the mark of where we left it last time?

Prof. Deeble—You have. The summary in here is exactly what the report said, and there is nothing that I would change in that. There is a second report. The Commonwealth undertook to fund a revision every two years. There is a second review about to start, so that will report late next year, I would imagine. It is being done by the Institute of Health and Welfare, but I would be involved in that as well. That will hopefully refine some of the information, particularly on an area called community health, which is very vaguely defined and which was the weakest part of our study. We think we have got the hospital thing fairly

right, but we need to do a bit more work on part or the rest of it. I have some other comments on the general thing, but that will come later.

CHAIR—We will come to that later on.

Prof. Deeble—When do you want it?

CHAIR—Go for it now. Until we get our full contingent, I am going over familiar ground. I am just hoping we can get another three or four members in. I would just ask you to continue on.

Prof. Deeble—Maybe some of the people who are not here would not altogether agree with some of the things that I might suggest. Generally, I have several concerns. The infrastructure requires at least as much attention as the health services. The infrastructure expenditure, daunting though it might be, is one of the things that would have to be done in order to make primary health care effective. It does seem to me that there will be a lot of money spent on attempting to correct what are defects in the living conditions of people that cannot be solved by the health services. If I had a choice, I would give it at least equal weight. That is not an area that I am very familiar with.

The other point which bears on some of your models is that it seems to me, having worked a little with a couple of the trials in the Northern Territory, the Tiwi trial and the Katherine coordinated care trial, the cashing-out trial, and having a little bit of knowledge from Canada—I have also had some words with Peter, who has been in Canada too—that we should not expect too much too quickly from those trials.

One thing that he particularly noted, and that I would agree with from Canadian experience, was the great amount of investment in capacity that needs to be made before those trials could be expected to produce a real return; that is, the capacity on the ability of the administration and the ownership board to actually make decisions. As I think I said to the committee at an earlier stage, it is rather like asking the town of Gundaroo, where I live and which has 700 people in it, to buy its own health services, which it could not. There is no way in which the town of Gundaroo could buy its health services and could make any decisions—and this is a fairly affluent town, by the way. It will rely on the mainstream services to make those decisions. It should have an input to them but it cannot buy or make those kinds of decisions from the ability within that community even.

I do think that we should hope that the trials produce a more refined purchasing system but it would be unrealistic to expect it to do it straightaway. The people from the office would have better information on this, but the Canadian experience appears to be that you need to spend a long time and a lot of money in training the people who will be the buyers in how to do it. That means involving them for some years pre the trial handover so that, before they have a responsibility to do it, they know the process and are familiar with the process of doing it. For all those reasons, I hope that people do not put too great an expectation on those trial results.

CHAIR—That is excellent because you have come to the how and the practical reality of a lot of the issues. Your example of Gundaroo—

Prof. Deeble—It could not do it.

CHAIR—No.

Prof. Deeble—It does not have a doctor and it does not have a hospital—it relies on Canberra. To give it the responsibility of deciding what health services it would have would be ludicrous, it seems to me, because it cannot make those decisions from its own resources.

CHAIR—As you may be aware, we have these various models where the states do it all, the Commonwealth does it all or there is pooling. It is a debate about how you best deliver the service. It is in that same kind of general overarching administrative discussion, as well.

Prof. Deeble—My submission, right at the beginning, I suppose.

CHAIR—Yes.

Prof. Deeble—It seems to me that there is no alternative to the states running the mainstream hospital systems because the Commonwealth cannot and will not. Who else is going to do it? I am interested in practical things and the practical thing says that the states are going to do it. Whether the states can provide any specific program for indigenous people within those mainstream services is the big question. It may be able to do so in remote areas but it may find it administratively impossible to do so in anything other than remote areas because it will not be able to identify any particular program that it can administer through the mainstream hospital services in the larger areas. Those services are just swamped by the big one. I do not think the Commonwealth could, or should for that matter.

I do have some concerns about a couple of other practical matters which I am sure many people would disagree with, so it is open for discussion. You have manpower problems mentioned in here: people who are working short term in particularly remote areas, the difficulty of attracting and holding them, and the difficulty of finding people who are aware of the cultural requirements. That does not apply only to medical people—it does apply to some nursing people—but presumably it gets closer to the community as you go down that professional highway. That is one concern.

Also, some years ago an American visitor who was with us and who wrote about Aboriginal health and compared it with Indian health services in the United States, pointed out that—this has gone in the United States, by the way—the Indian health service had a significant clinical effect because it was a career service and it was a federally organised career service. People saw their life's work in it and they were willing to undertake the training that was necessary. It seems to me that, for somebody who is outside an Aboriginal community, going into that for a period which might be as short as a year or six months, getting them to undertake the training that is necessary, is a long call. If you did, you will get a poor return on that investment because they are not in that for a career. They are in it as—

CHAIR—It is certainly supported by us going around. It was more the exception than the rule for people that had been there for any period of time.

Prof. Deeble—Absolutely. It does seem to me that at the primary care level—where are to be found the primary practitioners, the nurses or doctors, and the Aboriginal health workers and the people who would be involved in the health impact of infrastructure—it is entirely appropriate for that to be controlled at that community level. But there is a lot more beside that which is being spent even now. It is all that specialist work which often comes through the states by secondment of specialists to go and visit once in a while.

The experience, by the way, in the Tiwi trial is that they are the worst keepers of records because they do not see themselves as part of the community thing. The record is for them; they take the record away with them; it reminds them, but they do not record anything. So those visiting specialists from the states and territories are not engaged in the local thing at all. That is my second concern.

The third was that, from experience going back to the community health's efforts of the early 1970s, however we may not like it, professional people are reluctant to be employed by community boards. That is one of the problems that the community health movement found when it started 30 years ago. Doctors and nurses could not get on with the boards of the centres; they just would not work for them. I wonder whether there could be an employing authority of some kind, which could be a kind of Aboriginal health service not necessarily run by the Commonwealth as such, to employ those people. I am just trying to see what obstacles you could overcome.

CHAIR—I think I understand.

Prof. Deeble—They do not all have to be employed by the local authorities—

CHAIR—The AMSs.

Prof. Deeble—because specialists do not see themselves as doing that anyway; they see themselves as being something else altogether. It might be an alternative to your mixed model there. Something like that, which should not be beyond the ingenuity of people if they really wanted to do it, could overcome some of the staffing and administrative problems and give a national focus to a service. I think you can construct it between the Commonwealth and states. There is a good deal of money for that. Not all of the specialist services should be cashed out because I do not think they are purchased by the local group. Anyway, it is a long talk.

CHAIR—Just to pick up another point in there and, please, we want other people to come in at will. In community capacity and ownership, in the Gundaroo model—as we acknowledge, without offending anyone—Gundaroo could not do it.

Prof. Deeble—No.

CHAIR—I think you have partly answered this question anyway, but I am just trying to deal with AMS, Aboriginal control, Aboriginal ownership and community capacity, and bringing them together and delivering the outcome that we all want. Part of what you talked about in terms of, say, some outside employment agency, Commonwealth, state, whatever—

Prof. Deeble—Represented some kind of career.

CHAIR—Yes. As you said, it is like the Indian health services model in the US. What other issues are there in the administration and in the capacity of the general community to get that greater ownership? Outside the medical model, what other issues are in the community? You have talked about infrastructure. Is there anything that rings a bell? When the Aboriginal Medical Services talk about control, they might be talking about something they will battle with in certain areas and in certain communities, because AMSs do not cover all of Australia. They are, at best, spread spasmodically. Therefore, it falls back on to the state health services and others. Of course, the inevitable question underpinning this all the time is about mainstream services. I am just trying to wrestle with—and the committee will have to wrestle with—Aboriginal control and ownership. Have you got anything to say to help us with this? It is a tough question.

Prof. Deeble—For non-Aboriginal people, we have spent much time in setting up large organisations to organise self-services, such as state departments and big hospital systems. At the local level, most of it has been ceded away for those very specialised services. In some respects, we are saying that, for Aboriginal people, we should go back or have a model which is not the model that the rest of the country works on. I think it is a very great expectation to put on them. To be realistic, I do not think most of us—that is, non-Aboriginal people—could do it anyway. I believe the Aboriginal Medical Services should control them and should get a selective group of people who will work with them in that situation. I am not an expert in this because I have not studied the internal structure of the AMSs, but I am sure others could comment on it. To extend that to everybody who works in Aboriginal health, I think, is too big an expectation.

Ms Field—I currently work for the Heart Foundation. I previously worked, from 1991 to 1998, in Central Australia in remote area health services. I am quite familiar with a lot of the issues that John is bringing up. I agree with about 98 per cent of that. But I just want to pick up on a couple of things. One is the career aspect for staff. I am not disagreeing with John here; I just thought it was worth picking up as it is a really important issue. One of the biggest things that you battle against, as a health professional working in remote areas, is that turnover of staff. It is extraordinarily expensive to be always recruiting and trying to bring people up to speed so that there is safety for them and safety for the people they are looking after. I think that is an enormous issue. I think building professional career paths that really value what people are doing are currently not there, although there are some moves.

The area that I want to focus on a little bit is the network of university centres of rural and remote health that is now around Australia. There is one in Alice Springs. I would just like to advocate that universities are really supported and strengthened as being absolutely key in this, because they are key to developing that career path. I am familiar with some of the work they are doing.

The other point that I wanted to pick up on was the community controlled health services. I worked for Territory Health when I was in Central Australia. Again, that was something that we grappled with all the time because we were a government health service. We were the biggest health care provider in remote areas. It was an enormous struggle to try to balance being part of the government and having sufficient community input. I strongly

believe that, if it is done right, you can do that. I actually wrote a paper called *Community control in government health services: is this an oxymoron?* I argued that it is not. In fact, if you do it right, you can actually balance the two.

I think that is one area that needs a lot more focus and a lot more work, and not just in relation to Aboriginal medical services. There are a lot of government health services out there, and we really need to build up the capacity of community control within those health services and balance out the power differential a little bit. We worked quite hard at it, but I cannot say that we made any significant headway. I felt that someone from NACCHO would have jumped right in on that one, and they probably will. My view is that it is a capacity thing. I think Aboriginal people can manage and run their own health services and communities. There are examples where they do it very well.

I think Nganampa Health is a very good example of that. It is a health service that has been functioning well in Central Australia for many years. I think there are a few factors in that, and it is a model that we can probably draw on. It is an Aboriginal council that controls the health service, but they employ, and always have done, very skilled managers in that health service. People are not sitting there saying, 'We can run our own health service.' They recognise and acknowledge they need to buy in the skills and, at the moment, it is predominantly white health service managers that come and do that. Hopefully that will change as we develop Aboriginal people's skills in those areas.

That health service certainly buys in the expertise that they need, and those people report to the community council. One of the reasons they can do that is, if you look at the funding of Nganampa Health—I might not get the figures right—it is around $1,800 per capita as against between $600 and $800 per capita in a lot of the other health services. I am not sure why Nganampa is so well funded, but it is quite well known that it is. I think the measure of that is that we are actually getting the outcomes, and those people are able to do it, whereas a lot of the other health services, with the best will in the world, are underfunded and are struggling. They were the two main things that I wanted to raise. I have some specific heart matters to raise, but I might get to them later.

CHAIR—That is fantastic—thank you for that. I would like to welcome a few people: Dr Robert Cooter and Mr Stephen Blunden from NACCHO.

Mr Blunden—My organisation is a member of NACCHO; I am from the Durri Aboriginal Corporation Medical Service.

CHAIR—That is Kempsey?

Mr Blunden—Yes, Kempsey.

CHAIR—I would like to welcome Mr Peter Buckskin. Robert, to put you right on the spot—you have written a very comprehensive submission, which we are grateful for—would you like to open up with some preliminary comments and we will go on from there. We have had some interesting information from John Deeble, as always, and from Pat Field, so we have just started. John will be revisiting some of these issues anyway.

Ms HALL—I want to ask Pat something, if I may.

CHAIR—Yes, just a quick question. It will give Robert a bit of time to prepare.

Ms HALL—Pat, do you think that Nganampa is performing well and gets the funding because they are good at putting in applications and that a group of AMSs is missing out just because it does not have that expertise? And, if so, how do you think that can be countered?

Ms Field—I think that is absolutely right. Nganampa have a very slick, well-oiled machine that is right across all the issues. They know where to go for the money and they are very successful at getting it. You are absolutely right: there are small Aboriginal medical services out there that are hugely disadvantaged because of the complexity of the funding.

I was recently involved in a workshop looking at cardiovascular disease in Townsville, which came out of the National Health Priority Areas report, looking particularly at indigenous rural and remote cardiovascular disease. One of the general things that came out of that was that we have to look at simplifying the funding mechanisms and also making them more transparent. This crossover between states and Commonwealth is a nightmare for people sitting out there with minimal resources. It is a big issue and needs to be addressed.

CHAIR—Thanks. Robert, do you want to say a couple of words?

Dr Cooter—I do not know whether everybody here has read my paper.

CHAIR—I would think not everybody would have had access to it. The members have had access to it.

Dr Cooter—I thought I would highlight some of the salient points in it that should be brought forward at this meeting. First of all, I do believe that Aboriginal people in the remote areas are the ones that have not had equitable health services ever. They have not had doctors. In my paper I mention that we sent a survey to 150 communities. Only 22 had doctors there at that time. Most of them did not stay very long. There has not been a constancy of general practice services.

I think it is basically general practice. A lot of people do not agree with me. They say that the nurses and Aboriginal health workers can run the services. But I think it requires the depth and breadth of training of a general practitioner to supervise primary health care programs, make diagnoses and carry out management of patients. This can only be done by doctors who have had six years of undergraduate training and three or four years training afterwards.

There is really very little difference between an Aboriginal community and an urban non-indigenous community from the point of view of the health problems. There are a few diseases that Aboriginals do have and non-indigenous people do not have, but they are very few and the health problems are largely those of Western communities—Western diseases, but with greater incidence and complexity.

The idea of having a resident GP service should be foremost in our minds. I had communication with a young paediatrician who had worked in Darwin for some years. In a letter to me, his thoughts on the GP presence in remote indigenous communities were that GPs are critical; their presence is essential in remote communities, and this can also be said for rural nurses. I believe him. It has been my contention that it is a general practice exercise. I am not saying that because I am a general practitioner myself.

CHAIR—We agree with you, Robert. We are pretty interested in how we would do that.

Dr Cooter—I will come on to that in a moment. I think it is the remote indigenous communities that need the provision of a constant health team and funding. The urban and less remote Aboriginals can have access to good medical care. The health infrastructure has to have the medical facilities. In a lot of the communities that I went to they were quite inadequate.

The only state where I saw excellent facilities was in the Cape York area. The Queensland government have spent more money than any other government. I went to four communities up there and they all had new facilities. There were excellent buildings. They even had a dialysis room.

CHAIR—Which communities, Robert?

Dr Cooter—There were four. Kowanyama was one but, I am sorry, I cannot remember the others now.

CHAIR—That is all right. The committee has visited a lot of these communities, so it would be valuable just to relate to them.

