COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON ABORIGINAL AND TORRES STRAIT ISLANDER AFFAIRS

Reference: Needs of urban dwelling Aboriginal and Torres Strait Islander peoples

WEDNESDAY, 28 FEBRUARY 2001

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON ABORIGINAL AND TORRES STRAIT ISLANDER AFFAIRS

Wednesday, 28 February 2001

Members: Mr Lieberman *(Chair)*, Mrs Draper, Mr Haase, Ms Hoare, Mr Katter, Mr Lloyd, Mr Melham, Mr Quick, Mr Snowdon and Mr Wakelin

Members in attendance: Mr Haase, Ms Hoare, Mr Lieberman, Mr Lloyd, Mr Quick, Mr Snowdon and Mr Wakelin

Terms of reference for the inquiry:

To inquire into and report on:

the present and ongoing needs of country and metropolitan urban dwelling Aboriginal and Torres Strait Islander peoples. Among other matters, the Committee will consider:

1. the nature of existing programs and services available to urban dwelling indigenous Australians, including ways to more effectively deliver services considering the special needs of these people;
2. ways to extend the involvement of urban indigenous people in decision making affecting their local communities, including partnership governance arrangements;
3. the situation and needs of indigenous young people in urban areas, especially relating to health, education, employment, and homelessness (including access to services funded from the Supported Accommodation Assistance Program);
4. the maintenance of Aboriginal and Torres Strait Islander culture in urban areas, including, where appropriate, ways in which such maintenance can be encouraged;
5. opportunities for economic independence in urban areas; and
6. urban housing needs and the particular problems and difficulties associated with urban areas.

WITNESSES

Committee met at 4.19 p.m.

EVANS, Ms Helen, First Assistant Secretary, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Aged Care

McDONALD, Ms Mary, Assistant Secretary, Program Planning and Development Branch, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Aged Care

KROON, Ms Marian, Director, Health Financing Policy, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Aged Care

CHAIR—Welcome. I declare open this public hearing for the committee's inquiry into the needs of urban dwelling Aboriginal and Torres Strait Islander peoples. Thank you for coming today to meet the committee. The House is sitting at the moment, and so some committee members send their apologies, and members may have to leave if the urgency of business in the House calls us away.

The committee is interested in the range of programs in which the department is involved, and we hope that you will be able to further assist us by discussing some of these today. Although the committee does not require you to speak under oath, you should understand that these hearings are legal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament.

Before we ask you questions, I would say how grateful I was for the very substantial and valuable submission that you have already given us and which we have already authorised for publication. We congratulate all of the team that was involved in preparing it. I realise it must have been a very big task. But it has given me a lot of insight. Do you have a short opening statement to make before we proceed with questions from members?

Ms Evans—Thank you, Mr Chairman. I do not think we have much more to add than is in our submission. Most people here will be aware that responsibility for Aboriginal and Torres Strait Islander health transferred to the health portfolio in 1995-96. At that time, we took over from ATSIC the funding of AMSs and substance misuse services. Since that time, we have expanded and developed on the Commonwealth leadership role in Aboriginal health. Our approach is very much a two-pronged approach: to try to ensure that the mainstream health and aged care services are more responsive and appropriate for Aboriginal and Torres Strait Islander people, and also to support and develop the quality of comprehensive primary health care services provided by the community controlled Aboriginal health services. But there is a very strong feeling in the portfolio that it has to be a whole of health system response. It cannot just be left to one part of the health system to respond to the needs of Aboriginal and Torres Strait Islander people.

CHAIR—Thank you for that. Members have a number of questions of their own that they will ask, and also the secretary has assisted members with proposed questions. Time will probably mean that we will not get to ask all of those questions. So I foreshadow that we will be writing to you with the questions we have not been able to reach, asking whether you would be kind enough to give us further written responses or elaboration, if that is the case.

I am going to depart from my script a little and just ask you—because I am very interested and concerned—about the recent publicity about the petrol sniffing and the tragedy of that. Just as an example, I would ask you to give us an indication of what direct action is undertaken at the moment or being looked at, in respect of that very tragic situation with some of the young Aboriginal people.

Ms Evans—Yes. Petrol sniffing is a tragedy for the communities that it affects and for the individuals. It is an issue and a problem that we are still getting, I guess, a handle on. But there is no doubt that it arises out of communities—and it is largely central Australian communities, as Mr Snowdon would be aware, I am sure. It is largely among young people, young men, and it seems to be tied up with boredom and lack of direction and alienation. It comes and goes: some communities may have petrol sniffers for a while, and then it may stop and then it may come back. So it is very hard to get a handle on the numbers and the reasons, except that it is clearly to do with alienation, boredom and a lack of cohesion in communities.

Communities where there is strong leadership and activity seem to take on board those problems and react to them fairly quickly, whereas those communities which are more dysfunctional do not. There are communities in the northern part of Australia, around Nhulunbuy, Ramingining and Maningrida ,where there is also petrol sniffing.

I should also say that, in the overall scheme of things and in terms of substance abuse, alcohol and smoking are undoubtedly a much bigger health problem and cause much more long-term effects, but petrol sniffing, where it happens, is very problematic. But there is no single solution. We are funding a number of projects in Central Australia—and I will table with the committee details of the projects we are funding.

The largest amount of money goes to NPY, the women's council in Central Australia. They have been producing kits for communities' information. They also fund recreational and prevention activities. They provide advice to communities. They go out and counsel communities. It is the Yuendumu/Mount Theo program that we fund. There are about five projects in Central Australia. We are also just about to convene, at the request of the Northern Territory government, a tri-state meeting between Northern Territory, Western Australia and South Australia—initially government officials, and then involving communities—to see whether we can have a more coordinated approach, because it affects communities in Central Australia, which does not mean just in the Northern Territory.

