
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, 23 MAY 2001

CANBERRA

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

**INTERNET**

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to: **http://search.aph.gov.au**

**HOUSE OF REPRESENTATIVES**

**STANDING COMMITTEE ON ABORIGINAL AND TORRES STRAIT ISLANDER AFFAIRS**

**Wednesday, 23 May 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 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 4.15 p.m.**

**CHAIR**—I declare open this public hearing for the committee's inquiry into the needs of urban dwelling Aboriginal and Torres Strait Islander peoples. As you know, the committee began its inquiry at the request of the then Minister for Aboriginal and Torres Strait Islander Affairs, Senator John Herron. The new minister, the Hon. Philip Ruddock, has also indicated his enthusiasm for the committee to continue its work. The inquiry will assist the government's continued introduction and development of practical measures to help indigenous people. We are consulting as widely as possible, and today's hearing is one of a number that have been conducted around the country. We wish to hear from all interested parties, Aboriginal and non-Aboriginal, in a spirit of cooperation. The hearing is open to the public. A transcript of what is said will be made available. If you would like any further details about the inquiry or the transcripts please ask any of the committee staff here today.

I will introduce my colleagues here today. Mr Harry Quick is the deputy chair, and we have Mrs Kelly Hoare, Mr Barry Haase, and Mr Warren Snowdon. Mr Jim Lloyd has had to go into the House for duties; he will try and join us later. As it is the day after the budget we may be interrupted a bit. I apologise in advance if that is the case and hope you will be patient with us.

[4.16 p.m.]

**COUNCILLOR, Mr Henry, Executive Director, National Aboriginal Community Controlled Health Organisation (NACCHO)**

**DALEY, Ms Lee-anne, Deputy Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (NACCHO)**

**HANSEN, Ms Kirstie, Media Officer, National Aboriginal Community Controlled Health Organisation (NACCHO)**

**HUNTER, Dr Puggy, Chairperson, National Aboriginal Community Controlled Health Organisation (NACCHO)**

**KEHOE, Ms Helen, Policy Officer, National Aboriginal Community Controlled Health Organisation (NACCHO)**

**RITCHIE, Mr Craig, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation (NACCHO)**

**TONGS, Ms Julie, Director, National Aboriginal Community Controlled Health Organisation (NACCHO) and CEO, Winnunga Nimmityjah Aboriginal Health Service**

**CHAIR**—Welcome. 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 the parliament. Hansard reporters will be taking a record, and from time to time we may ask you to repeat or spell place names in order that we can get an accurate record. We have received your submission. We appreciate that very much. Before we ask you questions, you may have an additional statement you might like to make.

**Mr Ritchie**—Thank you. I will make some brief introductory remarks before we answer questions. As you will have seen from the NACCHO submission, NACCHO has a view that urban Aboriginal people constitute a significant proportion of Aboriginal Australia but are often the invisible blacks—and that is a myth that in our view must be exploded. The health status of Aboriginal people living in urban areas is on a par with the health status of those Aboriginal people that live in rural areas and indeed in remote areas. There is a remarkable degree of consistency in the health status of those peoples. One of the misconceptions that many people proceed under is that because there are Aboriginal people who are living in urban areas, and urban areas are deemed to have a wide range of services and facilities, access to those services is not an issue for Aboriginal populations in urban areas. That is just simply not the case. Isolation occurs in different forms and in different varieties. There is obviously geographical isolation, but a population can be significantly isolated within an urban context. That is certainly true for many Aboriginal people who are living in urban areas. So it is our hope and our intention to raise those points and emphasise them in the hearing this afternoon.

**CHAIR**—Just on that, can I record that the minister's request for the committee to undertake this inquiry is recognition of the need for the committee and the parliament, hopefully, and others—the government and other members of decision making bodies—to have regard to the needs of urban dwelling indigenous Australians.