Dr Cooter—They were outstanding compared with the other states that I went to

CHAIR—John Deeble mentioned that earlier in terms of the sorts of infrastructure issues.

Dr Cooter—The health team I describe in my paper is the doctor, the nurses and the Aboriginal health workers. I have been involved with training and recruitment of country doctors for 20 years now. I am rather disappointed that voluntary recruitment of GPs to remote communities, not only to Aboriginal communities but to the remote non-indigenous communities, has been poor and has virtually failed. It is not likely to improve, mainly because of the attitude of the new graduates who do not seem to want to go to country practice.

CHAIR—Give us a bit of hope.

Dr Cooter—I do believe—and I am a heretic when I say this—that the time has come for an introduction of mandatory service through the provider number issue and scholarships, such as they have in Queensland. Queensland is the only state where they have these scholarships.

CHAIR—I understand the Commonwealth cannot conscript doctors to service because the Constitution restricts it.

Dr Cooter—There were 300 graduates refused entry into the training program of the college of GPs last year. Couldn't they be approached for the provider number?

CHAIR—Yes, there are issues around the provider number.

Dr Cooter—Those 300 were refused.

CHAIR—Sarah Strasser will jump in there.

Dr Cooter—Were they ever approached by Dr Wooldridge?

Dr Strasser—Off the top of my head, I would say no. However, in South Australia they were approached to go to the Riverland, which you would think might be a bit more acceptable, and we have not been able to get them to go there either.

Dr Cooter—There are students going to the Riverland.

Dr Strasser—But these are people who did not get into the training program this time. We have a shortage of registrars in the Riverland area, so we specifically requested whether those who had applied to South Australia would be interested in going out there with whatever we could provide for them, but they were not interested.

I will not let you lose hope. There are a lot of undergraduates, particularly with John Flynn scholarships, going through. I also work for Monash University and deal with electives. I have an increasing number of students asking for electives, particularly in the northern part of Australia, to be able to go and work with Aboriginal communities. That has increased exponentially over the years. The difficulty is that there are limited places that can really take them on.

Dr Cooter—If we are going to give all these Aboriginal communities an equitable service compared to what we are giving ourselves—

CHAIR—Robert, we will just ask Steve to jump in there too.

Mr Blunden—I have a point about mandatory GPs to go into the communities. We spoke to Dr Wooldridge two years or maybe three years ago about the same issue. Basically we felt that it should be brought in. The only reason we thought that it should is because it is not just Aboriginal people suffering out there; it is non-Aboriginal people as well. If you take Walgett as an example, they are lucky to have one doctor running the hospital and the medical service. On occasions they have to send people to the next town and that is totally unacceptable.

People were looking at trying to have doctors come in from overseas but they have come up against a lot of red tape. We have doctors in Australia who want to live in the cities because of their lifestyle and we do not blame them but I think if it is good enough for the

police to be stationed at different places and schoolteachers to be placed around the states, I think the doctors, with all due respect to them, would find it good for the young people to get out there and learn. I think they could learn a lot of different medicine in the country areas.

Dr Cooter—My idea is that we should try to develop this provider number issue more because we are lacking about 700 doctors in country areas in the non-indigenous community plus about another 150 if we are going to give Aboriginal people an equitable service. Why were these 300 refused training in the college? Surely there must be a large number of them who would be prepared to take a provider number and work for two years minimum in a remote community, whether it be an indigenous or non-indigenous community. I think it is the only way we are going to solve our problem. I am sorry about that.

CHAIR—That is fine. We are here to discuss these issues. We have other people here.

Dr Strasser—I should say that the option is already there for them to be able to get a provider number to work out in rural areas and they are just not going.

Mr NUGENT—That is why we did it—they are just not going. And the trouble is, if you are going to live in a democracy, how can you direct people where they are going to live?

Prof. Deeble—That is the problem with the provider number system. The possibility of conscription arises. I do not think it applies in many other cases but it does there. That would limit you.

Dr Cooter—It is an option they are given. They do not have to comply.

Mr Blunden—In terms of retention rates in AMSs—I think you touched on this issue earlier—the way we do it in Kempsey is that one doctor has been doing it for close on 14 years and the other doctor for five years and so forth. Basically, it all comes down to professional people feeling secure in an organisation. That is one issue I would like to talk about today sometime and cover the structure and the life of a board—issues like that—in terms of not working in a social club but working in a business where professional people feel secure and they can go and mortgage a house or whatever. That issue is relevant in terms of GPs as well.

CHAIR—Thank you. We will appreciate your comments on that as we go through the day.

Mr NUGENT—Chair, could I ask Robert one question just to close the loop, if you like? As I understand it, what you are saying is that you want a degree of coercion, whether it is provider numbers, some form of drafted national service or whatever, for new doctors or young doctors. What about sharing the load and having national service for all doctors, say, for a two- or three-year period, and require them all to do it? How would that be accepted by the profession?

Dr Cooter—Not very well, I do not think. I personally would accept—

Mr NUGENT—Why discriminate against one part of your profession?

Dr Cooter—This is true. The point I made in my comments on the red book is that, in South Australia, some of the specialists that have become eminent have spent three or five years in a country practice in their early years and it did not disadvantage them from getting into the training programs. The Flying Doctor Service in South Australia, which I have been involved with, had 15 different doctors in the last 20 years and eight of them have got into specialist training programs because their work was good. They got priority over the city slickers.

I notice in the red book some doctor commented, 'It might affect my chances of advancement in another area.' But it does not. The specialist disciplines have been very kind to these doctors who are prepared to go out and do three, four or five years in a country situation. It has not prevented them from doing their specialty.

Mr NUGENT—I suppose what is behind my question is that, rather than applying coercion, should we not be providing some positive incentives so that if you do some time—five years or whatever the period might be—in a remote community it gives you some extra credits for then getting into some other specialty or whatever you want to do?

Dr Cooter—One of the incentives I have mentioned in my paper is that they be given priority if they want to pursue a different career in medicine. I listed about 10 incentives, including things like giving good salaries. In one community I went to husband and wife doctors were getting a base salary of $85,000. I do not know whether it was NACCHO or ATSIC but if they stayed two years they got an extra $50,000. But even that is less than what they would earn in a single man practice on Eyre Peninsula. You would agree, Barry, I think. I think we have to give them incentives.

Mr NUGENT—You talk about numbers that members of parliament do not understand.

Dr Cooter—There are not only financial incentives. There are other incentives such as taxation reductions.

Ms ELLIS—The committee has discussed this issue so much and one of the angles concerns training and the recognition level of practitioners. I think Robert just said it. After practitioners have been out in rural and remote areas and they wish to go back into a mainstream practice there should be some recognition, either at that time or during the training of doctors, to show that they have done training and practised in rural and remote medicine.

It has been said to us often that it is not a fear of not being able to enter a specialty. Some people have said that it is a suspicion or a fear that, when they have stepped out of what they see as the busy highway of medicine in mainstream Australia, they feel they have difficulty re-entering even at that level or that they have divorced themselves sufficiently that it is hard to get back. I cannot understand that in reality because it seems to me that the more time they spend out there doing that sort of work the more their skills are honed in a variety of ways that they would never experience in a city or suburban practice. There must be some way of incorporating that into the recognition levels for them.

Dr Cooter—The only comment I can make here is that in my own instance after I spent 18 years in a country situation I was approached by four different practices in the city. They heard I was leaving. This applied to a lot of my colleagues. The city practices seek out the country doctors that have performed well.

Ms ELLIS—Maybe we need to debunk these perceptions. Is it as simple as that?

Dr Cooter—Yes.

Dr Strasser—I do not think it is as simple as that, unfortunately. How I see people working in Aboriginal communities having difficulty in moving back is from my own background in general practice alone. I cannot really speak for the specialities. What we have noticed is that the issues for those doctors mirrors the same issues that are there for rural doctors going back into urban practice, only to a much greater extent.

The issues are things like buying into another practice. The goodwill that has to be paid when you go back into a city practice is huge, whereas there is virtually no goodwill in rural practice now. You do not get anything for the practice that you were in in the rural community, yet you have to pay out a huge amount to get into the city. The house you may have bought in the country will not have increased in price in the time that you are there—if it has not actually fallen—to enable you to buy a house in the city. The cost of moving is something that people forget to take into account, but I gather that the average—this is from South Australia—is from $15,000 to $20,000 just to move the family back in. It is all of those issues that have to be addressed as well.

You are right: there should be recognition of work done. We are finding that quite a lot of our registrars are wanting to do postgraduate qualifications so that they have a little extra ticket to say that they have done this. With regard to Aboriginal health training within the RACGP training program—I think I mentioned this before—there is a compulsory component that means they all go through cross-cultural awareness programs now. We have found that, to get that instilled for the registrars, we have had to do a lot of professional development with our own medical educator and administrative staff.

We have also had to support Aboriginal people going through the same courses and facilitator courses to be able to have sufficient numbers to actually deliver that cross-cultural awareness program. That is one aspect of training. They can take that further. If they do, then after a year in Aboriginal health, mainly in rural and remote Australia, they can apply for a graduate diploma in rural general practice. That is the qualification that we can currently add to what they are doing.

We also have the component of registrars actually doing Aboriginal health placements, mainly in AMSs. This covers both urban and rural. I am sorry to keep saying that things are mirrored with rural, but that is what we find. We find that some of the things have worked for rural, though not as well as we might like, but that it is even harder with Aboriginal health. We should perhaps be looking at having an Aboriginal health training stream like we have a rural training stream. The people who go out there are very dedicated people. They need to be facilitated into that process rather than having some barriers put up. Inevitably, because it is a bureaucratic organisation, there are some.

We also find that people who work in an AMS in a rural area will probably move into an AMS in an urban area. There is a kind of circle through AMSs and there is less division between urban, rural and remote than there is between, perhaps at the moment anyway, urban and rural general practice. The issue of having a career structure is important, and I have not seen any evidence that it is really there.

Dr Cooter—Through you, Mr Chairman, with regard to the goodwill that you mention in city practice, it is fast disappearing. It has disappeared in the country, I know, but there are very few practices, in South Australia anyway, where goodwill is paid. The young graduates will not pay it. I do not know whether that is a surprise to Melbourne. You work from Monash, don't you?

Dr Strasser—I work for the RACGP so I deal with registrars. Nationally, goodwill is still there. It is still a problem.

Dr Cooter—I think it will disappear completely.

Dr Strasser—We would try to encourage that it did. We try to encourage our registrars to say no, but it becomes quite difficult for them.

CHAIR—We have two more participants, Julie and Mary. Is there anything you would particularly like to say?

Ms Buckskin—I am on the board of management at Winnunga Nimmityjah Aboriginal Health Service and Julie Tongs is the CEO there.

CHAIR—Will you come in with your two bobs worth as we go along?

Ms Buckskin—We will.

Ms HALL—Sarah, with regard to page 22, where it talks about doctors, do you think creating a speciality for indigenous health would assist with this problem?

Dr Strasser—This is probably more of a personal viewpoint than one that is authorised.

Ms HALL—That is all we want.

Dr Strasser—The problem with general practice at the moment is that it is being split up amongst too many little subspecialties and we have lost some cohesion. I agree with Bob that general practice is the main component of primary health care and we should retain that. I would like to see this Aboriginal health stream within training for general practice and facilitating that career within a broad base of general practice.

Obviously I am a bit biased, but the RACGP, with the training program, is much further ahead than our speciality colleagues in terms of Aboriginal health training. The Committee of Presidents of Medical Colleges have recently had a meeting—the colleges have all met—and there has been a kind of show and tell about what they are all doing. That enlightens some colleges as to what they could be doing. It is something that we do in partnership with

NACCHO and in partnership we should be able to help the other colleges to come up to scratch. That would be a more appropriate way to do it than to actually develop a specialty stream on its own. That is my gut feeling.

Ms HALL—You are probably right.

CHAIR—Good question and good answer.

Mr NUGENT—Developing this theme, presumably if you can resolve the problem of attracting doctors to the country, you can apply some similar principles to nurses and whatever. Apart from special training and all of that sort of thing, and the various other inducements that Robert talked about, if one of the problems is how you move back to the city at some point in the future because of cost—and I will not get into the professional argument you are having about goodwill in practices—there is obviously a real problem in terms of housing costs.

Business has a similar sort of problem. If you want to move an executive from Adelaide to Sydney it is a real issue. Is there, therefore, some benefit in saying for argument's sake that if you serve for five years in a remote area you get a particular bounty of $50,000 or whatever figure it might be that would be there specifically after you completed? It would not be on a pro rata basis; you would do a minimum period and get a lump sum to help you get back into the mainstream community.

Dr Cooter—The other alternative to what you are suggesting is the taxation side of it—if the tax were reduced to 25 per cent instead of the 45 per cent some of them may be paying. That would give them extra money to do that.

Mr NUGENT—My suggestion is not to ease or to add. I accept that you may have to pay some extra salary to get people to go there and maybe tax reductions are the way to deliver that, but I am specifically talking about associating a resettlement lump sum, if you like, directly with completing a period of time. If you give them something that is ongoing while they are there all the time, they can milk the benefit for two or three years and then up and go.

Dr Cooter—We do have the rural incentive program. There is quite a lot of money in it which could be tapped for this purpose. Would you agree, Sarah?

Dr Strasser—Yes, I was going to add that. The other thing is that there has been a study, I think commissioned by the department of health, into the sustainability of rural general practice, and this also covered Aboriginal practices. What has been highlighted—I wish I had brought a copy with me, of course—is that what is required is a specific contract between the doctor and the community as to what service is being provided and the length of time they are expected to be there so that the community has an adequate period of time to be able to either negotiate with that doctor to stay on or to be able to advertise for someone else to come in. It does take a year or more to get someone there.

I would support what Pat was saying. The community controlled systems are the way that we would ideally like rural general practice to go. That allows some ownership of the

problem and a sense of commitment by the community to support their doctor there. We do have a number of doctors who leave because of the overwhelming demand of the community. Unless they have some ownership and a sense of commitment to that GP, it becomes too much.

CHAIR—That is a good point.

Ms Field—Picking up on the issue of recruitment and retention of doctors predominantly in rural areas, it is an issue of obvious importance that we have grappled with now for some years and, I would say, with minimal improvement. There is a little bit every now and again that people claim, but I do not know. As I said, my most recent background is in Central Australia, where remote area nurses are predominantly providing health care in remote areas. However, they are flying by the seat of their pants a lot of the time and they are really not properly trained for what they are doing. I am not advocating that that system is good enough.

However, I have given some thought to it over the years and maybe we do have to very seriously recognise that we will never get the number of doctors that we are going to need for those areas. We can maybe do a bit better than we are doing, but I doubt that we will ever fill the gap that we currently have. Therefore, we need to seriously consider upskilling and—I keep using the word 'capacity'—increasing the capacity. I know it is in here on page 23.

Every time I come to this sort of meeting the biggest focus is always on: what can we do about getting doctors out there? I reiterate that that is important, but let us have a look at how we can provide a good service by utilising other health professionals better than we do now. That is a retention issue with respect to doctors staying out in remote areas. I draw most of my experience in this from documentaries and that sort of thing. The ABC has gone out and talked to rural doctors and rural doctors say that 24 hours a day, seven days a week they are out there on their own with little or no support.