CHAIR—We wish you luck with that, of course. In the context of the recent publicity, I noticed in your submission a very wise observation that adverse publicity about indigenous communities—these are my words, but this is the thrust of what you were saying—can have an adverse effect on morale and create further erosion of self esteem, et cetera; and I agree with that. On the other hand, publicity which is educative and which highlights the damage that might be caused by the stupidity of petrol sniffing can be a weapon to influence young people about not getting involved in it and also taking action if they see someone doing it. I guess it is about getting a balance, isn't it?

Ms Evans—Yes.

CHAIR—Will there be any programs to alert young Aboriginal people to the horror and risks of petrol sniffing, and alcohol and drugs?

Ms Evans—That is certainly one of the aspects that NPY based in Alice Springs is funded for—to provide information; to go out to communities at their request to provide advice and direct hands-on comments. There is also a whole range of kits and information to alert people to the problems, the dangers and the possible consequences.

Mr SNOWDON—The Prime Minister recently announced $1 million over three years for substance abuse, and that is obviously very welcome. But he is calling for a submission based approach from small organisations for pilot programs. Why would you need pilot programs? We are told that the first of those pilots will be at the Top End, and we have just acknowledged that the major problems are in Central Australia. Could you give us any insight as to why this money is being put up in this way, where the money has come from and what the purpose of the money is, if there are already existing organisations who could use this money if it were given to them?

Ms Evans—The money, as I understand it, does not come out of the program OATSIH manages; it comes out of the diversionary money that was an agreement between the federal government and the Northern Territory government. So it comes from the National Drug Strategy funding. There are undoubtedly communities in the Top End that have petrol sniffing, and we are all still trying to find our way in terms of what works and what does not work; and this is another opportunity to provide resources into those communities in the Top End where there is petrol sniffing, and also to draw on the expertise from Central Australia: my understanding is that they will draw on the lessons learned in Central Australia and hopefully develop them further.

Mr SNOWDON—I do not dispute the obvious need. I must say though—this is not a matter for you—that I am very sceptical about the use of this money.

CHAIR—Warren, if you don't mind, I do not want to be rude to you, but we are fact finding and you can make your observations when we are writing the report.

Mr SNOWDON—This is a committee which is talking about impacts, and I will continue to ask the question. In your introduction you talked about the need for a coordinated approach to these things, which we obviously all accept—and this is not a criticism of the federal government, so let's be very clear about that—

CHAIR—I am glad you said that, because it sounded as though it was going to be.

Mr SNOWDON—I think there are real questions to be answered as to how the $1 million is being used, but that is not the issue. You have rightly pointed to the fact that the Commonwealth puts in money for these programs—and, for your information, I did research for the ANU on petrol sniffing as far back as 1978, so I have some knowledge of it—but I am interested in the combination of factors that lead to infrastructure in communities which allow people to be able to do things other than sniff petrol. I am talking about recreational facilities. It is clearly not your job, but as I will ask later on when we will talk about couple of other issues, it is clearly the Northern Territory government's responsibility to provide the infrastructure. If we are

talking about remediation and hitting the issue at source, $1 million will be of some assistance, but they are dealing with the end product and I am wondering how your negotiations over the use of money from your program can be built into considerations being taken by ATSIC or by the Northern Territory government or the Western Australia government about how infrastructure is developed in communities to address the needs of young people.

Ms Evans—This is certainly the starting point for this tri-state meeting that we have convened, where not only will state health departments be present but also ATSIC and Family and Community Services. The Department of Family and Community Services at the federal level, as I am sure you are aware, have a Stronger Families and Communities Strategy. We will be working with them cooperatively to build in the infrastructure that is needed to strengthen communities, which is really the starting point.

Mr SNOWDON—I will just follow up with two very quick questions relating to two specific issues.

CHAIR—Warren, I am happy for you to continue, but I am conscious of the time. Keep it short because I do want other colleagues to have the chance to ask questions.

Mr SNOWDON—These are very relevant.

CHAIR—Just keep them short, please.

Mr SNOWDON—They relate to the issue of TB at Maningrida. Maningrida, Chair, is in Arnhem Land. It has a population of 2,200, so it is an urban community.

CHAIR—I have been there.

Mr SNOWDON—The other question will relate to Tennant Creek and kidney dialysis. The average TB infection rate across Australia is five per 100,000; in the Northern Territory, it is 18 per 100,000; at Maningrida it is a staggering 523 per 1,000 thousand and there have been 12 new cases this year. The Northern Territory government refuses to fund a disease control program to deal with TB and other diseases. I am asking this question in the context of the first points in your submission, which relate to the role of your department and your unit. I would like a comment on that. The second question relates to the issue of kidney dialysis. The Northern Territory government has flatly refused to provide these services despite recommendations from professional bodies that the regions in Australia with the highest need for kidney dialysis are the Barkly region and Tennant Creek.

On all indices, TB in Maningrida and kidney dialysis in Alice Springs are issues of national importance. What impact can you have in your negotiations with the Territory—indeed, I would assume this would exist in other state and territory governments—to ensure that they carry out their responsibilities to deliver the primary health care that must be delivered to Aboriginal people to give them better health?

Ms Evans—I will start by answering in general terms about how we work collaboratively. I will ask Marion Kroon to comment on the Maningrida situation. We might need to take that on notice, but I think she may have that information at hand.

CHAIR—The chair will permit you to do that.

Ms Evans—Thank you. In relation to working collaboratively, you may well be aware that we have signed with each state and territory a framework agreement that locks the Commonwealth, the states, ATSIC and the community sector into working together. That clearly recognises that the provision of primary health care for Aboriginal people is a joint responsibility. I think we are all keen to get over the buck-passing between Commonwealth and state. As part of that exercise, the four parties have worked together to look region by region at what the needs are, what is there, who is providing what and what the gaps are and then trying to negotiate who has responsibility for filling those gaps. Just in a general sense, that is how we are trying to strengthen primary health care services for Aboriginal people—we are trying to do it collaboratively rather than ad hoc or piecemeal.