**Mr Ritchie**—Absolutely.

**CHAIR**—I have been privileged to be chairman of this committee for a few years now, and I have been conscious sometimes of indigenous people saying to me informally, 'Lou, we noticed you are doing work in the outback and in the Torres Strait; couldn't the committee come and do something in relation to the urban situation?' It was partly as a result of this inquiry that I spoke with the minister about that and he readily agreed. Yesterday in parliament we spoke about our late colleague, Peter Nugent, who was the deputy chair of the last inquiry by this committee into urban dwelling of indigenous people. So you are most welcome today. We are very keen to hear you and get your advice on the focus that you are talking about.

**Mr Ritchie**—For the sake of clarity, my remarks are not directed at the committee or, indeed, the parliament, but there is a significant view abroad in the Australian community that the Aboriginal people who live in urban areas are somehow not real Aboriginal people. We certainly often experience that in the context of the delivery of programs and the targeting of resources to provide services. I come from an urban area, and I worked for many years at the Aboriginal medical service in Newcastle. We say that with the view that the work of the committee and the findings of this inquiry may help to dispel those myths that may be abroad in certain sections of the broader community.

**CHAIR**—Sure.

**Dr Hunter**—This is an area that we keep bumping into all the time. Dealing with the government system and the bureaucratic system, it is not so much the ministers making decisions about sorting things out. When we are dealing with the bureaucratic system they come to it with that same feeling, 'They are not real black fellas; they are all okay; they are just like me. How come?' We are dealing with that sort of structured thinking inside the department a lot of the time. For instance, someone asked us a while ago if we were raising some of the issues about different places—this is senior people asking us—and whether there are medical services in the cities. We are one-on-one with this department, so we are disappointed that we keep bumping into these sorts of people—and they are not junior, these are senior people. Somehow this myth has rolled through the system and it is corrupting the process that we are dealing with one-on-one. As it corrupts it through the system, it comes out to the ground. In the cities you are dealing with another person, really.

The concept of what is a real Aboriginal and what is not a real Aboriginal is not for someone to decide; it is for the people themselves to know who they are. I have seen welfare reports where they used to tell me I was half of this and a quarter of that, but I do not know how they judged me by looking at me. That concept is still inside the system and it is clogging up our relationships because, as an organisation, we represent all Aboriginal members and our members are made up from the cities right through to the remote areas.

I do not see Aboriginal stats differently. I do not see Aboriginal problems differently. I honestly believe we are all in the same boat. Some of us are just sitting next to an area where you can maybe access stuff, but the reality is we are all in the same boat. The stats tell us that very clearly. The sad thing about stats is that we are only collecting stats from three places in Australia, and I think that something needs to be done. We keep arguing with the bureaucrats and with governments that somebody should be collecting stats in the states and territories. Whoever is collecting stats, I would like to show my appreciation to them in the sense that at least we have got something to talk about, but the reality is that the other states are still receiving money for Aboriginal people and arguing the point, 'We are getting too much' or 'We are not getting enough,' or whatever. The point is that they have not got any data, and no-one is making them collect data.

All Commonwealth stats are built off two states and a territory and the reality of that is just not good enough. Most of us mob live in the Melbournes, the Sydneys and the Brisbanes, yet those states do not even collect data, so you are behind the eight ball straight away. We constantly get told out in the real world that you have got to have data, you have got to have statistics and you have got to have outcomes. So to get those things, we do not know how the Commonwealth does it with us or the states do it with us when there are states that do not collect data. I am confused about that.

**CHAIR**—Would you like us to ask the minister to clarify that?

**Dr Hunter**—Yes.

**CHAIR**—We can do a letter to him. I think my colleagues would support me on that, that we write and ask the minister to give us a briefing on that, which we will share with you.

**Dr Hunter**—Yes, because WA, the Northern Territory and South Australia collect the data for Australia. That is not good enough.