If you have upskilled some of the health staff around them, then maybe they will not be quite so isolated. That works very well in Central Australia. You get very much a team approach and there is a lot of strength in that approach. I am advocating maybe upskilling the nurses in order to complement the doctors. There may be some areas where the nurse practitioners actually take on that role.

CHAIR—That is a very valuable comment because certainly, as you say, up to this point the bulk of the load has fallen on the nurses in much of remote Australia. The whole process says not to give up hope on the doctors' side, but it looks unlikely in the foreseeable future that that will be overcome. I and the committee would be supportive of those comments as well.

Mr Wilson—I refer to the comment on nurse practitioners. The Australian government, through the department of health in Papua New Guinea, was faced with the problem in the late 1950s and early 1960s of not being able to get sufficient qualified medical practitioners to go out and man out-station hospitals. It tried to bring in doctors from overseas who were

more or less refugees who could not get registration in Australia, but even then they missed out.

A lot of the out-station care fell to a group of people known as 'European medical assistants'. They had to do a certain amount of in-service training with doctors and others in major hospitals and they went out and kept the bush hospitals open. As an example of that, at 22 I was running a 48-bed hospital in a district of 18,000 people with 12 aid posts scattered through the region staffed by indigenous health workers. It is amazing the work that we had to do.

I feel that if we cannot get the doctors we should be encouraging nurse practitioners and other paramedics to go out because they will probably be able to handle 95 per cent of the demands made. Provided they have got back-up by teleradio and transport to evacuate people in emergencies, they could probably do a great job and provide a good quality of service.

Ms HALL—I was interested to hear what Steve was saying earlier about valuing professionals and how that links in with this whole concept of the shortage of professional staff in rural areas.

CHAIR—You are quite right, Jill. Steve did indicate there was this link and that he had some comments he would like to say about it. Now might be the time to make them.

Mr Blunden—I suppose you have to make all of your staff in the medical service feel good. You want to make them feel as if they want to come to work. In saying that, I mean that you need to create an environment that is very stable. There are a lot of issues which come into that.

Basically, as for the structure of Koori organisations, for many years most Koori organisations would, under the councils and associations act, look at standing their full membership of the board of directors down after 12 months. You would either get some of them re-elected or sometimes you might get a full 12 people elected if you like—I will just choose that number.

What needs to happen there is that, to make your organisation stable, you need to basically—which is what Durri has done over the years—create an environment where, of our 12 board members, we have four of them for three years, four for two years and four for one year. As CEO of the organisation, I can say that helps me a hell of a lot because it is my job to help train the board to start with. One aspect of that is that every 12 months I will be only looking for money to train four people, so there is a saving of some dollars. The other eight board members will participate in helping to train those board members as well and hopefully the four people who stood down can get re-elected.

The staff in an organisation like to know they are secure. That is basically where it starts: with the structure of the organisation. You have to make sure it is secure. If some board members are not doing the right thing, as the registrar of Aboriginal corporations can tell you, there are avenues through which you can get them taken off. One point that I want to make clear is that we found that over the period of years after making the organisation secure the staff felt good about themselves and they felt good about coming to work. Now

some are even buying homes because they feel the organisation is stabilising. I believe that professional people are not going to hang around in your community if the organisation is not stable. That is just one aspect of it.

CHAIR—That is a very valuable comment. Thank you for it. Can I ask the departmental people to come into the discussion at this point. Mary and Andrew, are you familiar with the work of the department of health with the sustainability of GPs across the community?

Dr Strasser—It is the sustainability of general practice in a variety of places.

CHAIR—Aboriginal, remote, regional, rural and urban areas.

Dr Strasser—Yes, they picked up about eight models that could be followed and did cover Aboriginal ones as well.

CHAIR—Are you familiar with that, Mary?

Ms McDonald—I am familiar with the fact that the work happened, but it was not in my area. There is a report which goes through the sustainabilities of practice and we can certainly provide the committee with a copy of that report.

CHAIR—Would it figure in the OATSIH discussions? Where would it sit and how long ago would it be?

Ms McDonald—Certainly some of that work has been drawn on within the office. As new models of service delivery are set up, that is part of the work that a number of communities have considered—what sorts of models of service delivery they have. There is within the sector a whole range of different models, as I am sure a number of people here would be aware. One of the comments that someone made earlier was about the possibility of a career service of some type and basically having a better pool of workers there—doctors or other workers—that communities might then draw on. There are models around at the moment that are using that sort of concept and the career services they are using tend to be either state government services or the Royal Flying Doctor Service. For example, some communities, under purchaser-provider arrangements, might purchase services from a state government. Territory Health might be an employer of doctors, nurses or even Aboriginal health workers. Those are purchasing arrangements with the state government there and the personnel effectively work within the community.

Another example would be the Royal Flying Doctor Service where, say, in the Wilcannia coordinated care trial the service employs the doctor and the community then purchases those doctor's services from the service. That means the doctor has a career structure so that they can then move to other jobs. If the doctor is sick for some reason, the Flying Doctor Service is then able to put another doctor into the community for a period. It is the same with holidays. They also have a professional group of other doctors that work for the service. So there is a whole range of models around out there that are trying to increase the sustainability of the supply of qualified professional personnel for communities.

CHAIR—Do we have much on the general work being done? It comes back to Steve's point and it is something that the committee has felt for a long time with AMS in particular and in the indigenous health area: the stability of service related—I would not be so bold as to say related to 'outcomes'—to how well those services are functioning. I accept the sustainability of service will be in the study of various models, but do we have much in terms of indigenous stability of service?

Ms McDonald—Can I clarify what you mean by that. One thing that we are looking at at the moment is the stages of development of services and the capacity of services. Someone mentioned Nganampa, which is a well-developed, well-functioning service. It has a number of key personnel with particular professional expertise. Certainly services like that do have a huge capacity and are very sustainable models, but in other cases you have newly developing services that require support. Within the department we certainly look at those issues and we have support programs for those newly developing services.

CHAIR—So there are various models and there are services at different stages with perhaps different approaches to those area services.

Ms McDonald—In the longer term one of the things that we are looking at in our funding is how you do support especially those newly developing services and then, as they develop more capacity to be able to take on new activities, being able to increase their funding to then enable them to move on and do other things. So they might start off purchasing in a lot of services or even providing basic clinical services but, as the capacity of the service is increased in terms of their management capacity and also in terms of their relationship with the community, where the community want to use the service as a resource to be able to then develop programs that address some of the specific health needs in that community, being able to then look at getting some additional resources in to facilitate those sorts of things happening. That is happening through the roll-out of new funding in line with the regional planning processes. But that involves a careful look—and working with the communities in each region—at what stages they are at and what their needs are.

Dr Cooter—They have had good administration and they have had resident doctors who have stayed there for some considerable time. For instance, their peri-natal mortality has gone down to nought now because the doctors are shipping out the women to have their babies in Alice Springs and that sort of thing. With these sorts of things the presence of a doctor is terribly important to screen the population for the at-risk people and so on.

Ms McDonald—I will just add one other thing to that. There is the issue of the presence of a doctor and key personnel, but there is also the ability to draw on health expertise in a number of areas, whether it be the epidemiologists or other key people. The ability to draw on expertise for setting up management structures, financial management, health planning and all of those sorts of things is very important as well. We have a management support program, which I mentioned earlier, that is assisting a lot of communities.

The example I was going to mention was the Katherine West coordinated care trial, which set up a new service in an area that had very poor health services. It was all state government delivered and it was a fairly ambitious coordinated care trial in that way. They spent a large part of the development phase and the key part of the implementation phase

was building up the community capacity and the management capacity. They have now got to a point where they have recruited three doctors to the trial and they are starting to expand the health services within that area. But there are very long lead-ups and there is a lot of work there. Now that they have got the doctors you can see a whole lot of other things starting to move in that community. That is one of the key areas.

Ms ELLIS—You commented previously about the watch the department has got on how you develop these services and the new way of observing. You were saying that you are very keen to watch how they develop and how you can then come in and assist with more funding and so on. In that regard specifically, how flexible are you able to be when you allow that new funding to flow through? I am asking that question on the basis that some services seem to be a little bit hamstrung by inflexibility in some relationships towards funding. As a service emerges and you can see that they are doing better and coming for more, are you able to be flexible in how you give them that funding so that they can then respond to their community as they see it rather than ask for money for specific things and then be restricted in the development of their service as it evolves? Does that make sense?

Ms McDonald—Yes, it does. I suppose what we are talking about, too, is a move between two systems. We have got a historic system that used to exist, which was the submission based funding. We are now trying to move away from that to a more planned approach. But, as you are aware, it takes a long time to get the data and information on which to be able to plan, and the regional planing is the key component there.

The areas that we are looking at with this new system are only the areas where the regional planning is complete. We have just started on that work. So it is not across the board; it is really in those new areas. We are certainly working with the communities themselves, ATSIC and the state governments within those areas to help target which areas are the highest priority and which are most ready. Historically, there has been a fair bit of funding given for particular health strategies and bits and pieces. That funding, because it is targeted at particular things, as you were saying, is not very flexible.

We are looking at the new funding going towards comprehensive primary health care that is within the priorities of the community. There is a fairly broad range of things on which that funding can be spent. It can be spent on basic clinical services or it can be spent on education, health promotion and all those sorts of things. But it is limited to the broad area of comprehensive primary health care. It could not be spent on, say, developing sewerage systems or housing and that sort of thing.

Ms ELLIS—I understand. That is fine. What I am really getting at is that—I think I am correct in saying this—in the past it has been far more specific, and we need to recognise and acknowledge the primary health care bucket into which fit so many things. The emphasis might be a little bit different or quite dramatically different in one community versus another within that primary health care bucket. What I am suggesting—and you are obviously agreeing—is that the communities as they emerge and develop are allowed to use that within the category where their needs and requirements exist rather than being too restrictive.

Ms McDonald—That is right.

Ms ELLIS—And that is happening.

Ms McDonald—Yes.

Dr Strasser—I want to support what Pat and Mary have said. Particularly in Aboriginal health, it is a multidisciplinary team that provides the care; however, when the doctor goes, a lot follows. We see that in rural communities too. Picking up on some of the things Peter said about feeling secure, one of the issues for the doctors we have communicated with is their sense of isolation, particularly with other doctors working in AMSs. What has revolutionised general practice is the development of divisions and the network that has been established in local communities.

I understand that divisions were originally set up on a geographical basis. I am not sure if it was NACCHO or the doctors working in the AMSs at the time who tried to set up a kind of virtual division which at that time, because of the geographical funding basis, was knocked back. I gather that NACCHO tried to develop something further along those lines. I do not know if anyone here can expand on that at all, but certainly communication and reducing the isolation barriers are really important to the security of people in these positions. I think it would be good to be flexible in the approach that it is not a division concentrating just on the GPs or the doctors who are there but that the nurses and the Aboriginal health workers should be somehow incorporated so that team spirit is maintained.

Ms McDonald—There are some examples of divisions of general practice that are geographically based that have looked at that issue of the broader range of health professionals. I think the Central Australia Division of General Practice is picking up health workers and remote area nurses as part of its membership, as well as salaried doctors and AMSs and state connections.

CHAIR—Thank you.

Dr Sibthorpe—That proposition about an indigenous division is up to the stage where the GP branch have asked NACCHO to come back with a specific proposal, so that is out there at the moment.

Dr Strasser—This might be an area where we might be able to help them.

CHAIR—That is excellent. We are finding out these things as we go through.

Ms HALL—Mary, you were talking about your management support program. Going back to the question I asked earlier and linking into the focus of what you were saying, how do you in the department, realising that there are going to be some AMSs that do not have the same expertise, factor that in when you are evaluating the submissions so that you make sure that those that have the expertise do not get all the dollars all the time?

Ms McDonald—Is that in relation to our general funding or in relation to the management support program?

Ms HALL—Do the two come together at all?

Ms McDonald—The management support program is targeted where there are particular needs. There is not a general submission round or anything like that.

Ms HALL—How do you identify it?

Ms McDonald—We have project officers in each of our state and territory offices who work very closely with all the AMSs, and with the communities and the state governments as well, so it is really a one-to-one working with the services. There might be a financial issue or various issues within the community or with the board. There could be a particular reason why assistance is needed or the service may wish to take a more strategic approach to its work and better assess community needs and then they talk with the project officers. This is an avenue they are able to utilise. So it depends on what the particular needs are.

Ms HALL—And more generally?

Ms McDonald—In general, we are moving away from submission based funding for services. It is needs based funding. There are a number of criteria that are being used for that. The needs are identified through regional planning, and the regional planning is a look area by area across the country, dividing each large region into smaller zones and looking at what health services are there—both mainstream and indigenous specific, state and Commonwealth. It is done in conjunction with the community sector and with the services themselves. So it looks at what is there, what can be accessed and where the gaps are. It looks area by area with that.

Ms HALL—Is it through the partnerships?

Ms McDonald—It is through the partnerships, that is right. The planning is done jointly with all the partnership players, and the partnerships then work out what the priorities are for those areas. Commonwealth funding is based on need—where is the greatest need, especially in relation to shortfall of Commonwealth dollars, and where is the capacity to effectively utilise those funds. When an area has a need but there are no structures set up that would enable some services to be effectively delivered, then you might put some money into capacity building, setting up a board, or you might pay someone externally to provide services so at least people have basic services. It really depends on the actual needs within an area.

For the existing services, we have started collecting, for the first time, information about activities within the services, and the first service activity report went out last year. Through that, we have some additional funding to assist the services that are not yet covered by the regional planning so that they can start improving their capacity. The highest need services will get some additional dollars through that process.

Ms Buckskin—I just want to say something in relation to Winnunga and the capacity of our organisation. We have been going for a little over 10 years, and initially our Commonwealth funding was via the ACT government. So we really had no control over how we used that funding to meet our own priorities. We found it very difficult. We have just managed now to get direct funding from the Commonwealth, and we are hoping that that will enable us to plan more effectively and to use the money directly for our own needs.

However, that has only been happening for a short period of time, and the departmental people need to recognise that we do have strengths and an ability to plan, manage and identify our own priorities.

We have had some comments about needing to get back to our core business, but we do not need the department to tell us what our core business is. Our core business is based on the needs of our community, and we as a board of management and as an Aboriginal organisation are in the best position to place that. So, while Mary talks about flexibility of the department and changing their guidelines, often the flexibility is hampered by relationships, personalities and people. When you are talking about flexibility, I think it is important that it should be not only about the guidelines but about the ability of departmental officers in working with the organisation to allow that flexibility to happen. In theory it should be able to happen, but often it does not.

Julie and I have just come from the NACCHO AGM, and, while I am not speaking on behalf of other services, there is a big issue around departmental officers and project officers not really being flexible in letting communities determine, use priorities, et cetera, which hampers our capacity to meet the needs of our community. In relation to the points that Steve raised, we have gone through some trying times here in Canberra and it is probably fair to say that we are fairly stable. We have a number of people who have been on the board for about three years, and we have annual general meetings. Maybe we need to change our structure, but we think we are now in a position where we have some stability, and hopefully that stability will translate through the organisation and our ability to plan more effectively. So I think the points that Steve raised are very important.