CHAIR—In partnership.

Ms Evans—Yes, in partnership, absolutely.

CHAIR—That was an initiative of Dr Wooldridge.

Ms Evans—It was, yes.

CHAIR—I think they call them memorandums, don't they?

Ms Evans—We call them framework agreements.

CHAIR—Thank you.

Ms Evans—Marion, I do not know whether you feel you are in a position to respond to the particular issue around Maningrida, which I am familiar with in general terms. If you are not, then we could take it on notice, with the committee's permission.

CHAIR—Fine.

Ms Kroon—I think it is probably better to take it on notice, because I know that there have been some recent discussions. It would be better to provide a more up-to-date response.

Mr SNOWDON—What about the issue of dialysis in Tennant Creek?

Ms Evans—Dialysis is a difficult issue. It is a huge issue for Aboriginal communities, as you know. The provision of dialysis is significantly a hospital issue.

Mr SNOWDON—There is a hospital in Tennant Creek.

Ms Evans—Yes. My understanding is that Territory Health Services have provided dialysis at Katherine and are looking at how that works out before they make a decision about Tennant Creek. But, once again, I would have to take that on notice. Please recognise that the issue of end stage renal disease is one that we are grappling with in terms of what is feasible to

decentralise. Providing dialysis is quite complex. It is not just a matter of dollars; it is a matter of infrastructure, of water, electricity, specialists, et cetera. There is an issue as to the degree of decentralisation for which you can provide dialysis, and we are certainly looking at that. On the primary health care end, we are working with services to try to put in place early screening and treatment to stop it moving. As you may be aware, in Tiwi they have had quite considerable success.

Mr SNOWDON—They also have a dialysis unit in Tiwi.

Ms Evans—Yes.

Mr SNOWDON—Let me make just one point, and I will finish on this. The head of the AMA in the Northern Territory said that the reason why there is no dialysis in Tennant Creek is that it was a political decision taken by the Northern Territory government. His advice is the same advice as that of other professional health experts: there should be dialysis in Tennant Creek. This is an issue that the Commonwealth government has direct responsibility for and it impacts on the Northern Territory government. I will be making a long issue of this, and I make it very clear that I will not rest until there is dialysis in Tennant Creek.

CHAIR—The chair will indicate now that he welcomes the offer of the department to come back with responses after due research. I am sure those responses will explain the position of the various partners in the responsibility for delivery of health care. So we will have the facts.

Mr QUICK—I am lucky enough—or unlucky enough—to be a member of the House of Representatives Standing Committee on Family and Community Affairs, and the chair of that committee is sitting beside me. I guess the department is aware that last year that committee put out a report on indigenous health, called *Health is life* and, as yet, the minister has not responded. In that report, we raised the issue of framework agreements. I would be interested to know, in light of the Australian National Audit Office report, on page 86, which states:

The ANAO considers that the Framework Agreements are 'in principle' agreements, without any detail committing the parties to undertake specific action, provide a level of funding or achieve quantifiable outcomes within an agreed timeframe. Furthermore there is no recourse for DHAC where States and Territories do not comply with the requirements of the Agreements.

One wonders what has changed since 1998 in light of those statements by the Australian National Audit Office and whether you think that there ought to be some sanctions. Our recommendations were:

The Commonwealth ensure that the provisions of the Framework Agreements are incorporated into the next Health Care Agreements to be negotiated with the States and Territories, to ensure that there is a more direct link between:

. the Commonwealth's funding for Indigenous health, both direct and indirect;

. the Commonwealth's national policy role, including the expanded role for the Commonwealth envisaged by the Committee;

. the States and Territories service delivery roles; and

. the role of the community controlled services.

So has anything changed?

Ms Evans—The framework agreements are agreements to work collaboratively. As we have discussed before, no, there are not any sanctions, because it is an agreement to work in partnership. So there are no sanctions that the Commonwealth can provide to work collaboratively. There are however quite clear areas of agreement that we work collaboratively on and there is also an agreement by health ministers that there will be an annual report—which there has been—on the achievements and deliveries under those categories of the framework agreement. There are also performance indicators that each jurisdiction reports on annually to health ministers. So, no, there are no sanctions that can be made, because it is an agreement to work in partnership. But there are clearly defined areas and there are clear reporting requirements.

Mr QUICK—Is it true that there is no detail committing the parties to undertake specific action to decreaing the ratio of deaths per thousand? Is there that detail in the framework agreements?

Ms Evans—In the performance indicators, there are targets.

Mr QUICK—Can you give us details of that and what has happened in those performance indicators over the last two years—whether there has been improvement or a decrease in expectations?

Ms Evans—I can table with the committee the framework agreement report, the performance indicators and a report on the performance indicators.

Mr QUICK—Are those framework agreements the same between the Commonwealth and the Northern Territory government, the Commonwealth and the Queensland government, the Commonwealth and the Western Australia government and the Commonwealth and the South Australian government? Or is there a general agreement between the Commonwealth and all the states?

Ms Evans—No, there are specific agreements but they are four-way agreements. They are not bilaterals; they are agreements that are signed by the Commonwealth, the state or territory governments, ATSIC and the affiliate of the community controlled sector in that state. There are separate agreements for each state and territory.

Mr QUICK—Can we get copies of each of those?

Ms Evans—Certainly, and they are basically the same. Each state has some minor variation but the headings under which people have agreed to work and report are the same. There are minor variations.

Mr QUICK—My other question goes to the issue of data and funding and the linkage between them. It seems from our two-year study of indigenous health that each state has its own mechanism of collecting data, and in lots of cases there are huge gaps. The Commonwealth does not seem to be in the position to collect data but, as the honourable member for the Northern Territory alluded to, suddenly someone for whatever reason plucks $1 million and

says 'We've got a problem with petrol sniffing.' What is the improvement between data and funding? Is that part of the priority list of saying, 'Well, our data shows that on Tiwi there is a problem with this and in the Northern Territory there is a problem with that'?