**CHAIR**—We will seek advice on that and share it with you.

**Mr Ritchie**—Thank you.

**Dr Hunter**—The other point in our submission that we keep saying is that we see ourselves as one mob, and we constantly get things chucked at us to break us into pieces. And we know what happens when you break off and go by yourself. We have been there and done that. That is not how we want to address Aboriginal health; we want to address Aboriginal health in a holistic framework. When I have a meeting with my members, as I said, they come from cities as well. So when we are constantly dealing with policies that come out addressing a remote area—it just so happens I live in a remote area—it is a bit embarrassing in a sense. As chair you would like to think you are addressing the whole gamut of all our problems such as programs for doctors to go out and work in these remote areas because some of these towns have never seen a doctor. And there is the structure of who calls what 'remote'. That is another thing we are having a problem with. We are broken up by the ARIA classification which breaks us into pieces. Then the system actually agrees with us under those ARIA processes where someone in some place that is not a bad place is classified as remote. We cannot help that.

So we constantly cannot understand why someone picks some place to be remote, and not this place, when we are talking about one people. That is what we have got a problem with. Just like the states: they break us into pieces all the time. So we see ourselves as one mob with one problem. We make up 2½ or two per cent of the population. Honestly, if 98 per cent cannot fix the two per cent, something is wrong with the 98 per cent. That is really where the problem lies: it is how that 98 per cent relates to us as trying to sort some of these things out. If you are broken up into 'remote' under the system, you cannot look at one another as one because you have to go and get a program to suit that system or another system. It is a headache, honestly.

**CHAIR**—I have asked Harry to lead the questioning because of his great involvement in the inquiry into health. Barry Wakelin, one of our colleagues, may join us—he was the chair. It is a great pleasure for me to have the expertise of Harry and Barry. I am now going to ask Harry to lead the questioning.

**Mr QUICK**—We have been talking about statistics and who is responsible for what. Recommendation 33 in the *Health is life* report—and it is interesting that we have now got the government response—

**Dr Hunter**—Yes, I have not heard it yet.

**Mr QUICK**—It is interesting to note that, under 'Research and data collection', recommendation 33 in the report of the House of Representatives Standing Committee on Family and Community Affairs recommended that:

The Commonwealth pursue initiatives to improve the collection of data on Indigenous health as a matter of urgency. Additional resources should be allocated if necessary to support the process, recognising that in many instances it is a State matter, but that additional support from the Commonwealth must be sufficient to encourage the States and Territories to resolve the issue.

It is interesting to note in the government's response that they talk about NACCHO:

The Commonwealth Department of Health and Aged Care has developed and implemented, in a joint process with NACCHO—

on page 38 of the response—

an annual data collection reporting from services funded by the Department. This Service Activity Reporting is now in its third year with two years data collected. A questionnaire is used to collect service level data on the activities over each financial year. To assist data collection at the service level, OATSIS is providing additional funds to services for the installation of computer hardware and software and for training for the establishment and maintenance of patient information databases.

Could I ask you just how well it has been going for the two years—whether the resources are adequate?

**Dr Hunter**—Honestly, we have been holding our breath for this budget and it looks like we have got to hold it a bit longer.

**Mr QUICK**—On page 38, it says:

(It) is now in its third year with two years data collected. ... To assist data collection at the service level, OATSIS is providing additional funds to services for the installation of computer hardware and software and for training for the establishment and maintenance of patient information databases. Also, each service receives an individually tailored report back on how that service compares to the national average.

**Dr Hunter**—That is right. Yes, we have been collecting data for almost three years now. We are just rolling out the next. We do not want anyone to stop it. That is the whole point about collecting data. They told us that we have got to have data for them to make decisions and this is the first time ever—

**Mr Ritchie**—Resource decisions.

**Dr Hunter**—Yes, resource decisions; that is the real word, not a couple of computers to collect more data. The point was to see where the gaps actually are between the states and the territories. In a sense, it was part of our plan because we have all done plans out there as well. This is another thing we have all done—planning. We have been planning for the last three years as well. But if you go back a bit further, before the three years, we had another thing called rebasing. We still do not understand what it means in the long term but it was supposed to find out where there are pieces where you can shift a bit around and make things work. That caused some dilemma with us around the country because some of us lost money and some of us gained money, so it was robbing Peter to pay Paul as far as we could understand. All this time we had salary increases and we were supposed to find it within our budgets somehow.