We talked a lot about doctors. We arrived a bit late, but I think we should not underplay the role of Aboriginal health workers and Aboriginal people within the organisation in meeting the needs of our community. And it is not only from a cultural aspect. We have some real skills and strengths to enable us to plan programs that effectively meet the needs of our community, so we should not underplay the role of Aboriginal health workers and other Aboriginal people within the organisation.

CHAIR—Thank you. Just a quick question. What would be immensely useful would be for you just to give us an example where you found a difficulty, where the inflexibility just beat you for a while. Can you give us a practical example?

Ms Tongs—A lot of the funding that we get now is specific. For example, there is a position for a sexual health worker. Not every community needs a sexual health worker. We might need a drug and alcohol worker. We do not work in body parts, we work in holistic health, so we do not break things up. This is what is happening. Because there might be an outbreak of STD in the Northern Territory or outback New South Wales does not mean that every service needs a sexual health worker. We should have flexibility to access that funding but to decide how best to use it.

Ms Buckskin—Even if we do access the funding, and we recognise that funding is often made for specific purposes, there is also an inflexibility in how we use the funds. For sexual health, for example, we use that across the program. The doctor does some stuff and our two liaison officers will do some stuff in relation to sexual health. So we spread it across the

program. We provide programs in relation to sexual health but it is in a much broader framework. Often that is not acceptable, even though we are using the funds totally on that area.

CHAIR—Trying to be as sensitive as I can, one of the more difficult areas to deal with is to understand the cultural issues. Some of the definitions have been along the lines that some basic understanding and some empathy are a good start, but can you give us a clue, without intruding, of the cultural issues? What culturally would help the situation, do you think? Are you able to give us a clue?

Ms Buckskin—I am not quite sure whether we can really answer that, but I want to mention the importance of Aboriginal people having input and having control, for example, having Aboriginal medical services managed. If you cannot get all Aboriginal staff, at least you have a board of management that will, on behalf of the community, identify what the priorities are, set the priorities and develop programs which will be accessed by the community. Speaking from a personal point of view, often non-Aboriginal people think about cultural issues or cultural awareness training or things like that in a very narrow sense: 'Is it to do with language? If I am going to work in a particular community I want to know what some of the cultural practices are.' It is much broader than that. So it is important to work with the local Aboriginal community to find out what that community might mean in relation to cultural awareness or cultural preparedness so that you are able to provide a service that meets specifically that need.

CHAIR—Thank you. That has helped me. This is consistent with what we have been doing in recent weeks.

Mr EDWARDS—I want to touch on the question of accountability. One of the things that we pick up when we go out talking to various communities is the frustration that they often feel of having to spend too much time being accountable. When we come back here, we get a fairly high level bureaucratic view that there is a lack of accountability on the ground. I think this is an issue that we need to pick up on, because flexibility for those people who are doing the job on the ground seems to be related so much to this matter of accountability and the different views that are held about accountability at this level here as compared to out there in the scrub. Perhaps Mary might be able to comment briefly on that for us.

Ms McDonald—Can I just say one thing before I move to that question. I want to clarify for the committee that most of the OATSIH funding that goes to AMSs is actually global funding where, within that broad ambit of comprehensive primary health care, it is really the community and the service working together to decide how that funding is spent. The particular areas that Mary and Julie are talking about are where, on top of that global funding, the government has given particular funding for particular health strategies and with that has come the ability of services to access some funding for particular positions, say, sexual health. Another program that is similar to that is the hearing program where hearing workers are then available for communities. But the bulk of the funding is global, and certainly in the longer term that is the direction that things are moving.

From our point of view, when parliament appropriates money for a particular program or purpose—and this is linked to the accountability issue—in relation to how that money is spent, it is accountable to the government and we are accountable to the parliament. That is where that linkage comes in.

CHAIR—You might say that is something to do with us legislators.

Mr EDWARDS—I have had a bit to do, too, with the bureaucrats and their policies—that was the point I was trying to get at. I think it is something that we have to visit.

CHAIR—Absolutely.

Ms McDonald—The other issue was accountability. Accountability in the past has been, largely, financial accountability. Basically, budgets have been provided to the department and the money had to be spent on particular things because that is why it had been provided. In the longer term, the biggest issue is accountability: it is accountability for outcomes or outputs for what is actually being delivered. The money is not being given to be spent on particular things; it is there to provide health services to improve health outcomes. We are certainly looking at moving to a more partnership type arrangement with services, where the services themselves, working with the communities, go through a more strategic planning process. With that, we look at funding agreements that reflect the community's priorities.

There is a limited amount of funding that goes out at the moment. There are only so many things that a community can do. Fitting within those community priorities, as Julie and Mary were saying, is very important. Maybe we should be moving to a system that involves more of a strategic planning agreement between us. We should be saying that these are the community priorities, and the amount of money that the government has given us will buy only this much; if more money is available, these are the sorts of things that the community sees as a priority. So then we would have a better understanding between us, and we could look at signing off on that sort of thing, which is really about what is being done with the money and what is being achieved and fitting that in better with the community's needs.

Ms Tongs—In Nimmityjah, we have been in operation now for nearly 11 years, and we have had a doctor, Dr Sharp, who has been with us for 10 years, and he is a full-time doctor. Our dilemma is that, when our funding came as a specific purpose grant through the ACT, they locked us into having this worker and that worker and we had no flexibility. Our core budget is only $318,000, and we have got 3,500 patients that access that service. That is not very much funding when we are paying nine workers, including a full-time doctor. We have been training a doctor through the RACGP. We took on our first trainee doctor, paid for by the RACGP, in January this year. The trainee doctor comes for six months and is there for 1½ days a week. We also have a part-time female doctor, who is part of the ACT government's contribution. The ACT give us the building and a female doctor on Thursday afternoons, and that is it.

People have the perception that, because we are in the ACT, we have the regional hospital and a lot of mainstream specialist services, but it does not work. The thing is that there is no point in having all those services if people are not going to access them. You see Aboriginal people, like Mary, Peter and me, who are in well-paid jobs, but we have more

disadvantaged Aboriginal people in this community than there are Aboriginal people who work. We have got one of the fastest growing communities. It is a transient community; we have got a lot of movement in and out. There are huge problems. But all people see are the politicians, public servants and people like us.

It is not a true record of our morbidity rate because a lot of people actually live here for most of their lives and then they go home to die, or otherwise they go home and have their babies and come back. There is a lot of pressure on this community. We are a committed group of people, but the thing is that we are all going to be burnt out shortly if we do not get some support. We do not need to be looking for more money; we need to take the funding from the mainstream services, which get funded to work with Aboriginal people but do not deliver, and put it into our organisations and to build them up. Then we will work with the mainstream services and make them accountable, instead of putting a token Aboriginal person in a mainstream service.

CHAIR—Thank you very much—that was excellent.

Ms Buckskin—I will just add one more point before we go on in relation to the regional planning process. I think it is important, in relation to Canberra, that the regional planning process is really a part of the framework agreements. It is an extension of that process. It is important to recognise that, here in the ACT, there is only one AMS, but we are not a formal signatory to that framework agreement. Although we go to the forums and we are invited to participate—and we do participate actively—we would like more formal recognition of the role that we play in that regional planning process. We have an issue with the regional planning process that has taken place here in the ACT. There are partnerships and there are partnerships. We had very little input into the regional planning framework process and its signing off. We need to be able to say, 'Yes, that does meet the needs of our community.' In fact, we are really a de facto partner in relation to the framework agreement here in the ACT, and I think that needs to change.

CHAIR—Thank you.

Ms ELLIS—I want to ask Julie and Mary to give us an example—not just because it is in Canberra; I think it is a national example that you can use here—in relation to the global funding question and to the question of funding on top of that for a specific purpose. You have had a lot of publicity in the last few weeks about the drug and alcohol problem within your community. It is not exclusive because the drug and alcohol problem is huge in every community: indigenous and non-indigenous. The disadvantages in your community that lead to that are probably different to some extent, or there are some other extenuating circumstances. Can you just give us an outline of your community that, according to the statistics, is now having severe social problems with drugs and alcohol? What do you believe that, as a service, you require? How do you require it to begin to approach that problem, given the funding? It is the funding regime—the global funding and the bits on top—that I am talking about in relation to this. How do you think funding can begin to assist you in solving that specific problem here?

Ms HALL—Steve might like to comment on that path as well as Mary because we have two services here. It would be interesting to link the two together.

CHAIR—That is a good idea.

Ms Buckskin—I would like to make a comment in relation to regional planning. Even though we are not happy with some of that—and we are working towards changing that—it is not like we are sitting back and doing nothing. Julie mentioned that we have only a small budget to provide a service to a community that is in great need. But, having said that, in our relationship with ACT Health, we do actively try to work with the mainstream services that are provided by the ACT government, such as working with the hospital liaison officers, the mental health branch and a whole range of other services. We do not believe we can do it ourselves, nor should we because ACT Health has a responsibility to provide a service. We would just like to make sure that it provides a service that is suitable and appropriate for our community.

Part of the reason why Julie has been actively agitating and bringing the drug problem issue here on behalf of some community members is because, after trying to work with the drug and alcohol service here, we are not getting anywhere. We do not want to take it over, but it is just that it is not providing any kind of basic service that will meet any of the needs of our community.

We want to work with mainstream services because we think that they should provide a service to our community, but where there is a need they are not meeting, and where they are not willing to work with us to try to meet that need, then we will try to get something that might meet the need.

CHAIR—That is very important—this is the nub of a lot of our issues. When you say they will not work and cannot work, what are the practicalities of that; what does it actually mean? Do you approach each other and then it does not happen, or are you excluded—what is the problem?

Ms Buckskin—A lot of it is attitudinal, and we have been trying to work through that, but there are some specific issues to do with their inflexibility in providing it. They are not even willing to sit down and think about it. For our community, a lot of it is opportunistic. For example, if you get a client who comes in and wants to do something then and there, you try and do everything you can to meet their needs, particularly in relation to drug and alcohol issues. But they seem to be totally unwilling to even look at the guidelines they may have in relation to overall management treatment of patients; they just seem to be unwilling to change.

CHAIR—Thank you. That is a very valuable comment.

Ms Tongs—We had an incident about eight weeks ago where I tried to get two brothers, a 16-year-old and a 22-year-old, both heroin addicts, into detox at Canberra Hospital. They would not accept them because they were brothers. They have a policy where you do not have family members, siblings or partners, together. But the family connection is the backbone of our community; and those two boys would support each other to get through that. Otherwise, when we ring they say, ‘No, there are no beds available. Ring back at 8.30 in the morning.’ Well, they could be dead by 8.30 in the morning.

Like Mary said, we do not particularly want to be separate, and we want to make mainstream services accountable. Maybe one of the options, instead of us setting up our own detox service, is that there could be dedicated beds in the detox unit and also Aboriginal workers so that there is a two-way learning—we learn from them. That is how we work with ACT Mental Health, and I must admit we have a very good relationship with them.

CHAIR—That is a good news story; that is excellent.

Ms Tongs—Yes. We have a very good relationship with ACT Mental Health and we trained one of our workers there and sent him off to the Goulburn program that is specifically for Aboriginal and Torres Strait Islander mental health workers. ACT Mental Health paid the HECS and accommodation fees and we paid the traineeship fee. We were the support—the worker worked in Winnunga—and ACT Mental Health gave that worker the clinical support, so it was a two-way process. That is even the case with the RACGP—we have a very good working relationship with the doctor educator, Graeme Thomson. He has a private practice as well and he got the tender to deliver a service to detainees at Belconnen Remand Centre. He buys in the services of our doctor.

CHAIR—Yes.

Ms Tongs—So we are trying to do good things, but we need more resources to be able to do it.

Ms ELLIS—It is an example of how, when partnerships are done properly, they can work properly.

Ms Tongs—That is right.

Ms ELLIS—That is the point you are making. The drug and alcohol one is an example of when they do not work, how dramatically bad they can be.

Ms Tongs—That is right.

CHAIR—That is excellent. I know we need a break, but we need to hear from Steve and Pat to finish off.

Mr Blunden—The drug and alcohol area is devastating for our people. I would like to see somebody come along and say, 'Here are a couple of workers—a male and a female—as a minimum for each AMS.' I am sure we would do a hell of a lot of good with that. Up home in Kempsey I recently had a meeting with Benelong's Haven, the drug and alcohol rehab centre. I said to them, 'The biggest problem we have is that there is no after-care program. You fellas treat people in here and they just find their own way back home. What we need is for you to do some sort of referral back to the AMS. If the patient so wishes, AMS can then provide support to that patient and to the family as a unit to help them come back into the community.' That is one approach. They felt good about that, so we are looking at moving in that direction.

The second point I made to them was that we need to 'infiltrate' the primary schools. One of the health workers would show a video to the children on the ill-effects of substance abuse, and Steve Blunden, who is recovering from alcohol, would come back from Benelong's and give a personal testimony to the classroom. He would basically say, 'I have done this to my mother, my father, my brother and my sister, I have really destroyed my life, but I am recovering now, I am coming back and I would not like to see you little kids go that way,' and really lay that on the line to the children. Ultimately, it will make them become fence-sitters, and they will go back to their home environment, but if we can save a few of our kids I think it is worth while doing. The third point in that program would be the practice of AA, with those individuals supporting themselves in and around the community.

Basically, I believe that OATSIHS and the federal government should provide funding back in the communities. I know we get a global budget, but when you look at historical operations of organisations the money is already tied up. I think you need to treat drug and alcohol as a separate stream; it is just as important as HIV-AIDS or any other outstanding issue. I will give you an example to do with methadone. We have had three young blokes up in Kempsey who have been refused their normal dose by the local chemist. I tried to organise for them to go by community transport across to Port Macquarie. Macleay-Hastings Community Transport, that just received an extra $30,000 from Health to run community transport, basically made it quite clear to the boys that they were not welcome to use that service. The point is that there is no access there for these people. Basically, our people are still losing out. I want to touch on transport later on as an issue, because there are a few things I need to say on that to this committee.

CHAIR—Thank you. Some good and some bad—still some barriers and some better stories.

Mr Blunden—It is like a marriage—you have your good days and your bad days, your ups and downs. I think you have to work at partnerships. Like Sister said, there are partnerships and there are partnerships, depending on the personalities and whether they wake up on the wrong side of the bed every day. Having said that, I have brought down to table and give to your committee a partnership which we are about to launch on the mid North Coast of New South Wales, the Birpai Aboriginal Medical Service. The mid North Coast area health service in Durri is going to launch that on 22 December. We cover all aspects of health—even men's business, Sister. It is the first with the men's business. I think our men were left behind. The women are leading the way in everything.

Mr EDWARDS—You're no Robinson Crusoes!

Mr Blunden—On domestic violence issues, we have to try to sort out the men too. We are looking at working at that to reduce those types of problems.