Ms Evans—Are you asking about data and funding to—

Mr QUICK—Funding to indigenous communities, yes.

Ms Evans—Communities and community controlled services?

Mr QUICK—Yes, and also to state governments. Someone suddenly discovered that there was a priority to get to petrol sniffing in the Northern Territory. Our evidence showed that petrol sniffing is a problem right around Australia. Why does the Northern Territory suddenly get $1 million? Our evidence over the two-year period is that the states are hopeless in gathering the data, and the Commonwealth does not seem to have an overall role to ensure that the data is collected. It is all haphazard between various states. There is no one body that collects it all and says, 'Well, okay, when we sit down with our framework agreements, we need to do this, that and the other. This disease is more predominant than the other.' Where do you see the role of the department?

Ms Evans—I think there is a range of areas to collect data from. We absolutely agree with you that the data is still very patchy, but the greatest problem in the collection of data is identification. It is not that the data is not collected; it is that the data identifying Aboriginal and Torres Strait Islander people varies enormously. A lot of that has to do with the history of Aboriginal and Torres Strait Islander people, their being prepared or willing to identify themselves and how that information is collected. On the large administrative data sets that both the Commonwealth and the state collect, there is a big effort to strengthen and improve it. But it is more an issue of the quality of it rather than of people not collecting it. It is a major issue of Aboriginal and Torres Strait Islander people being prepared to identify.

Mr QUICK—Where do you see your department's role? In our report it says that the ABS publishes data on indigenous deaths only for Western Australia, South Australia and the Northern Territory, and not for any other state.

Ms Evans—We have a range of roles. We fund a unit with the Australian Institute of Health and Welfare and the ABS in Darwin. There was a major report, which I think you may be aware of, called *This time, let's make it happen*, which outlines the various areas of data and where the inadequacies are. There is an action plan that is being implemented and there is a committee, under the Australian Health Ministers Advisory Council, that is working on the implementation of that across a whole range of areas. Within our own department we have negotiated over some time and with some difficulty an agreement with the Aboriginal community controlled services. We fund to provide annual data on their activities and the range of services they provide, so that is improving. The ABS has developed in the last 18 months a more expanded program for regular surveys and collection of data on Aboriginal and Torres Strait Islander health and social status, which Mary McDonald might like to talk about. We have also commissioned work on biannual collection of data on expenditure on Aboriginal and Torres Strait Islander health. So there is a range of activities going on.

Mr QUICK—Are you in control of the lot? Are you driving it, or is it like most things in the area of health that I have discovered—that there is this patchwork quilt and no-one seems to be in charge of what the final quilt will look like?

Ms Evans—I think it is true that the data comes from a whole range of sources, so I would not say we are driving all of it. There are aspects of it that we are driving, there are aspects of it that we are working on collaboratively with the AHMAC subcommittee and there are aspects that we are working on with ABS and the Australian Institute of Health and Welfare. But there is an overall plan, which came out of the work that was done several years ago, that maps where the gaps are and where the activities should be.

Mr QUICK—When the National Health and Medical Research Council allocate research funding, our evidence showed that the amount of money expended in research on indigenous health was pitiful compared with the problem. And no wonder if we have this mismatch and this patchwork quilt of data collection that no-one seems to assume responsibility for! One would assume that the Commonwealth, now that it has taken over indigenous health, would assume that key principal overarching role.

Ms Evans—I do not think it is correct to say that we have taken over Aboriginal health. We have responsibility for it at the Commonwealth level but we have to work collaboratively with the states, ATSIC and the community.

Mr QUICK—But let us go back to this framework agreement. Isn't that data and funding part of the framework agreement?

Ms Evans—It is, absolutely.

Mr QUICK—Has that changed? If you do not have any sanctions, and there is only a framework agreement which the ANAO said is basically without any detail committing anyone to undertake specific action, surely something should be done to rectify it.

Ms McDonald—There have been significant improvements in data over the past few years. Helen mentioned that I am involved at the moment in the development of the second expenditure report, which is tracking expenditure on Aboriginal and Torres Strait Islander health across the whole health system—state, Commonwealth and private expenditure. The first report was the Deeble report, which I think was in 1998-99, and we are currently working on the second one. One of the things that is very apparent in that process is that the quality of data and the availability of data to track expenditure is far better than it was two or three years ago. That is certainly an encouraging sign, and it is right across the system. Each of the state governments has better data. There are improvements in the hospital identification, the health status data and the deaths data that you mentioned earlier. Whereas the data systems themselves still have a long way to go, there is now a better understanding of the level of underidentification. That means that, even if you are still trying to improve the identification within those sets, you have a better handle on how right or wrong your data collection is, so you can provide better estimates. There is still a long way to go—it is not all sorted yet—but certainly across the system we have seen a lot of change over the last few years in that area.

Mr WAKELIN—Just on that data, how difficult is the identification of indigenous people from the data, particularly in the mainstream system? What are the discussion points at the moment? That is not compulsory to identify, is it?

Ms Evans—No, it is entirely voluntary for people to identify. Mary might like to comment on this, but I guess the biggest single source of data in the mainstream is the hospital separation data. That is collected by hospitals, obviously. There is an issue around people being prepared to identify. There is also an issue of how people—receptionists and people admitting—as the questions when you go into hospital. There has been a concerted effort arising out of the report I mentioned earlier to run training programs for staff who take this data. There has been an improvement. I know that in Western Australia they did a validity and reliability check on their hospital data, and they got a more than 98 per cent reliability and validity. That is a huge improvement. Western Australia, South Australia and Northern Territory still have the best data, but Queensland is also working on that. New South Wales has also improved quite considerably.

Mr WAKELIN—How cooperative are the states?

Ms Evans—There is no doubt that everybody wants to make a difference. There has been an effort put in right across the states to improve their data.