Then we had the service activity. We were part of that. There is no doubt about it because we were sold on the idea that we had to have data. So for the last three years we have been waiting for those. There was one lot of money put up through the last budget and now they are breaking that budget down from the $78 million, I think it was. That has got to be broken over five years. We have not seen a roll-out of any money. We have seen small bits coming through but not to what we call our regional plan. So we have got all these regional plans sitting out there and we are wondering what we are going to do with them.

**Mr QUICK**—Allied with that, our recommendation 35 from the Family and Community Affairs Committee in *Health is life* said:

For the next five years, the Commonwealth ensure that the National Health and Medical Research Council allocate at least five per cent of total annual research funding for indigenous health research

The government's response on page 40 is:

To this end the Aboriginal and Torres Strait Islander Research Agenda Working Group RAWG, a working committee of one of the National Health and Medical Research Council's principal committees, the Strategic Research Development Committee, was established as a joint initiative between the National Health and Medical Research Council and OATSIS in 1997.

So what has been happening from that?

**Mr Councillor**—One of the things we wanted to highlight during our partnership with the government was needs based funding, and that was to look across the board from a rural, remote and urban perspective. One of the things was how we can do that jointly and establish a central database system that would identify those areas. One of the things we looked at quite seriously

in terms of the urban areas was the lack of resources going to health services and the lack of infrastructure to support that mechanism. Developing this database system in joint partnership with NACCHO and OATSIS was not only to identify statistics of patient intakes and client presentation but also to identify infrastructure in terms of a doctor's space in a consulting room or the capacity of a data input clerk in terms of number of hours. All of this, in joint partnership, was supposed to be developed.

Unfortunately, no more than two weeks ago we found that some of the information that had gone into the system was incorrect. That was not the fault of anyone. It was just an oversight. We need to go back into that and restructure that. But the data that was collected is basically true and correct raw data which is still in the hands of the joint forum. One of the things we had to look at was what allocations could be distributed to research in terms of real and proper and true research and what the output from that research would be.

That led from what Puggy talked about earlier with the rebasing. That again was a joint agreement that NACCHO and OATSIH would look at rebasing to find the core cost of establishing or funding our Aboriginal health services and for its access to services. That is where we led off from. It was supposed to be reviewed in 1999-2000 and then re-established. But that has not happened as yet, and I do not know why.

**Dr Hunter**—The finding from the service activity reporting—which is a good thing for us because we constantly get bombarded that we are duplicating state governments—is that no state government does anything like we do. So this whole myth about our duplicating has gone out the door. That has been put to bed, because no-one does the sort of stuff that we participate in. If you look at the data, you will see even a small service with a small amount of money is identical with a big service with another small amount of money trying to do similar things—picking up people, running around the service, making sure the medication is right, following up. It is quite funny in that I did not think that it would come out that way but it does. It reflects quite clearly that, from the smallest one to the biggest one, we are unique in the sense that we do the same things but in different areas.

One of the biggest areas that is bothering us really badly, because we cannot make any sense out of who is responsible, is oral health. We went back to the government to ask if we can have it under Medicare because we think that the teeth are part of your body, so we should be getting oral health under a Medicare number. We were told, 'We are not going to pay for everybody's teeth.' So I thought, 'Oh, well, that is another part of the body that we throw away.' Yet the states were told that they are responsible because the Commonwealth is not responsible any more. I can tell you that no-one has picked up the issue of oral health out in the states and territories. We are still pulling teeth out with pliers.