With regard to the drug and alcohol issue, those points need to be taken in because we talk about a holistic approach to health in the National Aboriginal Health Strategy but how often is it practised on the ground in terms of working in with, say, a substance abuse organisation like Benelong's? Groups like Benelong's and other havens and the service in Moree are Koori people and they are operating their programs, but for many years they felt as though they were alone. On the North Coast we have set up an Aboriginal Health Forum

where we have brought in the substance abuse organisations and the Booroongen Djugun aged hostel in Kempsey as well. Newcastle, Taree, Kempsey, Grafton, Casino, Armadale and Moree AMSs are working together as a forum. We give our brothers and sisters copies of our plans and, hopefully, they can implement the same thing in their communities to suit their environment. I have been looking at your report here, which I only read for the first time at 3 o'clock this morning. I have not been to sleep yet.

CHAIR—Thank you. We will come back to the transport issue later.

Ms Field—I will try to be brief but my head is running around now with all this. I think that what Mary, Julie and Steve have brought in here has been extremely valuable. There are a couple of things I wanted to pick up on. One is the necessity for health business in Aboriginal health to be very broad. There is plenty of evidence around that health is not just about clinical services, and I think we have tended to be pretty focused on clinical services here this morning. There is so much evidence around that the underpinning socioeconomic determinants of health are much more than just viruses and bacterial conditions, or whatever. It is important to remember that when it comes to funding of health services and when it comes to health practitioners. The 'fly in, fly out' model is sometimes absolutely necessary because you cannot do anything else, but you really have to try to have health practitioners who are part of the community and who are on the ground. Otherwise they are never going to get beyond that curative model and we have to get beyond that.

Steve mentioned the National Aboriginal Health Strategy. It is full of intersectoral collaboration. It is full of linking up with education, with food supply, with stores, with environmental health, and it goes on. But I do not see a lot of evidence of a huge amount of progress in that. Using the word 'evidence' actually makes me think. I wrote down 'evidence based' here. There is a danger in evidence based because if we are always looking for improvement in morbidity statistics, the intersectoral, the broader social determinants stuff, is a long time away from sometimes showing improvement in morbidity. So if we get too stuck on evidence based, we can lose a lot in there.

Finally, there are cultural issues and the access to mainstream services. I have bumbled through, as a health professional working in Aboriginal communities, and I have made a huge number of mistakes. I found, in working with Aboriginal people, that they are extraordinarily forgiving as long as you treat them with the respect that you would expect yourself to be treated with. That is the first golden rule and that is the first rule that I see consistently broken in mainstream health services.

One of our areas that we really have to look at—and I feel so strongly about this—is the first line receptionist administration staff. They can be incredibly arrogant. The health professionals are usually streets ahead on the whole, but that first line is incredibly difficult for Aboriginal people—and I can tell some horror stories, which I will not, about the way people have been treated. There is an enormous amount of work to be done there. Cultural training is important but it is just basic respect of other human beings that we are talking about.

Dr Cooter—I have one comment, if I may.

CHAIR—I am mindful that people probably want a stretch so let us wait until we come back.

Proceedings suspended from 11.08 a.m. to 11.22 a.m.

CHAIR—Ladies and gentlemen, let us begin. I know some people want to ask some questions and focus on certain issues and I am sure they will come up in the next hour and a half. What I would like to do now is to bring ATSIC into the equation, particularly in terms of the infrastructure issues which we all accept are very much part of the issue.

Dr Cooter—They are highlighting certain health problems of Aboriginals but, really, we have got to look at it holistically. We have got to have a cohesive, constant health team out there with doctors, nurses and Aboriginal health workers and an administrator who, I think, should be an Aboriginal person to look at the problems in that particular community. You need a health team to look at the problems and give priorities accordingly. Diseases like diabetes, and cardiovascular diseases, are probably more prevalent than some of the other conditions that were mentioned earlier and I think we have got to develop that idea of a cohesive health team.

CHAIR—Thank you very much. To our friends from ATSIC, you will bring your comments in where you think appropriate, but clearly we are concerned with the holistic nature, the amount of cash that might be required for the long-term nature of all of these things, what has been since NAHS, and those sort of things. Perhaps you could give us a bit of an opening burst and then we will pick it up from there.

Mr McCarthy—ATSIC does want to emphasise the holistic approach to indigenous health. We think that the National Aboriginal Health Strategy does outline some of the key elements and linkages. At the moment the National Aboriginal Health Strategy is being renegotiated so it may have a life of another ten years or so. An important aim is equity in health outcomes between indigenous and other Australians. When you look at one of the indicators such as life expectancy, the gap is roughly 20 years or so, and you ask the question: what are the impediments to that equity?

Yes, a lot of the answers are in the primary health area, but we think they are more so in areas like public and environmental health—the preconditions for health. We think a lot of the gains towards reducing that inequity are to be found in those areas, such as improvements in environmental health, infrastructure, water, power and sanitation and reducing overcrowding. We think nutrition is an extremely important area that tends to fall between the cracks. No-one is really looking at it. It is very hard to find someone who takes responsibility for nutrition. Then there are other things like lifestyle or general public health areas.

In terms of primary health, coordination is very important and I know that is the focus of the committee. That is where ATSIC is very interested. It is a participant through the memorandum of understanding with the department of health at state and regional levels. The services have to be relevant to the indigenous people in the region. We support the important links, such as drug and alcohol matters, mental health and looking after teenagers in terms of their recreation. There have been very important gains through addressing issues

such as recreation, healthy lifestyles and that sort of thing. We think the span of that focus needs to be broad enough to look at those issues.

As for responsibility, ATSIC is more responsible for environmental health. We think that the committee has picked up the issues very well in the document here. However, there are two main things. Again the issue is coordination within the Commonwealth and between the Commonwealth and state and territory governments responsible for elements of environmental health. We have some very good program delivery vehicles, what we call the National Aboriginal Health Strategy scheme or the health infrastructure priority projects. They work on the basis of bringing in all the parties to achieve a coordinated, holistic response to developing all the preconditions for health in terms of water, power, housing and so on.

The main challenge—even with effective program delivery—is that there simply are not enough funds. We have almost completed a community housing and infrastructure needs survey. The results will be available in March. They will be published by the Australian Bureau of Statistics. I have just tabled an analysis of the 1996 census on housing. Already that information indicates that we are looking at a backlog of capital—that is, housing, sewerage systems and so on that do not exist—of roughly $4 billion. That is one of the things we are working on. On top of that, there is a high rate of family formation and demand for new houses and so on. At the current rate of funding from the ATSIC capital programs, the Aboriginal rental housing program and various state programs, it will take up to 30 years to reduce that capital backlog.

At the same time, there is another very important shortage of funds for the sustainability of any infrastructure or public health system that is installed. We are facing the same sorts of issues there that we are looking at here in terms of the capacity of the sector. The right amount of funds is needed in order to employ people to be environmental health workers to make sure the water flows and it is of good quality, and that houses are maintained. There has to be some sort of employment stability so that people are willing to be trained and there is some sort of career service in that area. We fully agree with Professor Deeble's comments.

More and more information is becoming available and there is a report that the committee might wish to look at that pinpoints the gap in this area. It is a report commissioned for the Commonwealth-state working group on indigenous housing. It is a report that will go to the housing ministers. The authors are Spiller and Gibbons and it identifies the type of shortage. Effectively, in public housing, for example, there is a subsidy of $1,200 or $1,300 per household. That subsidy is not there for indigenous community housing. So, particularly when you consider remote factors, you are looking at a client group which has even more need than public housing clients, and yet less capacity in the sector to be able to deliver effective services, maintain houses and so on.

I mentioned nutrition as another precondition that we would like to see more emphasis on in the context of developing this new National Aboriginal Health Strategy. Then there are a couple of specifics that have not been picked up here as well and one of them has a lot of implications. There are things like hearing loss, which affects education and skill development. There is a whole range of those sorts of implications and I just pick one significant problem area which does not seem to be getting enough attention. I might leave it

at that, and ask my colleague to mention anything else I have not added. Then we are open for questions.

Mr Baxendell—In relation to the National Aboriginal Health Strategy, when we worked through that and advised the Department of Health—and that was written in 1989—we saw that it set ambitious goals over a 10-year period and none of those goals have actually been achieved. In fact, in some ways things have got worse. The revision of the National Aboriginal Health Strategy is obviously a very important point and we need to make that a priority. I refer to of some of the things that were said here this morning when commending the discussion paper. No discussion paper can cover everything in Aboriginal health. One of the omissions was hearing loss, but again I am not being critical.

The paper itself points out that 72.6 per cent of indigenous people live in urban areas—that is, they live in areas where there is no lack of access to a doctor. We were told this morning that there are 300 would-be doctors who cannot practise because the government maintains—and probably rightly—that we have enough. Yet Aboriginal people are still dying 20 years earlier. There has to be a reason for that.

I think the reasons are really fairly self-evident. We know why they are dying. They are dying of lifestyle diseases; they are dying from injury and self harm; they are dying from motor vehicle accidents; they are dying as a result of family violence. We know all of that. I suppose we know the reason why those things have to be fixed up. They have to be fixed up by empowering the community and getting the community involved. As Professor Deeble's work pointed out in terms of allocation of expenditure, in some ways the life expectancy and health problems of indigenous people are not all that greatly different from other very marginalised disadvantaged and poor groups in the community.

In a sense, we know what the problems are and what the answers are. We simply need to roll up our sleeves and get into it. I think that you need to look at why public health messages do not get through to indigenous people. They are probably not terribly much different from the reasons they do not get through to non-indigenous poor and disempowered people. We need to look at the links between health care and the broader environment—nutrition, housing, health and so on. We need to broaden it to things like unemployment and lack of education. All of those things are interlinked.

I do not think you can go through and do another National Aboriginal Health Strategy, set the same goals that you are going to bring Aboriginal health up to the standard of the general community, and in another 10 years simply say, 'Sorry, we got absolutely nowhere, we completely failed.' I just do not think that is going to be acceptable.

The taxpayers would rightly demand that there has to be some improvement in health. If health programs are put on the right track, and we do not get too diverted on side issues, the answer is to consider Aboriginal health as a whole, and look at the real reasons and address them in a holistic fashion and a cooperative way across all agencies. There is no secret. It just needs to be done.

CHAIR—Thank you very much, Noel.

Ms ELLIS—Chris McCarthy, I notice you are the Assistant General Manager of Housing and Infrastructure. I want to speak specifically about those. Can you explain to us how ATSIC go about coordinating—assuming you have that role—the development and process of infrastructure? The example I will give is a housing project somewhere. I refer to the fact that NACCHO tell us that in 1996 90 per cent of Australia's two- and three-bedroom households accommodating 12 people or more were Aboriginal and Torres Strait Islander households from only two per cent of the population.

You have said $4 billion or more is required. We understand all of that. If you go into a community and decide that you are going to have some house building programs through ATSIC, how do you coordinate the whole of that such as the sewerage, road, plumbing, garbage tip installation and housing building? Do you do all of that? Who does what?

Mr McCarthy—May I answer in two parts?

Ms ELLIS—As many as you wish.

Mr McCarthy—First of all, ATSIC is involved with part of its funding with the states where the ATSIC funding, the Commonwealth Aboriginal rental housing program funds and any state funds are pooled at the state level under a bilateral agreement and administered by an indigenous board. For example, in New South Wales we have an Aboriginal Housing Office. Before the agreement there may have been three separate approaches to providing community housing in the state but there is now one approach. It is the same in the Northern Territory and Western Australia and just recently in South Australia. Agreements are being negotiated at the moment with Queensland and Victoria.

So that process looks at the question of housing. The appropriateness of policies on housing are determined by that board, in association with local level committees and so on. There are fresh national standards on housing that were launched by Minister Newman about two months ago. Over the next couple of years we expect those to be picked up by each state and applied as minimum standards.

The other part of the approach is that ATSIC has its own program which it operates on a national basis. In the last four years we have spent $380 million in this program. There is another triennium starting next July wherein we will spend $200 million. We call that the NAHS, the National Aboriginal Health Strategy. That focuses on looking at communities in need, the greatest priority need in terms of health related outcomes.

There is a process of direct investigation called health impact assessments—I have tabled that for the committee this morning—which looks at all that needs to be done to improve health. In priority order, starting with water, it focuses on access to potable water, sanitation, overcrowding, power, internal roads—not external roads—and rubbish removal. All those factors are addressed by the program.

The work is assessed by the community and engineers together, prioritised and sort of scored to get a picture of national priority in order of priority. Then we attempt to address those priorities until the money runs out. They tend to be large-scale projects, about $3 million for a whole community. Typically, they might involve something like a sewerage

scheme, internal roads, a new power system or water, but they also address critical aspects of overcrowding.

The program will not answer all the housing problems in a community. It will try to work with the state housing authority or to get some other access to housing funds. In terms of coordination, it works through an ATSIC appointed program manager who in turn appoints a project manager for that specific project. All the relevant shire and state bodies are brought in.

Ms ELLIS—Who checks the building standards, the electricity standards, the water standards, the plumbing standards and the environmental standards? Where is that done? I am asking that question—it is a loaded one; I will admit that—because we have been to communities where there are relatively new houses, half of which have not been connected to filtered water, or where a group of new houses has been built with the garbage tip uphill from them. There are numerous other examples that have been given to us where the building standards that are basic to all of Australia have not been met, where the plumbing standards have not been met or where the delivery of clean water has not been met.

The frustration for us, if I can be blunt, is to try to understand where the responsibility lies. I cannot do that sort of thing to my house. Who allows people to be paid enormous sums of money because of the remoteness? I am wiling to admit that because of the remoteness the sums have to be enormous, but I wonder to what degree some money making is going on—not by ATSIC but by somebody in the process—in paying these enormous sums for inferior buildings and for the installation of inferior services. Where does the responsibility lie in measuring those standards? Is it with the shire or is it with ATSIC in that they have not checked that the shire has checked? It is very frustrating. What is your answer to that, seeing that you are putting up the coordination?

Mr McCarthy—I would need specific instances.

Ms ELLIS—We could give them to you if you require them. I am not making it up.

Mr McCarthy—Not at all.

Ms ELLIS—It is a fair question, I think.

Mr McCarthy—Frankly, the reason ATSIC went with this process of getting outsourced program managers and this holistic scheme is that the Dodgy Brothers were alive and well.

Ms ELLIS—And I think they still are.

Mr McCarthy—We have found that we have had to develop the standards themselves, because the various state jurisdictions typically do not cover remote areas in terms of housing standards or other standards. In the Northern Territory, for example, the plans for a sewerage system are developed by the project manager, they are subject to scrutiny by the program manager and then they have to go through a process where the Territory power and water authority approve the plans. The reason for that is that in the Territory we have an arrangement that if we build the sewerage scheme, the Territory will accept responsibility for

maintaining it. So those plans for power, water and sewerage, for example, in the Northern Territory get approved by the power and water authority. Where possible through these NAHS projects that formal drawing in of responsibility of the shire or of the relevant department is done, but there definitely are gaps. There is no comprehensive national coverage.

Ms ELLIS—Can I just interrupt you for a second. Forgive me, Barry, for going on a bit, but I know it is the bane of the committee.

CHAIR—It is very important. There are already two people who are interested in the same subject.