Mr WAKELIN—On the framework agreements, your submission prioritises the criteria for the nominated communities. It strikes me as interesting that there was quite a variation in the number of communities nominated by each state, yet only a modest number got through. In Western Australia more than 50 per cent got through. Would you like to make a comment on why so great a number? New South Wales and Queensland just barely got through. South Australia got a 50 per cent tick, but it only nominated two. I presume—and this is an aside—that it might have something to do with Nganampa Health being so active and the AMSs being well established in South Australia, but there were those communities under the criteria that would not necessarily be nominated. I am just surprised why so many were nominated and then a number did not get through. Is there any reason for that?

Ms McDonald—Is this in relation to the remote communities initiative and the process for the selection of the sites?

Mr WAKELIN—Yes.

Ms McDonald—Perhaps I can just explain part of another bit of the system, to put this into perspective. There is another area of data and information collecting that has been happening over the last few years based on health needs on the ground, the services that are there at the moment and the gaps. That is joint work being done underneath the framework agreement, with the four framework agreements being partners. It is called regional planning. The regional planning has always recognised that that sort of detailed work, region by region, was going to take a fair bit of time. The remote communities initiative was really a stopgap measure to identify those remote communities that had the most urgent need for health services, with either very little or no access to services within those regions. There was a process of looking at each state and territory without the regional plans and with the information on the ground—the information that could be collected in each area to identify the highest need communities. There

was a second selection process against a range of criteria, which worked out, relative to each other, the most urgent needs to be met immediately.

Mr WAKELIN—Across the four states?

Ms McDonald—Across those states. There are still a lot of other needs in those other communities and, as the regional plans are being completed, those needs are being looked at as opportunities arise within those states and territories.

Mr WAKELIN—I think I get that picture, but I am not sure that I understand why there is a big number there, with very few actually get through.

Ms McDonald—The total number nominated was 59, and 42 got through.

Mr WAKELIN—On mine it is 45, and 18 got through. Are we talking about different things? This is on page 109. The last question is on appendix H, I think figure 5. With the average number of government funded staff for Aboriginal primary health care service by state, South Australia is sitting at 23.8. The general point of my question is this huge variation. It may be—and this is where I ask for your assistance—that it is done on a fairly crude system; that is, you might have a large AMS or a small AMS, which may explain why there is a difference in staff per AMS or in the average number of staff per Aboriginal primary health care services. Can you explain why there is that big variation in the average number of staff per state?

Ms McDonald—The size of the services and the nature of the services differ markedly. There are large Aboriginal community controlled services that provide a full range of comprehensive services that are funded around the $2 million mark or so, and there are about 12 services in that sort of category across the country, down to very small services of 200,000 or 300,000, that might employ a few Aboriginal health workers, a nurse and maybe have a few hours of a doctor's time each week. It is just a historical situation that has occurred across the states with the historical submission based funding that has happened in the past. That is just the pattern we see as a result that.

Mr WAKELIN—Can I suggest that those figures are very difficult to have any real relationship with? It seems to me it is more number of staff per head of population, or something like that. I am struggling to understand why we would even bother to do that.

Ms McDonald—It is just a measure of the size of the service and the capacity of the service.

CHAIR—Barry, I am interested in what you have been developing. Those statistics, of course, do not include the mainstream services, which do provide a substantial amount of health care for all Australians. So, yes, in that sense the figures are incomplete for that reason as well.

Mr WAKELIN—I am just somewhat baffled.

CHAIR—Kelly has told me she has no questions.

Mr HAASE—I find that we are between a rock and a hard place—wanting information and wanting to get through in time. I will address my question to you, Helen. In a nutshell I am concerned about the outcomes on the ground. I have heard a lot of questions that pertain to statistics, the gathering process and what is done with that information once it is so gathered, et cetera. Firstly, what is your total annual expenditure across Australia?

Ms Evans—For the money that the office administers?

Mr HAASE—Yes.

Ms Evans—Only a small proportion—a minority proportion—of the money that goes into Aboriginal health, but our total budget at the moment is $180 million. I can get you the exact figures.

CHAIR—Do you mean plus mainstream?

Ms Evans—This is purely the budget that the office administers, yes.

Mr HAASE—So for Aboriginal health we have additional moneys contributed from the states and territories?

Ms Evans—Yes.

Mr HAASE—For Aboriginal health, a proportion of mainstream funding would be contributed to the improvement of Aboriginal health—non-specific mainstream services that provide some measure of service to Aboriginal people as part of mainstream?

Ms Evans—Absolutely. The bulk of services are probably provided through mainstream services—hospitals, tertiary, secondary care, as for all Australians. Aboriginal people use those services, yes.

Mr HAASE—I accept that it is basically anecdotal, but the perception in Australia today is that Aboriginal health is no better than it was 20 years ago. Because I have a rather unique electorate similar to but double the size of Mr Snowdon's—

Mr SNOWDON—It's a long way between Darwin and Christmas Island.

Mr HAASE—I have a great concern that, firstly, the perception exists and, secondly, that we seem to have no ability to change it. I would very much like your answers or comments to give me a better picture as to what the stumbling block is. You folk are those who would have an overall view of the situation of indigenous health. You may take to task the statement that Aboriginal health has not improved. If you can do that, I would very much like to hear what you have to say on it. The fact that the perception exists I think is a huge blight on Australian governments generally, and I would like to see it change. I wonder whether you can identify a particular hurdle that we are seemingly impotent to overcome. So that you can run on from that, I will ask a second question: would you like to give us, in a practical way, some demonstration of some successful program—something that you would like to advertise here that has been a

move in the right direction—that, for a given amount of funding got a great result regarding improved life expectancy, et cetera?