**Mr QUICK**—Can you tell the members of the committee the link between OATSIH, NACCHO, ATSIC and state or territory governments? You have four key players all with interests, hierarchies and funding bases. For the people at, say, Docker River what does it mean? They do not care who is funding it as long as they get a service, they have a nurse and they have Royal Flying Doctor Service access into the Docker River. If the road is impassable, then at least if you have got a broken back someone can look after you and fly you out. You have OATSIH, NACCHO, ATSIC and the Northern Territory government, for example. How do they

all work to ensure that urban Aboriginals in the Northern Territory are looked after; or doesn't it work?

**Dr Hunter**—The signing off of the framework agreement was supposed to be the planning. From NACCHO's point of view we live and die by the framework agreement because we do not go around signing things every day, and that is the only thing we have signed across the states and territories. Those agreements are really important to us, but we are the ones with the health problem; we are the ones with no money; and we are the ones who cannot impose any penalties on people who don't do things. So you are in a sense left in the lurch because you are the weaker partner. This partnership does not really make much sense when the state constantly has the out to go off and do what they want to do.

We do work with OATSIH across the board. It is always the same old story about 'That's historical funding', 'We can't make them do anything' or it is the constitutional thing. We are supposed to be Australians, that is what I thought, but the things that stop us gaining access are these so-called constitutional things, historical funding and good mates. That is how I see it. There is nothing else to stop me understanding anything different.

**Mr QUICK**—Our recommendation 7 stated:

> The Commonwealth ensure that the provisions of the Framework Agreements are incorporated into the next Health Care Agreements ...

They are being negotiated now or might be even signed off. We sought to have some sanctions in there such that, if any of the parties who sign the framework agreement do not meet their obligations, there ought to be some sanctions?

**Dr Hunter**—Yes, that is what we say.

**Mr QUICK**—Otherwise, if it does not have teeth—

**Dr Hunter**—There is no sense.

**Mr QUICK**—It is not a worthless piece of paper, but it is something you hang up on the wall and people are falling through the cracks. We have a mutual obligation in lots of other Commonwealth departments, and when there are breaches there are punishments.

**Dr Hunter**—We are aware of punishments; we know that; and we live in that area. It is like: we will tell you what to do but do not do what we do. Sometimes that gets on your nerves, because you see things just falling down. What is this last consultancy that they have just done around Australia—and they have to go back and talk to the Aboriginals now? This is what happens.

**Ms Kehoe**—Improved monitoring of entitlements.

**Dr Hunter**—Yes, improved monitoring of entitlements. The government paid some consultants who went around and talked to all the white people. Then they realised that we were here and then they asked if we wanted one of their kits. That is not good enough. That is what I

mean about people not understanding that we are a major part in this area. We are a major player in providing health services. Last year alone, just through our service activity, we have seen 1½ million episodes of care. That is only counting one episode of care every time someone walks through the clinic; that is not counting how many times someone might have picked someone up, seen a social worker, seen a health worker or seen a counsellor afterwards—we have not counted that. So just on our services alone we have seen over 1½ million people. So that makes us a player, as far as we are concerned, for our people when nearly 98 per cent of our clients are Aboriginal.

**Mr QUICK**—I have one last question. It states on page 13 of the government's response, and I am not being political here:

Lessons from work in areas such as the Aboriginal Coordinated Care Trials—

which I think have been working well—

the development of Regional Plans and the development and implementation of the Primary Health Care Access Program (PHCAP) will help inform the development of future funding arrangements.

Can you enlighten us as to what lessons we have learnt from coordinated care trials, regional plans and the primary health care access program?