Ms ELLIS—The point is not just the approval of the plans. It is very easy to approve plans; it is not seemingly as easy to approve the installation from the plans. I am not necessarily blaming ATSIC. I am saying that at some point somebody has to be responsible and show an attitude of care. Somewhere in the process I very strongly suspect that it is easier in a remote community not to care and to say, 'It will do,' rather than to have proper standards that are acceptable Australian standards. I am not having a go at ATSIC. I do not know who I am having a go at, because we do not know where it is happening. We can suspect.

Mr McCarthy—I do not think you are having a go at ATSIC.

Ms ELLIS—It is just so frustrating.

Mr McCarthy—This is the very reason why we have this program. The only thing is that this program does not cover enough of the Territory. Usually these responsibilities you are talking about are primarily state and Territory responsibilities.

Ms ELLIS—I know.

Mr McCarthy—Because of the absence of the sort of coverage you are talking about, the absence of the standards and the inspection, in the design of our program we have the program manager performing that function. The program manager has to visit the site and approve the installation of things at various stages, roughly eight times on each project. If you look at the distances—flying in, flying out and so on—that is substantial. We have had to invest a lot. Basically, the program manager is it, in the absence of the coverage of the various other jurisdictions.

Dr Cooter—Are you talking about the program manager in a community?

CHAIR—We have a lot of people very interested in this, and I want to be fair to Peter Nugent and to Graham Edwards. Graham has a separate subject. Kay and Steve want to speak on the same subject.

Mrs ELSON—We went to Dareton to have a look at a housing project there, and I was quite impressed with the houses they had built. I must say that this particular site had no water or electricity, but that was because of a disagreement between the land council and the

council. But it shocked me when the young girl who showed us through pointed to one of the corrugated iron dwellings, of which there were many, and asked, 'Can you do something about my mother?' I asked what the problem was and she said, 'She lives in that tin shack over there and she pays $90 a week to the land council to live there. She is a pensioner and she pays a $50 rental subsidy plus another $40.' I was quite shocked that the land council took that much money from her for a site that had no facilities on it. I know you are not the land council, but I want to ask you whether the land council pays over to your housing projects part of that money that they are collecting from the people who are living in those facilities. Where does that money go? Maybe you can help me there.

Mr McCarthy—No, but theoretically, if that land council is getting some sort of grant funding from ATSIC or what is now the New South Wales Aboriginal Housing Office, whatever rent is collected is meant to go into maintenance and provision of services.

Mrs ELSON—Those two things were not happening. Is there someone accountable for that money? There were lots of corrugated dwellings on that particular site. Is there anyone that makes them responsible for the money they are collecting and sees that they are actually providing the services?

Mr McCarthy—Yes. The organisation is meant to be responsible.

Mrs ELSON—I know that you are not the land council, but I am trying to determine whether the land council then puts that money back into housing projects. You would know that because you are the ones responsible.

Mr NUGENT—It depends on the land council. They have sources of income, of which that will be one, and they will have requirements for expenditure. They will try to balance the two at their own discretion.

Mr McCarthy—There are some organisations that are very well run. You have identified two parts of a general problem that I mentioned. One is that there is a lack of capital—there is just not enough money to replace tin shacks at the moment. So for the next 30 years, people will still be living in those conditions.

Mrs ELSON—But if you are paying $90 a week, surely that is a pool of money that could go into providing better housing?

Mr McCarthy—I agree. It does not sound fair to me.

Mrs ELSON—What I am trying to say is that we need better coordination of the money collected and the money spent.

Mr McCarthy—Yes, that is right. That is the other side that you mentioned—the whole sector needs its capacity developed.

Mr Blunden—Going back to council inspections, it is land council owned land and it is for special purpose use. Shire councils are not required to deliver those services. The builder—I am not sure about the project manager—does not have to forfeit that $5,000 or

$10,000, whatever it is, for each house to pay the council fees, and they are saving a few dollars that way. It needs to be brought right out. The homes need to be inspected in stages—stages 1, 2, 3 and 4—with proper progress payments made on work performed properly, because it is not acceptable the way it is.

Our people are living in supposedly new homes which the taxpayers out there see. They basically want our people to be accountable, but when you are living in third-rate buildings it gives a false picture. Something needs to be done about it. I am from Many Rivers Regional Council, and we are going to do something about that up there. I am talking to you as a councillor as well as a delegate here today.

Ms HALL—That is getting to the issue of the role of local government in the approval process, and how the builders and contractors slot into that. There seems to be a big problem there. We found that it varied between local government areas, didn't we?

CHAIR—Yes.

Ms ELLIS—Did we ever!

Mr NUGENT—I have an awful sense of deja vu. When I became the coalition spokesman on Aboriginal affairs six or seven years ago, I did a lot of travelling and I had a look at these things. It was patently obvious to me and to everybody I spoke to at that time that the National Aboriginal Health Strategy was never going to bloody well work. Sorry, but I am not frustrated and impatient like Annette; I am angry. I am just appalled that ATSIC in particular are not trying to do more about it. I am not having a go at you as individuals, but I am certainly having a go at ATSIC who have known that that strategy would not work for a long time. You are right; we have known what needs to be done for a long time, but we do not seem to have damn well done it. We have had plans and conferences and all those sorts of things, but there has been very little hard action on the ground.

I think it was in about 1991 that the old Industry Commission did an inquiry into the backlog of Aboriginal housing and, at that stage, they priced it at $2 billion. So the progress we have made in eight or nine years is to go backwards by a further $2 billion. From what you are telling me, with all the reviews, the managers and the bureaucratic structures that ATSIC has in place, it has become just as bad as every other part of the bureaucracy in that sense. ATSIC was set up to try to coordinate a lot of this and to cut through a lot of this bureaucracy, but it seems to have learnt how to be bureaucratic just as much as everybody else. That is not a personal comment; it is a structural comment.

It seems to me that you are telling this committee that ATSIC has no solution to this particular problem other than to say that they are dramatically underfunded for capital—which I think we accept—but that there is no other way of dealing with this problem in a realistic period of time. Through all that talk and all your committees and all your plans would that be a correct interpretation of what you have said, yes or no? If I am wrong, say no?

Mr McCarthy—No.

Mr NUGENT—Right. Now explain why I am wrong?

Mr McCarthy—First of all, I think some of your points about ATSIC are misplaced.

Mr NUGENT—That is all right. I had a go at you; you are welcome to tell me where I am wrong.

Mr McCarthy—First of all, the National Aboriginal Health Strategy had a number of elements to it—primary health, family violence, drugs, alcohol and a whole range of social things—and it had an environmental health element. For a while, ATSIC was responsible for the primary health and the environmental health side. ATSIC had about six people and $30 million to look at the whole question of primary health. It did not get much support from the mainstream department at the Commonwealth level nor the cooperation that was required from state level. Now that the responsibility has been taken over by the Commonwealth department, there are many more people involved, the budget is up now to about $120 million or so, and things are starting to improve in the primary health side.

On the environmental health side, ATSIC has targeted the funds that it does have in the most effective way. There is no argument that it has not targeted correctly. There have been evaluations and audit reports saying that the program delivery is innovative and cannot be much improved. ATSIC is not wholly responsible. In fact, ATSIC is a supplementary provider. Basically, you are talking about a failure of the mainstream Commonwealth and state departments to deliver services for however many generations.

Mr NUGENT—The bottom line of what I am asking is this: if we carry on as we are, are we going to fix the problem? What I hear you saying is that we are not going to fix the problem. We have a backlog on housing, which is not going to be fixed for 30 years, and in 10 years of the National Aboriginal Health Strategy we have not hit the objectives. It is almost as simple as that, it seems to me.

Let me say one other thing that may not be publicly known. One of the objectives that this committee set itself quite early on in this parliament, when it was continuing its inquiry, was to say that inquiry after inquiry has come up with a list of problems, which are well-known to everybody around the world, and that we want to come up with some recommendations that will actually fix some of the problems when all the previous inquiries really have not done very much. Therefore, the point of my question is: what is it that this committee needs to recommend that is going to make a difference this time, as opposed to accepting the status quo, continuing with what we have been doing in the past and, effectively, not fixing the damn problem? I may be simplistic, but I travel around the country—the committee has travelled around the country—and we have seen with our own eyes where, certainly, there are improvements in some areas, but in far too many areas the problem is not being fixed by whatever yardstick you care to use. That was a statement, as much as a question.

Mr Baxendell—When I came in this morning I noticed that my old colleague Bill Wilson was here. He worked here and he will remember that primary health care, as opposed to environmental health care, went from—correct me if I am wrong, Bill—the Department of Aboriginal Affairs across to the Department of Health and back to the Department of

Aboriginal Affairs and again back to the Department of Health. I think what you can say, in a sense, is that if you are looking for a solution that says: blame this bureaucracy or restructure this bureaucracy or do something like that, you are not going to get an answer, because the answer is—

Mr NUGENT—I do not want to blame anybody. I want to find out what we need to do to fix the problem.

Mr Baxendell—Let us look at a couple of things that they have done, which I think are steps in the right direction. First of all, they have put in a private enterprise contracted program manager. There are a couple for the whole of Australia. For the Northern Territory, for example, there is Ove Arup. They are the people who worked—you probably know all this anyway—on the Opera House and they are going to try to set standards. Secondly—Chris mentioned this, but I might be able to explain it more simply—Minister Newman has set up standards for housing which we are now going to enforce. They are building standards like councils have and we are going to try to stick to those. Of course, all of those things will be only part of the solution because the real solution, as Chris has mentioned, is more money.

The final point I would make is that politicians and ATSIC are not very popular in the general community. It is all very well to pick on people who are unpopular but, as members of parliament, you would know that popular prejudices are not necessarily facts. I think ATSIC, with a small staff and a small budget, does its best to complement the work that state and Territory governments should be doing and must be doing because the problem would be too big for ATSIC.

Mr NUGENT—The question I am asking ATSIC is: what do we need to do to extend Aboriginal life expectancy by another 15 years in the relatively foreseeable future?

Mr Baxendell—Empower Aboriginal people and give them more money.

Mr NUGENT—We have not done that in the last 10 or 20 years. What we have been doing has not worked. I am trying to find from ATSIC what plan is on the table to fix the problem. All I am hearing, with the greatest of respect, is more of the same and a bit of refinement of the same.

CHAIR—We have gone about as far as we can go on that at the moment.

Mr Wilson—You have asked a fairly straight question: what are we doing wrong and what should be done? What are we doing wrong? For years we have been giving immunisations, we have been providing clinical care, we have been putting zambuck on when zambuck is required. Ninety per cent of our effort has been in clinical care. But if you analyse the causes of morbidity and mortality in the Aboriginal population, what will you find? You find problems resulting from unfortunate health attitudes and behaviour. We have never really struck heavily in trying to help people adjust their health attitudes and behaviour to develop a more healthy form of living. Last I heard, something like four per cent of our health budget was going on health promotion. That may be great for the clinical workers but it is not great for the population.

When you look at the Aboriginal health problems, you find a rate of tobacco use which is almost double that of the general community. I am not going to give you statistics for alcohol use because I do not believe the ones that are available. But I know that in some communities health care committees have found that 80 per cent of available income was going on alcohol. In other communities 80 per cent of available income has been going on kava, and they still have got to buy their smokes on top of that.

Historically we know why Aboriginal people are disadvantaged and we know why they have developed certain attitudes towards life. But if we want to make any real improvement in Aboriginal health, we have to devote a much greater part of our health budget towards programs which are going to help people adjust their attitudes and behaviour. The only way we can do that is by getting Aboriginals trained as educators or agents of change or community development workers to work at the community level. After 23 years of work with Aboriginal communities I have some great friends, but I would not say any of them would take my advice on anything, mainly because I am a whitey. You have to get your own people trained as educators and get them working out in the field, as health extension officers or Aboriginal health workers—whatever you want to call them. You have to work on this attitude and behaviour change, otherwise we are going to be here for another 20 years wondering what has gone wrong.

Mr Buckskin—I might add to Mr Nugent's comments about what needs to be done. At the risk of being criticised by my own secretary, the issue here is a real lack of cross-sectoral partnerships across the board at state and Commonwealth level. The National Aboriginal and Torres Strait Islander Health Strategy has failed because people are still working in chimney stacks. It is a health issue, an education issue, an employment issue. If the Commonwealth can show anything, it is leadership in terms of cross-sectoral support.

Ms ELLIS—Absolutely.

Mr Buckskin—It is really empowering the Aboriginal affairs minister or the cabinet to have some power to coordinate amongst themselves better cross-sectoral interest. It is not about getting more money to Aboriginal education centres. It is about using what is in the current outlays of departments' budgets much more effectively. The deputy secretaries of Health, Family and Community Services and my department—and I think we have invited ATSIC to be a part of that as well—are to do a project in the Pitjantjatjara Lands.

For the first time since I have been on the Commonwealth scene—over seven years—I have seen a group of deputy secretaries having a look at cross-sectoral issues. Instead of looking at what you can do in health, education and employment, we should have a look at the money that we all pour collectively into that and be more flexible about its use. That means not saying, 'That's not my responsibility—that's Hearing Australia's responsibility,' or, 'That's the state government's responsibility,' but actually looking at the bucket of money and being more creative and flexible about what we do. If anything, this report should really push the emphasis of cross-sectoral work so you just don't just have a National Aboriginal Health Strategy talking about soft things, such as coordination, but one that is actually empowering people to call people together and to be held accountable.

Either that is done by someone in the cabinet room or you empower the minister for Aboriginal affairs, who always sits outside the cabinet room and only gets to come to discussions on Aboriginal affairs when there is an Aboriginal education, health, employment or housing issue for some technical advice. If the issues are collectively discussed in the main business of government, you will always be on the outer and the ability for ATSIC to deliver on health or education in isolation from that strong coordination and leadership. In a sense we need some statesmen type leadership and bipartisan political support on this particular issue if we are going to create change. We have got that in lots of governments in Australia but there really is a need for more cross-sectoral interest. We need to move out of our chimneystacks to work more laterally across the departments of government and not just say, 'Coordination is an ATSIC issue.'

Recently we have been trying to respond to the Collins review which is a major report into the education of indigenous Australians in the Northern Territory. That clearly shows that we have failed as a department to identify the level of health issues in the school population for the NT. As a result of that, we have been in major discussions with Hearing Australia. I suppose the outcome of that is to ensure that every indigenous Northern Territory child has the ability to be screened for a whole health check and that not only is there the ability to do that at the beginning of the year, but there is also maintenance of that type of work for those particular children.

If you are looking at such a small population, it is not an unachievable goal to ensure that every child in the Northern Territory is screened for hearing loss and that you develop a program to deal with that. So you don't just look at the clinical issues about hearing, you actually look at how you educationally manage that once it has been identified and ensure that there is maintenance and follow-up. We hear that in the Northern Territory and also in northern parts of WA state health officials usually visit a school once a year. They might identify the hearing loss but there is no maintenance or follow-up. For some 14 years some children might be targeted as having hearing loss but nothing is ever done—there is no management about it. That is because no-one has gone to talk to the education department or anybody else about how you do it.