Ms Evans—I agree with you that there is a perception that nothing has changed in the last 20 years. I do not think that is a correct perception. There have been improvement. There have been improvements in infant mortality and childbirth weights, and there have been improvements in areas of infectious disease, et cetera. There have been areas of improvement, but overall the macro statistics are not positive. I think they disguise areas and regions where things have improved, but undoubtedly Aboriginal health is very poor and it is significantly poorer than the rest of the Australian community.

I am sure you are all well aware of this, but there are a number of factors that impact on the health of all of us, not just the availability of health services, and the core business of this portfolio is health services. There are issues around socioeconomic status, there are issues around alienation, education and employment that will all have an impact on people's health or their capacity to look after themselves. Our core business is focusing on health services, and there is plenty of evidence both internationally and locally that, if people access primary health care services that meet their needs, they can get an improvement in health. Undoubtedly Aboriginal and Torres Strait Islander people have not used the health services that the rest of Australians use, though some do. As an indicator of use of services, if you look at the use of MBS—the payments that go significantly to GPs, and to specialists even more so—despite their perhaps three or four times worse health, Aboriginal people use them at about a quarter of the rate. If you put that next to the use of hospitals, there is a disproportionate admission to hospitals by Aboriginal people, and often for conditions known as 'ambulatory sensitive', that should be dealt with by primary health care services. So what we are focusing on is trying to ensure that there are primary health care services that meet Aboriginal people's needs and that they are services that they will use. That is the major focus of what the office is doing.

You asked about successes. Yes, I think we have had a number of considerable successes. I will ask Mary to talk about the coordinated care trials, which are probably the best documentation of where putting in resources has actually made a difference. If you put in resources and you work with communities, you can make a difference.

CHAIR—Just before Mary does that, I would welcome a couple of examples. Also, on notice, could the department provide details of the last three years of programs where they have identified benefits? I realise Mary cannot cover them all now, but I would like to have a comprehensive list.

Ms McDonald—There were four Aboriginal coordinated care trials that were set up as part of the overall coordinated care trials across the country. Instead of focusing on particular sick individuals within communities, they had an all-of-community focus and looked at providing appropriate health care services as well as ways in which they could improve health outcomes through a broader range of population health programs, working with individuals around care planning and initiatives to improve individuals' health and also looking at community based planning for initiatives that might improve community health as well.

The four Aboriginal coordinated care trials were in the Tiwi Islands in the Northern Territory, Katherine West in the Northern Territory and there was a twin site in Western Australia—Perth-Bunbury and Wilcannia. Each of the trials was different, but they had the same sorts of aims.

Mr HAASE—If I may interrupt you, it is very important that you put into the evidence that those four you have named are extremely different. They probably would be a sample of the extremes of Aboriginal environment. Would you agree with that?

Ms McDonald—That is correct, yes. The trials were funded jointly by the Commonwealth and state governments and involved pooling of funds. They also involved additional resources that were provided by the Commonwealth in lieu of MBS and PBS because those systems did not work very well for Aboriginal people. For the mainstream trials there was a cash-out of existing MBS and PBS arrangements, but those Aboriginal communities only used MBS and PBS at a fraction of the amount that the general population did and it was seen that there just would not be enough health resources in the system if you did not supplement those with some additional funds.

The trials ran for various periods of time. We have a short paper in the submission, which tells you a little bit about the trials. The national evaluation report of those trials is about to be released. The local evaluation reports have been released in most of those sites. The national evaluation report is about to be released. Overall, the outcomes were very positive. The trials themselves increased the amount of health services available in the areas. There were signs over the time of increased community and individual involvement in health, and there were also signs of tailored programs that the communities took responsibility for that were implemented as part of the program.

As far as outcomes are concerned, a number of the trials did health assessments on their populations and detected levels of disease that had not been detected before, which meant that people could then been provided with appropriate health services so that the conditions did not worsen because they were picked up early. Immunisation rates for children were increased across a number of the trials, thereby the preventing the risk of diseases later on. In a number of cases there were issues that were outside the health system that were identified as affecting health status, and action was taken by communities to address some of those issues. For example, in Katherine West the community identified nutrition as a key health issue. So, through the trial, plus some money that came from the stores and other places within the Katherine West community, a nutritionist was employed. That nutritionist works with the stores to try to increase the accessibility of healthy food and works with mothers' groups and with special groups like diabetics around appropriate food, which over the longer term should help improve health outcomes. There are a whole lot of examples like that. We expect that report to be released soon, certainly during the time that this group is considering its work. As soon as it is available we will give you a copy.

CHAIR—Would you mind if I just added something in context here?

Mr HAASE—I would like to put a bit on the end also.

CHAIR—Would you forward to us that report as soon as it is available?

Ms McDonald—Yes.

CHAIR—Would you mind giving us a summary at that time, or before if you are able, of the steps along the road that led to that initiative being taken? What we are trying to do is to show other communities in Australia some examples of how a problem can be tackled, properly strategised and solved to try to get people to believe in themselves.

Ms McDonald—The other thing that is important is the capacity building steps that take place. It is not a matter of just coming in and putting health services on the ground—there is a long development process in working with the communities, having services that people can and will access, and ensuring that people have ownership of the issues and have local solutions to them. That was one of the keys of the trials. It took a long time to get this. You had what appeared to be not a lot of action while all these processes happened in the beginning. Even during what was called the live phase of the trial, a number of the trials where those community processes were happening did not see action on the ground and results until much later in the process. It was critically important that those things happened along the way to the success.

Mr HAASE—There are two things directly in the vein of what you are saying: from the department's point of view: was there any additional resource required on an ongoing basis? Did you need to supervise very closely or any such thing?

Ms McDonald—Certainly there needed to be partnerships between government and the community. The communities also needed to buy in professional expertise to help establish the trial. In the case of Katherine West, because of the language and cultural differences for the very disparate communities there, they also employed a community interpreter who was able to then break down the government processes and very Western society health issues into language and symbols and things that could be used to work with communities and to explain to them about these in a different way so the communities could understand some of that information. So there were a whole lot of processes like that. On the issue of strong support from governments, both Commonwealth and state: project officers from the Commonwealth work closely with communities, and the same for the state governments. In the case of the Northern Territory, they actually set up a small unit where they provided a lot of professional expertise to the boards. The health boards also employed their own CEO and had their own management structures as well.