**Dr Hunter**—I will talk on one on them, and Craig or Henry will speak on the others. The one I have always been harping on about is coordinated care. We have always had an issue with the coordinated care and they always ask me why I complain about it. One of my complaints is that they cashed Aboriginal people out at the national average. Even when they know that the level of disease and suffering and the death rates of Aboriginal people are so high, they would cash us out at the national average. The national average to us was an increase, so that is how importantly we must take that. The national average was an increase to the ones that went into the coordinated care trials. First of all, you gain more money because you come up to the national average. We were a bit confused about why they actually cashed out the white people at six times the national average—that is what we could not understand. We still do not understand that. Every time I mention that, they tell me that I should not talk about it. But that is an issue with me.

**Mr QUICK**—Who is they?

**Dr Hunter**—Government, the bureaucrats. I talk about this at the health council. I mention it all the time. It gets in my craw.

**Mr QUICK**—Whereabouts do they cash out the white people you are talking about?

**Dr Hunter**—In North Sydney.

**CHAIR**—Who cashed out?

**Dr Hunter**—The Commonwealth.

**Mr Ritchie**—There were Aboriginal coordinated care trials and there were mainstream coordinated care trials. One of the coordinated care trials in the mainstream sector was based in North Sydney, where people's cash-out figure was six times the national average use of Medicare.

**Mr SNOWDON**—They are richer up there.

**Mr Ritchie**—They are sicker, probably.

**Mr SNOWDON**—They are sick of carrying their wallets around.

**Mr Ritchie**—And for Aboriginal people the cash out was at the national average. The aim that was put to us was that, because there is no identifier of aboriginality in the Medicare database, it is really hard to measure Aboriginal people's access—or lack of access—to funding under Medicare. Then because there was no accurate way for us to do that we had to settle on a figure, so the national average seemed to be the most logical one—never mind that Aboriginal people tend to be probably three times as sick as the national average. So that has been a particular issue for Puggy for some while.

**Mr QUICK**—Where was the primary health care access program operational?

**Mr Ritchie**—The primary health care access program is an old budget measure. I think in 1999-2000 there was $78 million over four or five years; and there was some additional funding to that in last night's budget, and that was linked to regional plans. As Puggy said, our services have been involved in developing regional plans for the last two years since that budget measure was introduced.

As I understand it, it has been rolled out to some extent in Central Australia and South Australia and, according to the information I got from the department last night, in some places in Queensland. But, by and large, regional planning processes are completed around the country, as I understand it. There is some confusion on our part as to how that is going to issue in either strengthening the Aboriginal medical services that currently exist or extending the network of community controlled health services through that program, notwithstanding the increase in last night's budget, which is a pretty small increase.

To take an illustration—and this flows on from the rebasing—the medical service that I worked for and ran in Newcastle had a service population in the order of 10,500 to 11,000 Aboriginal people. For the purposes of applying for additional funding from OATSIH, we worked off the figure of 10,000. We had, at that stage, four Aboriginal health workers funded by the Commonwealth—four positions funded in that medical service. That is one Aboriginal health worker for 2,500 people.

We are getting briefed by members of the department on Friday about how this is going to roll out and how it is going to work, but we have participated in the regional planning and in the service activity reporting. As Puggy said, that reporting shows that we deliver 1½ million episodes of health care, we have an active client population in our service sector of 300,000, and we are the single largest employer of Aboriginal people in the country—that is excluding CDEP, because CDEP is not an employment program; they are not employers; they do training

and all that sort of stuff. Next to CDEP, the National Aboriginal Community Controlled Health Organisation is the largest employer of Aboriginal workers in the country. That is what the service activity shows, but what it does not show and what it has not issued in is real increases in resources to identify the gaps.