The direction we are heading in in the education area is to try to show some leadership about this. As I said, we have failed to do this in the past but we are going to try to ensure that we promote this as a real issue of working more with the health area, Hearing Australia and Aboriginal controlled medical services because if the government health authorities cannot make inroads into this particular situation then we need to engage and empower indigenous community controlled organisations to actually manage that health situation.

Mr Baxendell—Hearing tests were recommended in the 1989 National Aboriginal Health Strategy.

Mr Buckskin—Yes.

CHAIR—Peter, thank you for that. Steve, do you wish to make a comment?

Mr Blunden—Peter stole half my thunder. Ultimately, I agree that governments have to work together—local, state and Commonwealth—in their planning. I will give you a couple

of examples. In New South Wales you have the Office of Aboriginal Affairs running a project. They are looking at doing a survey in the Kempsey community. You have the State Department of Health running a housing health program. They are doing a survey in that same community. Basically they have not spoken to ATSIC about that—do you know what I mean?

If these agencies contributed a few bucks each, they would not have to do three surveys. You would have just one survey and you would not hassle the hell out of our people—they are sick and tired of being surveyed. So you would go there the one time. You would go there and approach them in a really proper manner, and you are spending a lesser amount of money and you are getting the positive information off our people on what their real perceived needs are. I think that needs to happen.

I keep talking to the Many Rivers Regional Council about that, so we are heading down that way. We are having communities do their own little environmental health and disease plans. So they would have a stepping stone themselves—they would own that plan—and that is ammunition with which they push the governments for funding. There is the example of Barrabool being funded as a health post. ATSIC was behind that. Look at other areas like Oldburn Bridge: the Durri Medical Service did an environmental health and disease survey for Oldburn Bridge. We are one of two communities receiving this money in New South Wales. That is because the AMS did that report, but we go back to the community themselves as a tool to use to get government departments to come in and fund it, so we had to go to that extent. But I really believe that people need to talk to each other rather than having—as I said—these individual chimneys because they are wasting money. The money needs to get to the people on the ground and this is one way of solving that problem.

Mr Chairman, I have to leave at 12.30 and I wish to give you some quick points on otitis media, glue ear. In the early 1990s the federal government, through OATSIS, funded 30 positions around the country. There were actually five positions in New South Wales for health workers to become audiometrists—an Aboriginal health worker working on ear health. In Kempsey we were successful in getting one of those positions. We basically provided further training for our worker to become an audiometrist.

We felt that it was a very positive move to train that person down that line—going into preschools and checking the children's ears, referring a child to a GP and then to an ENT specialist if required. Recently the State Department of Health of New South Wales has developed 10 more positions. These 10 positions have gone in now as coordinating positions, so they are coordination roles. I will tell you now that it is a waste of money.

Who are they going to coordinate? Are they going to coordinate the same people out there who are supposed to be doing the jobs over many years? The point is that these people should be clinical workers. They should be trained, as the other five people were, to become audiometrists. It is just a waste of money otherwise. It comes back to people talking to each other. They should have come back to the AMSs and asked how successful were our programs on the ground in terms of what direction we were headed. I have to say that we can get the maximum benefit for a child because we have looked at the child, what the problem is and found an ENT specialist who can fix the problem. The other way, where you

have a person just coordinating it, means the child might get serviced in three or four years but by then it is too late—the child has missed the opportunity of life education.

CHAIR—That is a point well made. Any comments?

Mr JENKINS—I want to hear from Julie and the others but can I say a few things. I think that Peter as an individual, rather than as a member of Her Majesty's Civil Service, said what I would have liked somebody to have said. I think this needs some leadership where we say, 'We're going to do it.' I remember, when we were in the room several months ago during the seminar here, things being said like 'no need to reinvent the wheel' and 'strengthening existing rather than reinventing'. When we have been out among the traps, people have not criticised the national healthy strategy; they have just said, 'Why hasn't something been done about it?' That is not a partisan political statement; it is just a statement that it requires political will and national leadership where we say, 'We're going to do it. We're going to help the people that are in the communities and also the individuals.'

At the moment, when we are saying 'Why isn't this one doing it; why isn't that one doing it?' we are feeding the lack of cross-sectoral cooperation. It might mean putting the minister for Aboriginal affairs in cabinet or whatever. I think the committee, in a bipartisan manner, is trying to drive that.

Ms Tongs—In the ACT, we do not ATSIC bash because we do not get anything from ATSIC, but we do not get anything from the Territory either. A lot of our people access public housing, but some of the houses our people live in in the ACT are like ghettos—whether it is housing trust houses or blocks of units, such as Burnie Court or Bega flats or Gowrie Court, and they are no better than blocks in Redfern. That is where a lot of our social problems are happening.

A lot of our babies are born into poverty. They are taken to housing trust houses and, because of overcrowding—instead of having four people in a two-bedroom flat there are 10 or 15, and this is happening here in the ACT—they get respiratory problems, skin infections, such as scabies, giardia, which is like gastro, and those sorts of things. Canberra in the winter is very cold. When you have 10 or 15 people living in a little place with the heating going all day, because they do not work, they then have a big problem with the bills, the gas and electricity. They get evicted and they move in with another family. That then creates more social problems and overcrowding. Until we fix these other problems, we will always have health problems.

CHAIR—John, you have heard the discussion, you know the frustration and the difficulty of the past. As Harry Jenkins said, everyone is saying, 'Go and do it.' There is also the cross-sectoral cooperation that I think Peter Buckskin highlighted so well. You know the practical issues as well as anyone. You might like to open it with a comment, and I am sure others will have questions.

Prof. Deeble—I have some sympathy with what Peter said but it is a microcosm of the whole health care system—it is not limited to Aboriginal health. Everything that is said in here could be said about any other health care issue. The Commonwealth is going to run it, the state is going to run it—who is going to shift across to who because, literally, the

opportunity is there for both of them. That is because of the way we have grown up and that is what we have got for now. It is not about saying what we should do in an ideal world, it is about what we are doing with what we have got.

One of the things—and this is taking the broad view—is that I cannot see how, if we decided to spend more money on Aboriginal health exactly, we would do it and how we would see that it was done. The states have very few programs for Aboriginal health per se. They run mainstream programs that react to demand and they have some community programs which work specifically for Aboriginal health. But, as we found in our report, the amount of money specifically allocated to Aboriginal health is quite small. If we are going to do more in Aboriginal health, how do we do it and who does it?

With the way that most of the state services are structured, it would not be easy to specify precisely what you are going to do. On the other hand, if it is the Commonwealth that takes responsibility for, say, primary care how do you transfer those primary responsibilities and the expenditures that go with it from the state to the Commonwealth? If I have a preference in your broad thing, it is for your third alternative. That seems to me to be the only way you could avoid the rubbing between the jurisdictions to try to make it smooth rather than there always being a conflict between the two groups and where you could see that the total had been changed.

We have the continuous argument in the broader funding area where, if the Commonwealth increases money to the states, the states pull it out and say, 'If we did not pull it out sometimes we would always be putting in more and more.' It is a stupid argument but it is waged all of the time. The only way I can see that you could do some of that is to adopt some variant of your third approach. I know that says, 'Well, we have tried everything else, why don't we try this new one.' But I cannot see how, from my knowledge of the way the funds flow, you can get more money into Aboriginal health if all that the states do is respond to a bit of demand.

Many of their services run across non-Aboriginal and Aboriginal people. Only in a few cases are the Aboriginal people the majority. In fact, that is only so in one state and a part of another one. They are always at the tail end. A program that was important for Aboriginal people but which also had to be, as a matter of equity in the same area, provided to non-Aboriginal people will not get done because the consequences of doing it for everybody are too great.

The only place I can think of where that might not apply is in the Northern Territory and the top half of Western Australia but everywhere else they are a minority. How will a state provide a service in metropolitan Sydney, where the population proportion is less than one per cent of indigenous people? They cannot find them. They wait for them to come to the service. As a policy thing, I would support your third alternative. I know it might create another bureaucracy but—

Ms HALL—Are you referring to option D?

Prof. Deeble—Yes, that is right—sorry, not the third option the fourth one. It is the option that says to pool the money and leave the administration in the hands of the two

parties—that is, primary care to the indigenous health organisation, basically Commonwealth, but that what the states put in is to be taken into account. If that does not happen what we get is this shifting all of the time.

CHAIR—I am glad we clarified that it was option 4 and not option 3.

Prof. Deeble—My apologies, I was talking about option 4. Those descriptions of what goes on are just descriptions of the whole health care system. Oddly enough, if you get something that makes sense in Aboriginal health, it might even contribute to some of the other problems.

CHAIR—I have one question about mainstream services. In your practical experience, how do we get a bit of empathy from the hospitals to get mainstream services to reach out a bit better? You have heard the practical things this morning, that some programs are working and some are not, and you would expect that that is pretty consistent across the country. Surely the state system, with a bit of commonsense, could do some basic things which would enhance the situation.

Prof. Deeble—Except in the places where indigenous people are a significant proportion, it is a rare occurrence for a hospital to have to deal with these people. They do not give any importance to them really.

CHAIR—That is the problem we have.

Prof. Deeble—Yes. In some metropolitan areas it is half a per cent or something, and that sort of person is not going to be recognised or acted upon sympathetically by the staff.

Mr JENKINS—I have a sneaking suspicion that I raised this back in June when John was here. One of the things we have to do is try to cut down the difficulty of accountability. We have stressed that is not where the dollar goes, but it is the outcome and the output.

At a national level it gets a bit clouded when we cannot pick some outcome indicators of improvement in health that are broad enough to capture the public's imagination and that would enable whoever is driving it to say, 'On these indicators, this is what is happening and this is what we are trying to achieve.' Have you got a feel for four or five indicators we could use to say, 'Bang. If we are going to this national approach where we are going to try and educate the wider public that there is something happening, these are the things that would sufficiently give an indication of what was happening generally'?

Prof. Deeble—We actually did achieve one thing over the last 30 years of so, and that is a significant drop in infant mortality. It has been argued that while we were concentrating on infant mortality we were neglecting particularly adult male mortality, but you cannot do everything at once.

Mr NUGENT—That is a bit of a problem for the adult males.

Prof. Deeble—It is. But it shows that with a concentrated effort, when people did concentrate on infant mortality—it started about the 1970s—the indicator did show positive

results. I am not sure that you will do anything about adult male mortality within this generation because the preconditions for that adult male mortality are there now and have been established for some time.

Mr NUGENT—Absolutely.

Prof. Deeble—Mr Wilson mentioned the attitudinal factors. Many low income people in Australia share the same health habits as the Aboriginal people. They drink too much, which is illogical in the sense that that is where their income goes, and they smoke too much. They practise bad health habits. The only thing that is ever seen to be effective for that that I know of, and I am not an expert in health education, is community disapproval. That is the only thing that has altered tobacco consumption. Price might have helped a bit, but community disapproval has been the only thing that has effectively limited tobacco consumption—not the belief that you might die from it, because people apply statistical probability that is in their favour. So it is a community education question, and I do not believe that anything other than the community's own approval or disapproval of those actions will help.

Ms ELLIS—I have a question for John, given his area of speciality. We have had discussions in the committee about giving strength in the report to the government of the day, and future governments, to have the confidence—the basic guts, in fact—to allow appropriate time line measure. You touched on that a moment ago when you said generational. My own view and the view of, I think, many on the committee is to say, 'There are things we can measure in two to five years; there are things we could possibly measure in five to ten years and there are things we can measure in ten years to generational.' I feel very strongly that we need to talk in that language in the report, to give the courage or whatever the word is to governments now and in the future to actually continue with what programs they begin as a result of this report. Would you agree?

Prof. Deeble—Yes. I would think that something like that child mortality was partly due to maternal practice, because a lot of that was from infection and things which could be remedied fairly quickly and child mortality reduced. And we were reducing child mortality among low birth weight children in our community, not just in the Aboriginal community. Nevertheless, there were measures that did it. If there were particular things that you could measure, in the public health area I think it is possible to look at the behavioural things that you were talking about and measure them. We believe that the number of Aboriginal people who drink is no greater than in the non-Aboriginal community but the number of people who drink to excess is greater. Can we look, even within the alcohol consuming group, for a small advance in something that is obviously damaging? There are criteria there which are intermediate measures. The outcomes would be a long way down the line but the intermediate measure could measure what proportion of various populations has reduced risk behaviour. But the question of mortality and even a good deal of morbidity is beyond the belief of any government that they will see a result.

Mr NUGENT—You have got to have vision.

Prof. Deeble—You have got to give it a long time.

Mr NUGENT—You have to believe you can achieve it long term. You can never stop first steps.

Prof. Deeble—I remember that there was a lot of emphasis in the early 1970s about it, but it was not until the middle 1980s, really, that the reduction became substantial.

Dr Cooter—I think it was because they were shipping women into Alice Springs and Darwin to have their babies instead of having them in the mulga. I know the RFDS flew a lot of these women in to have their babies.

CHAIR—Mary, did you want to come in?

Ms Buckskin—Yes, I do not think we should lose sight of some of the points that Peter raised about it.

CHAIR—That is fine, but do you want to ask John anything specific?

Ms Buckskin—No, but he did make a point about what state health departments do in relation to health. In fact, they do not really provide really good services in the primary health care sense. On the point that Peter raised about cross-sectoral things—in fact, AMSs—Julie gave a good example. AMSs are really doing that. So that really comes back to the issue of what our core business is and looking at health in a bigger sense. Julie gave an example of working with housing; Julie does a lot of work there. Many AMSs deal with housing and with the justice system. We are involved actively with Quamby here, which is a juvenile justice centre, and Belconnen Remand Centre. So AMSs do that and they need to be resourced effectively for that; state health departments do not do it.

So, really, the big difference about AMSs and Aboriginal community controlled health services is the way they work. They work in a community development capacity, and meaningful work—

CHAIR—Can I interrupt, Mary? I am sorry to do this, but John has to go.

Mr NUGENT—I want to take you back to your first statement this morning when you referred to the little town you live in—and I cannot remember the name—

Prof. Deeble—Gundaroo.

Mr NUGENT—and your recommendation that approach D is probably a reasonable way to go. I will put a proposition to you: if you have a body that looks after a holistic approach to Aboriginal health—and I do not just mean the doctors, the nurses and the clinics—but also perhaps has responsibility for planning, housing, water and all the infrastructure things which we all know are so integral to fixing health problems, would it be, therefore, appropriate to say that it deals with your community or that community and that it does it on a holistic community by community basis and cuts out all the middle layers that are in the system at the present time?

Prof. Deeble—The body that was suggested here, I think, was a fairly limited body which had a notional pooling of funds. The funds are still spent by the individual bodies that spend them now.

Mr NUGENT—I am taking it another step.

Prof Deeble—Yes.

Mr NUGENT—I am asking for your answer?

Prof. Deeble—That would mean—and I will be cautious for a minute; one step at a time—that you would establish a separate agency at arm's length dealing from the parties, which does not have to be a huge agency. It would determine where the funds would be allocated. I do not believe that you would actually manage to determine that the funds would be allocated, but you can justify a very strong recommendation, because I do not see this money being transferred to that body. I see it being reviewed by that body and that pressure would be put on the various governments to alter their spending in response to that. It is the sort of thing that OATSIHS could do were it not the Commonwealth's own agency at the same time. You cannot very easily be the agent for one player and the reviewer for all the other players.