Mr HAASE—Finally, and only if you have experience with this factor, could you comment on the veracity of installation of swimming pools and the supervision thereof in communities, especially remote communities?

Ms McDonald—No, I cannot.

Ms Evans—In Western Australia they have certainly had an initiative with a number of swimming pools, and that is being evaluated through the child health research unit there. I could inquire and find out for you where that evaluation is going.

Mr HAASE—If we may, that report would be greatly appreciated.

Ms Evans—I think that your point, Mr Haase, about people's perception that nothing changes and that nothing can change is a real issue and of real concern. One of the things we have done in the last 12 months to try to turn around that view is to do an extensive search of what reputably researched and documented information there is on projects, services, et cetera, that have made a difference and achieved success. There is not a huge amount of material around, but we intend to produce that. We have some really very interesting and useful documentation of different projects and services where things have happened and things have changed.

Ms McDonald—From that, we have been able to draw out a list of critical success factors—that is, the sorts of things in the health area that make a certain service or an approach successful.

Mr WAKELIN—Are you prepared to make it available?

CHAIR—The chairman is hungry for this information. I think it would be useful if we could get it and share it with you. Would you be able to help us in relation to that?

Ms Evans—I think so, yes.

Ms McDonald—Yes, we are pulling together the material now. There are certainly some examples from that study that should have been checked and that we can give to you soon. As soon as we get the other material together in a form that has been checked and ready to go out, we will get that to you as well.

Ms HOARE—You might need to take this on notice. I go back to your comment—I think it was you, Helen—about the large disparity between Aboriginal and Torres Strait Islander people accessing general practice services as opposed to self-admission into hospitals. You would be aware that there has been a trial at Maitland public hospitals with an after-hours GP service that is being provided up there, and I think it is sponsored by your department?

Ms Evans—Yes.

Ms HOARE—Has there been any data collected from that to see whether Aboriginal people in that area are, firstly, accessing the service; and, secondly, taking that extra load off the emergency part of the hospital? Could that be a proposal? I am talking about urban areas where there are big public hospitals and emergency after-hours type places. Would you see that as an avenue for delivery of more appropriate services to Aboriginal and Torres Strait Islander people if they are not going to go into a stark white waiting-room type area but are more comfortable going into a busy hospital type area?

Ms Evans—I will have to take on notice the question about the Maitland after-hours project, which I am aware of but I do not have data on, and follow it up. I think the same factors that inhibit Aboriginal and Torres Strait Islander people from going to private practice GPs in their suburban surgeries are likely also to impact on their not using after-hours programs. But that is just a comment off the top of my head.

Ms HOARE—But the after-hours program at Maitland hospital is a service which either they go into hospital emergency services or they get attended by a GP.

Ms Evans—Yes.

Ms HOARE—So they would be directed rather than—

Ms McDonald—There are some good partnership projects happening around the country with local GPs working in partnership with Aboriginal communities and Aboriginal health services to improve access to GP type services. There is one on the south coast which appears to be working very well. One of the key issues was not just about the way doctors reacted and their ability to work with Aboriginal patients; there were also issues around the receptionist. Quite often Aboriginal people did not make it past the receptionist, so it was seen in a lot of cases there was a need to work with the communities and also the receptionists—to train them as well.

Ms HOARE—Was that done through the division?

Ms McDonald—It was a combined program with the divisions of GPs working with the local Aboriginal health service.

Mr QUICK—The incarceration rate of indigenous people is 14 times greater than in non-indigenous society. I visited Goulburn jail last Monday and saw what was lacking. Health in jails is a state issue, and there are state health and correctional services. Is there anything in the framework agreements to ensure that someone is doing the right thing not only looking after the health of the indigenous people in jail in light of the deaths in custody but also establishing post-release mechanisms to ensure that they are not coming back in again? You might need to take that on notice. I think it is a real key issue.

Ms Evans—To answer your question about the framework agreement, yes, health of Aboriginal prisoners is identified as a priority area. It is a big issue. It is hard to take on board because it is not only a state responsibility but it is not largely a state health department responsibility. However, we have just recently funded a scoping exercise to document what is happening in prison health services. At the meeting of AHMAC, it was identified as a priority area for further progress. If I remember rightly, South Australia and Victoria have taken it on as an area they are going to progress.

Mr QUICK—I would be interested to get some evidence on what the other states are not doing. I have two other questions. Obviously indigenous people do not live to a ripe old age and do not go into hostels and nursing homes like the rest of us will end up hopefully doing—touch wood. What sort of flexibility in aged care packages is there? If they get to 50, they are old. What sort of flexibility is there in the system. I have been out to Coober Pedy in the middle of nowhere.

Ms McDonald—There is some flexibility in the system, but the details of that we will have to take on notice. Certainly there are things like a lower age limit for accessing aged care subsidies for Aboriginal people, recognising that, while in terms of number of years of age Aboriginal people are not old, the ageing process takes effect on their body earlier and quite often they require some of that care earlier than the general population. There are also a number of flexible packages and high use of community care services, as opposed to nursing services, by Aboriginal people. I can get you some information from our aged care division on that.

Mr QUICK—And on the linkages between home and aged care, HAAC, and the state government in the provision of such services, we visited some areas where they wanted to set up nursing home/hostel type establishments, and the rules and regulations had to be so flexible—

Ms McDonald—There are some flexible multipurpose services that we fund in conjunction with state governments. Where there are not enough residents for either a nursing home or a hostel, you can have a combined facility with Commonwealth and state money. Quite often there are those sorts of facilities in a number of remote areas.

Mr WAKELIN—In fact, Coober Pedy is embarking upon such an exercise at this time.