In fact, the Commonwealth has been a bit shifty about that because when the SAR was being talked about they talked about a thing called reciprocal accountabilities. In other words, a formula was worked out that in a given population size, with X number of episodes—they were called 'occasions of service' in those days—you ought to be resourced at this level. And there was a commitment on the part of the Commonwealth that, in exchange for us providing this information and helping measure the gaps and identify where resources were needed, they would come to the party. The legal branch said to them, 'You cannot say that, because you cannot make commitments against future appropriations.' So they have moved away from that and there has been no movement on the SAR. In fact, it is only in the last 12 months that individual service reports from the first round of SAR, three years ago, have been sent back to services to say, 'This is what your information showed us three years ago.' That was based upon a misunderstanding on the part of the Commonwealth of the resource allocation formula that was contained in the SAR. So there is a bit of reserve on our part when looking at some of those measures, particularly in primary health care access and regional planning and how it should roll out. Sorry if that is a longwinded answer to a short question.

**Mr HAASE**—There is a lot to ask about and a lot to answer. Generally, your submission and your opening statements today make much of the fact that we are looking at urban dwelling Aboriginal people. I do not think we ought to apologise for that. Quite specifically, our brief was to study urban dwelling Aborigines. I can understand and accept quite readily your point of view that the problems for medical services and health of indigenous people are equally a problem across the country. I accept all of that. But I have not absorbed from your submission any particular detail about what it is that is more inadequate with regard to urban services provided, and I include all mainstream services in urban situations as well.

In detail, can you give me some practical examples of where the urban facility for medical attention is not serving your people? For starters, I would expect that there would be more GPs in urban areas who would provide a standard service, for instance, than would be available to people in remote areas. Can you answer that for starters?

**Dr Hunter**—The point that we need to put to bed as well is that, with the House of Representatives committee when we travelled around, while there were GPs in these towns they do not bulk-bill. That is another issue again. You can have 20 GPs in this town but, if they do not bulk-bill, then they will not see anybody. That is the decision that the GPs make. We saw that is what has happened in a lot of towns when we went around. People had to travel over 100 kilometres to go and see a doctor in another town who was bulk-billing, because the doctors in this town did not want to bulk-bill or they had a selected clientele—they are very clear on who they see. That is how the system works. While there seem to be a lot of doctors in a town, a lot of doctors do not bulk-bill. There are lots of areas like that.

**Mr HAASE**—Let me reiterate or focus you on the point of my questioning a little more. Perhaps we should define 'urban'. Are you talking about large regional centres or are you talking about metropolitan areas surrounding capital cities? Because I would expect to find more bulk-

billing GPs in urban areas of capital cities than I would expect to see in remote areas. That is the point I make. You are talking about regional rural centres not having bulk-billing, are you?

**Dr Hunter**—No, this is the issue with the ARIA classification. You might think that is a rural area, but I am telling you that you will find it is not a rural area. It is under another classification. This is what we are having trouble with as well: you might think that some big town is classified as rural or remote. What is that place in Queensland that is a beautiful tourist attraction—Caloundra?—it is under the remote area and is classified as remote.

**Mr Councillor**—When we are talking about bulk-billing of MBS, if you take Bunbury for instance—there are probably eight GPs in the Bunbury region—this is where one of the coordinated care trials was actually run. But they had difficulty starting those trials up on the basis that the doctors were not able to bulk-bill—they chose not to bulk-bill.

**Mr HAASE**—Not one of those eight GPs in Bunbury?

**Mr Councillor**—Not one of those eight GPs in Bunbury.

**Ms Tongs**—Can I give you an experience from the ACT which is much more urban than that?

**Mr HAASE**—Please, Ms Tongs.

**Ms Tongs**—Our people have great difficulty accessing mainstream services here in Canberra. If you look a little bit different or you are a little bit different, it is very difficult. We were in the back of the Griffin Centre, which is in the heart of the city, up until three years ago. What we found there was that we saw a lot of homeless and disadvantaged non-Aboriginal young people. They would try to access the doctors around the city area to no avail. They would be treated very badly. The same happened with our people. If they went into a mainstream service, straight away they would say, 'We don't have any cash or drugs or whatever.' That was the receptionist's first point of contact; that is what she would be saying to these young people. Even in the hospital system, it is appalling. You have to fight every step of the way. It is the system.