I think that it would be the organisation which would try to determine the standards. In our expenditure report, we threw all the money in from everywhere because it is the only way you can do it. We got some broad conclusions about those things. By doing that on an area basis, which would be bigger than Gundaroo, I would think—

Ms Buckskin—You are picking on Gundaroo.

Prof. Deeble—That is the point. I was trying to emphasise the difficulty of translating the difficulty of doing a small Aboriginal settlement to my situation of a little town at Gundaroo. It is very difficult to imagine the people of Gundaroo being able to say, 'What are our health problems?' because, for God's sake, the situation will change next year. In the perception of the community, things will change. When one thing goes off the agenda and something is done about it, another one will come up, particularly in a very small community.

Mr NUGENT—We went to Maningrida on this inquiry. I was there five years ago and it has not changed at all.

Ms Buckskin—You ought to pool all your funds. How does that tack on to the points that Peter raised about responsibility? It is not all about ATSIC or anyone. You can pool the funds, but we have already said that having more money is not necessarily the answer.

Prof. Deeble—I know that.

Ms Buckskin—How does this new approach address all these other issues?

Prof. Deeble—It addresses an issue only if you think you need to spend more money. For instance, you can get more money spent just by deciding you are going to. The states spend their money through the mainstream health services, most of which are not for Aboriginal people. If you want to spend more money and guarantee it, the only place in which you would be able to do that would be in the Northern Territory because it is such a big proportion. Otherwise, you are going to ask them to allocate a bit more of their existing money to it. But how do they do that in the way they are structured? That is why I had the notion of an Aboriginal health service, because you can give it some money and it is going to go to Aboriginal health.

Ms Buckskin—That is right.

Prof. Deeble—This maybe would be the start of something that could become a health service of a kind. There is no Aboriginal health service through the state systems as such. They go to hospital and they get treated in the ordinary way like anybody else—

Ms Tongs—Oh, no.

Prof. Deeble—No, I know. There was a study of expenditures that said, 'You spent that much on Aboriginals,' and, of course, that is a bit mythical. Nobody knows what they spent. It is a notional allocation based on the proportion of work that should be done, and they are a bit scarce on it. What they actually did, we do not know. I do not see how you can somehow or other, from a central edict—apart from, usually, moral pressure—see that more money actually gets spent there. It is really not very big; it is two per cent of our national health expenditure. Can we put somebody up who could, on a continuing basis, do an ongoing review of that?

CHAIR—We have not touched on access to MBS this morning.

Prof. Deeble—You would have a bit more money if you accessed MBS/PBS.

Ms HALL—Steve has to go and he said he wanted to bring something up about travel.

CHAIR—Yes. Do you have to go?

Mr Blunden—Yes, I have to go.

CHAIR—We had better sign off there.

Prof. Deeble—I have to go too.

CHAIR—Thank you very much, John. Steve, do you want to have just a minute on transport?

Mr Blunden—Just quickly. I assume people know what IPTAS is. I believe AMSs should be voted a proportion of IPTAS funding in the rural sector so we can help our people get to and from specialists. I believe that is a form of early intervention, and it does reduce actual hospital bed days. We have proven that. We are looking at transport services within

our region and at having a workshop to utilise the dollars more effectively for that sole purpose. I think AMSs funding should be balanced with IPTAS and without a kilometre barrier.

CHAIR—Thank you, Steve. We have just a few minutes left, and I really wanted a bit more time with Peter Buckskin on employment—and there are other issues around that we need to start to think about. It is not essential that we wrap it up—I guess people would need to break for lunch and come back—and I think we have just about covered as much as we need to.

I am sure Mary would want to say something else. I am sorry I had to cut her off earlier; I just wanted to talk to John Deeble for a little bit and keep it coming the other way briefly. Mary, do you want to continue?

Ms Buckskin—I just wanted to finish off what I was saying about AMSs and cross-sectoral linkages. In fact, AMSs are doing that all the time, but it is not considered to be a core part of health business. Peter raised some really important issues about the fact that it does impact on health, and it should be seen. AMSs should get resources for doing that role, and it should be recognised that it is a core part of health business.

CHAIR—'Cross-sectoral not seen as core business'.

Ms Buckskin—That is right. We do it with the justice system, we do it with housing, and we do it with a whole range of people. I just wanted to make a point about attitudes that Aboriginal people have to health. It is important to keep in context that—and this is why AMSs were founded in the first place—based on the principles of self-determination we have not in fact had that, and that is what community control and participation is all about. One generation ago my mother was raised on a mission, and they did not have any input, control or knowledge about basic health issues.

In addressing attitudes of Aboriginal people about drinking, smoking, et cetera, you can give them the information but it is important to acknowledge that we have had that information for only a short time—let us decide what we are going to do with it. It is an unrealistic expectation in such a short space of time. For my children it is two generations. My mother was raised on a mission, and other people had absolute control of her life. We need to recognise that, and that is why AMSs are so important: we enable our communities to develop in relation to attitudes to health in a realistic time frame.

CHAIR—To me that is the key issue: what is reasonable in that area of getting the ownership of your own life.

Ms Tongs—That is right.

CHAIR—At the risk of directing operations, Peter, on employment issues—

Mr Buckskin—Mr Chairman, I cannot comment on employment; that is Mr Reith's portfolio. I dare not speak for my colleagues on that.

CHAIR—Okay, so we can only talk about education.

Mr NUGENT—Sarah had something else to say.

Dr Strasser—After you.

CHAIR—Peter has made it clear that I am about 12 months behind in the portfolio issue.

Dr Strasser—There was one comment about the report that I had difficulty reading, and I think that my colleagues will also have some difficulty. In the medical profession, we use the RRAMA classification, which is the remote rural and metropolitan areas classification. In the discussion paper, at 1.3, you say:

. . . the percentage of the Indigenous population living in urban areas has . . . increased—

And you define an urban area as an area having more than 1,000 people. I do not know if that comes particularly from Aboriginal communities, but that really does not make sense to us at all. It kind of throws out everything that we say.

Mr NUGENT—It is a valid query that we need to clarify.

Dr Strasser—It would be worth using the same terminology.

Dr Cooter—I think it comes from the statistics branch up in Darwin. I get a copy of their reports every now and then, and I think that is where it came from.

Dr Strasser—Something that has happened since I was last here is that we have got 1,000 GPs who have been surveyed and have produced an amazing document. This tells you exactly what is happening in general practice today. There is a section on encounters with indigenous people, the reason for the encounters, and how the patients are distributed across the states, plus the RRAMA classification.

Mr NUGENT—Can you let the committee have a copy of that?

Dr Strasser—Yes, it is better to relate it all together. While sitting here I have had more thoughts about an Aboriginal health training stream, so I have written it down, Jill, to give to you now.

Ms HALL—Thank you.

Mr NUGENT—Perhaps you could give it to the committee secretary and then he could let us all have it.

Dr Strasser—These are my own personal thoughts rather than those of RACGP.

CHAIR—Thank you. Peter, I would like us to talk briefly about education leading to employment. Could you just briefly touch on the training issues and make any relevant comments you would like to make?

Mr Buckskin—I will not revisit our submission or the evidence that I gave at your previous hearing but, since we last met and I talked to the committee, Dr Kemp has talked about a national literacy and numeracy and attendance strategy. In terms of the health issues associated with that, part of the announcement will be about a strong commitment to the health of students in the compulsory years of schooling and to put a handle on what can be achieved in the short term. I understand what John Deeble talked about, but I think it is unreasonable to expect indigenous Australians to wait another generation for health improvement. We know that, all things being equal, you can actually achieve things in the short term; for example, with otitis media—glue ear. We know that about 90 per cent of indigenous Australian kids are experiencing some type of hearing loss. We also know that it is preventative and you can fix it up in the short term. We also know that there are educational strategies and methodologies that teachers can adopt in the classroom to ensure that children with hearing loss can actually achieve an appropriate learning outcome.

We need to focus on what we can do with the current outlays of funding to ensure that, say, Hearing Australia, is targeting this group of people. We understand that the amplification system that you might put in classrooms is around $4,000 a package. We know where the 110,000-plus indigenous kids are and in what schools. We know where there are significant proportions. We know where there are bad literacy and numeracy outcomes and we know where there is bad attendance. We need to ensure that this strategy is more concrete in ensuring that we go to the heart and the source of the problem—that we go to that school in that particular region and we develop appropriate strategies to ensure that we can achieve a learning outcome. The benchmarks there are probably the year 3 or year 5 literacy benchmarks which Australian education ministers have agreed to. The minister hopes to announce that strategy in the last week of January next year after the release of the reading data from the literacy survey.

It is important that this not be seen as an unachievable aim in terms of dealing with the health issue. It is unreasonable to expect that our people will wait for generational change. We cannot wait, and we know there are things that we can do. We have already talked about how birthing rates have changed. But we also know that, in the schooling area, we can treat this hearing loss. We need to stop talking about it and actually start doing something. That is the concrete nature of how we would like to go.

We also now understand that if state education systems cannot drive change in this area, you go to some other people who can drive change. That is why we want to have a strategic discussion with NACCHO. If government state health authorities do not want to provide appropriate levels of resourcing in the Kimberley region or in the Northern Territory or in western New South Wales to enable these kids to be looked at, we will buy that service from someone else. We will enter into some partnerships with non-government providers to ensure that they are resourced and are able to deliver.

I think it is also important to note—and I just want to comment on the new approach—that the answer is not in the establishment of another bureaucracy. John talked about the fact

that we are a minority and we are a dispersed race of people. There are clearly pockets of regional Australia where we are a significant and substantial proportion of the population and where we can actually do something. But the majority of our people have within their vicinity hospitals or a medical service that they can attend. It is making sure that they are more inclusive in responding to our needs. It is ensuring that we enter into more partnerships with the college of surgeons, the AMA, the nurses federation—any of the health working professions, in a sense—so that they understand more about this business and to make sure that they are more aware of the difficulties that we have, rather than seeing that it as a particular group's responsibility. It is everybody's responsibility, and that is why I talk about the states and the people and the things we have to promote. If you have a section of the community that is so disadvantaged, surely we as Australians would like to see that fixed up, whether you are black, white, poor or rich. The fact is that we experience, as you know, multiple disadvantages which, clearly, you have seen through travelling around.

We believe that, in the area of schools and education, we can solve some of those problems. Turning to training, as you know, when the first Howard government came to office we established those key learning centres and higher educational institutions. We gave substantial dollars to, say, James Cook University to become a centre of excellence in delivering health training and understanding issues of Aboriginal health. This is the last year for that funding, so it will be interesting to see whether those universities that have received funding have now made that work inclusive of what they do—so that they have learned what we have asked them to; they have seen the worth of it and the need there—and whether they can build that into the James Cook University, or into other universities.

In the area of training, we have been working, again, cross-sectorally with the department of health in its review of health worker training to ensure that people have access to appropriate levels of training. But we have not done that very well. I think we would get an F for fail on our report card for our ability to engage other Commonwealth portfolios, and some of that responsibility lies with us as we concentrate on our chimney stacks rather than working laterally across departments. It is to ensure that things like traineeships and the Australian apprenticeship system are targeting the health professions and that the work in the health area reflects some of the work and skills that we need, and we are working on that. I think that is about it, Mr Chairman.

CHAIR—I have a quick question, but it is not in your area, Peter—it is more in Andrew's area, perhaps, although not specifically in OATSIS. The department of rural health is picking up some of these training issues; have you come across the department of rural health and is there anything happening cross-sectorally?

Mr Buckskin—No, I could not comment on that.

CHAIR—What about you, Andrew? Do you know?

Mr Price—No, I could not comment on that, either.

Dr Strasser—I could probably comment on that. As well as departments of rural health—and some of those are more specifically orientated to providing service than others, and they are meant to be across all the boards of medical and allied health professional

training—we have the rural work force agencies. They, in particular, will be getting people into AMSs in rural and remote areas. There are also the rural health training units, which are more multidisciplinary and cover research as well as work force and training. They are all developing a better network to be more fully integrated with each other. So that is improving. They do have an Aboriginal focus, but it varies to an extent.

CHAIR—Thank you. We are just about at the end of our time.

Dr Strasser—I have one final comment. The issue of red tape and OTDs was raised at the very beginning. I would have to say that there has been a significant reduction in the red tape for overseas trained doctors coming into Australia at the moment.

CHAIR—We hope so.

Dr Cooter—Concerning the point that Peter was bringing up about intersectoral collaboration, I do feel very strongly that associated with the health team this coordinated administrator was missing in some of the communities that I went to. I envisage that that person should be very well trained, multidisciplinarily trained, in things like looking at the public health aspects—the sewerage, the water and all these sorts of things—and financial arrangements and reporting to bodies like ATSIC where the deficiencies are in that community.

As I said before, what we need is a cohesive health team with this multiskilled administrator in each community who can work with the health team in picking up what the health problems are, the infrastructure and all these sorts of things. It appears that that fourth person is a very important person in an Aboriginal community and I think that every Aboriginal community should have such a person.

I was talking to Brian Dixon in South Australia. He is the executive officer of Aboriginal health. He was quite adamant about this himself. He mentioned things in the training program like business management, public health, social problems, human and physical resources. There should be a training program for these administrators. I think it is vital.

CHAIR—We have picked that up pretty consistently, Robert.

Ms Buckskin—There was a pilot program that was running in New South Wales. It was funded by DETYA and the health department with the Australian College of Health Services executives—a pilot program for Aboriginal health managers. They would like to get funding to do it nationally.

CHAIR—Robert, thank you very much. Mary and Julie, did you want to—

Ms Tongs—Can I just say that we have got a crisis with heroin in the ACT. One of the old ladies I know about is 76 years old. She gets on the first bus of a morning and she is on the last bus of a night looking for her grandchildren. She lost two sons in January this year, one on the 1st January and the other one on the 3rd January. The one that died on the first died from a heroin overdose. The one that died on the third died from cirrhosis of the liver. She buried the two boys—34 and 35—on the same day in early January.

Now she has got the same problem with her grandchildren. She has got three grandsons—one is in Quamby. Do you hear any non-Aboriginal people saying what a great place a detention centre is? This old lady is saying what a wonderful place Quamby is because she knows her grandson is going to be alive tomorrow. This is the ACT. This is the capital of Australia. People need to take a good look. I think it is time that we were allowed to find the solutions to our problems but we need the wider community to support us to do that.

CHAIR—Thank you, Julie. Let us hope that we can give you some more tools to do that.

Dr Cooter—With regard to the scholarship system, I believe Michael Wooldridge is not keen on scholarships for undergraduates to go into rural practice. It is working in Queensland. It has been in existence for about 30 years up there. I would like to see this nationally with every state having a scholarship system.

CHAIR—All I can say, Robert, is that ministers might be wary of the state-Commonwealth issues. I am not familiar with the issue—

Dr Cooter—You are not.

CHAIR—No. It will probably be best to take it up with the minister's office. Thank you very much once again. It is much appreciated. This is our final gathering.

Committee adjourned at 1.04 p.m.