Mr QUICK—My last question goes back to the framework agreements. One thing we discovered was that there was a lack of appropriate allowances for recruitment, ongoing training and the provision of services for staff in many rural and remote areas. We even saw examples of nurses living in shipping containers. What is the Commonwealth's role in saying, 'Okay, how do we up the ante to give them better pay, ensure that they have adequate accommodation and, if they are out in the middle of nowhere, how do we link them into training programs?' These people are doing the hard yards compared with those in the CBDs. What is the Commonwealth's role there? Is that part of the framework agreement? If you are at Ernabella or Yuendumu or Docker River, you are doing the right thing and earning lots of brownie points, but you should not be punished with it impacting on your ability to get up to the top level of whatever it is—doctor or nurse or specialist.

Ms Evans—The AMSs we fund to have global budgets, and we do not set any rules about salaries. I think there is an issue about adequacy of core funding to ensure that they can provide salaries that will attract and retain people. Undoubtedly, they have to be competitive so that they can compensate people for going out to remote areas, and that is an issue of the size of their core funding.

In terms of housing and accommodation, that is a huge issue. We have done an infrastructure audit of all our services. Not only were many of the services that we took over from ATSIC poor—the clinic buildings were ageing—but, as you say, housing was often not available or completely inadequate and, if you are going to expect staff to come and live out in remote areas, they need to have adequate housing. We have progressively put in place replacement, or building of, houses in those worst areas. I hope that we do not have anybody living in containers any more. I know that they certainly did have some on the lands for a while. We have provided funding for all of those at Nanapurjura place. But we do not have a capital budget, so we are doing it as we go along.

Ms McDonald—We do the replacement and the upgrades. We made the first priority the fixing of the worst of the problem. So the clinic roofs that were falling in and, as you say, people living in shipping containers: just fixing those most urgent issues was our top priority.

In relation to any new services that we are putting in place, we are doing some work on the next steps from the Aboriginal coordinated care trials. We have a program called the Primary Health Care Access program that is based on the needs identified through the regional plans. We are working with the communities there and with state governments to set up similar sorts of

models of expanded health services. In those areas, one of our top priorities is making sure that a lot of the preparatory work around availability of remote area housing is addressed, so that staff can be recruited into the area. Clinic buildings: the issues there are looked at up-front as part of the overall planning process for those areas.

Mr QUICK—We all carry our Medicare cards in our purse or our wallet. We were given examples of Pitjantjatjaras wandering across a couple of states. We were given the specific example of there being a death in one of the communities and someone releasing himself from hospital. He was in need of medical care, but the doctor could not prescribe anything for him because he was registered somewhere else. Do we still have that problem? If so, how do we address it? We cannot tattoo them on the arm or the finger to enable them to say, 'Here's my MBS or PBS prescriber or Medicare number.' What is being done to ensure that, if people do wander across territories and states, as quite a few do in the middle, they do not fall through the gap and that they have access to adequate services? There is also the computerisation we have seen in some of the communities where they actually find time to do it; in other cases, the paperwork just builds up and, when they get a spare moment, they start going through it.

Ms McDonald—The Health Insurance Commission at the moment is doing a lot of work with Aboriginal services in trying to come up with better arrangements to ensure that people are enrolled on Medicare and to enable claiming under Medicare. Instead of having to get people to fill out all the paperwork and forms in registering—and there has been a big issue, as I am sure a lot of you are aware, that a lot of Aboriginal people do not even have Medicare cards—another mechanism has been not only picking up on people who do not have Medicare cards and getting them registered on Medicare but also putting in place more streamlined arrangements for claiming. A lot of services are working with the commission to ensure that all the patients they have registered on their system are already registered in Medicare, whether they are registered through another service or not, and there are checking processes and so on happening there. There is also a trial of streamlined claiming processes, which is an issue as well for Aboriginal people, especially where there are issues around understanding what assigning your benefit to a provider means; there are issues around signatures and giving informed consent. So a lot of issues are being addressed there. The issue of moving between areas is really one that means that the person either needs to be reregistered with Medicare or checked against a previous registration, or there needs to be a link made back to their own health services. So communication between services is important in those situations.

Mr QUICK—But in lots of cases with remote communities it is very difficult. You do not just pick up the phone, as you would know, Barry. In trying to get in touch with one community or another, you have to be on the right mountain.

Ms McDonald—I think things are going in the right direction. Not every problem will be picked up at this stage, but it is certainly improving. The access to pharmaceuticals has been improved significantly in remote areas. So, with that issue of having to have a health care card to get access to pharmaceuticals in remote areas, what happens now is that, under section 100 arrangements, pharmaceuticals are available in the Aboriginal health services in a number of state clinics free of charge. So the issue of having to prove eligibility is no longer a major issue in a lot those areas.

Mr WAKELIN—I would just ask for clarification on whether I have this right or not: do prisoners in jails get caught up under the Australian Health Care Agreement, or is that a specific state financial requirement?

Ms Evans—My understanding is—and I will correct this if I am wrong—is that, no, it is a specific state requirement; it is not covered under the health care agreements.

Mr WAKELIN—So all prisoners are directly paid for from the state coffers; there is no Commonwealth money whatsoever.

Ms Evans—That is my understanding, yes.

CHAIR—As there are no further questions, I would like to say that this has been a very valuable time that we have had together. We have touched on some issues about which we will get more information that you have made us hungry to obtain. I commend you all for the work you are doing. I think that the responses you have given indicate that there is a recognition, there is strategy and there is action—which is very healthy and very welcome. On behalf of the committee, I pass on through you to your team our appreciation and our encouragement for the work you are doing. Good luck with what you are doing.

Mr QUICK—Hear, hear!

Resolved (on motion by **Mr Lloyd**, seconded by **Mr Quick**):

That this committee authorises publication of the evidence given before it at the public hearing this day.

Committee adjourned at 5.30 p.m.