I hate to think what might happen to our people if we were not there. There is a real perception that the real Aboriginal people live in the Northern Territory, when we know that is far from the truth. We have an extremely diverse community here in the ACT. We have Aboriginal people from all around Australia. It is not just a meeting place for politicians. A lot of Aboriginal people come here to meet. Politicians, government people and bureaucrats see people such as me or other Aboriginal bureaucrats; they do not see what we see walk through our doors every day of the week. They do not see the devastation of the disadvantaged, the homeless and the people sleeping in the cubbyhouse at Winnunga. It is just terrible, and this is the capital of Australia.

**Mr HAASE**—Is there ever an attempt made to address what you are saying is lack of service and what I am perceiving as discrimination?

**Ms Tongs**—Yes, that is right.

**Mr HAASE**—Is there ever an attempt made by Aboriginal bureaucrats to address this issue as one of discrimination and to take to task the service providers in Canberra?

**Ms Tongs**—No. I feel like the Lone Ranger out there. You try to work with the bureaucrats. You think that you are starting to make some inroads, and all of a sudden the goalposts will move. You try to work with your community keeping them together, and then you have a disaster. For instance, a young Aboriginal man overdosed and went into hospital, and the lack of communication between the hospital and the family was terrible. My staff and I spent three days at that hospital trying to do the job that the hospital should have been doing. Everybody was getting offside with everybody. If the doctor and I had not been there, that could have turned into a very nasty situation. But, if we had been properly informed right from the word go and if the staff in the hospital had communicated with that family, we would not have had that problem. It is a real issue. And not everybody wants to go through cross-cultural training. You cannot teach people in two hours what we are feeling out there, the pain of over 200 years.

**Ms Kehoe**—If I could take up on a point there, it is important to note that the absence of discrimination does not equate to a culturally appropriate service. I think later when you hear Winnunga's submission in detail you will get a better idea of the lack of resources that people struggle against. In terms of resources, if we tried to follow up every case of discrimination, we would be doing nothing else, unfortunately. I have had the great honour of working with Aboriginal medical services only over the last few years. Before that, I had never been inside an Aboriginal medical service. I had lived in Canberra all my life and never seen an Aboriginal person. So for me to go to somewhere like Winnunga and walk in that door and experience what it means to be in an Aboriginal controlled environment and see how that works on the ground, even with very short resources, is the important thing. It is a completely different atmosphere and environment and one that Aboriginal people value very highly in terms of the statistics that Puggy and Craig have been talking about.

Where they have an option, people exercise the option to go to a culturally appropriate service. That is where they feel comfortable. That is where there are Aboriginal faces behind the desk. That is where they know that doctors are working to an Aboriginal CEO and not running the service purely for profit, not that I am suggesting that that is always the case with our GPs. It is just a different world and, just to reiterate that initial point, stamping out discrimination is a very important step, but it does not mean that culturally appropriate services just materialise, because of an absence of discrimination. There is a quantum difference.

**Mr QUICK**—If I can interrupt, the discrimination does not just extend to indigenous people. The chairman of the committee that wrote *Health is Life* was in the Northern Territory the other week on a substance abuse inquiry, and the committee were discriminated against, to the extent that Northern Territory public servants were not allowed to come to give evidence to the committee. It was not until the courageous action of the member for Grey, who stood up publicly on television and radio, that the committee were able to access Northern Territory public servants on the issue of substance abuse that the Commonwealth were funding, which was absolutely appalling.

**Mr HAASE**—I would like to pursue this a little more, because I think the assembled group has a lot to offer. I would like to hear your point of view about the direction we head in the future to solve this problem. It is one firmly held point of view that, if we concentrated on the is-

sue of discrimination rather than on the problems and the barriers created by independently funding culturally appropriate health, in the long term there would be no need for separate statistical data and people would be receiving public health services across the board. I realise, Dr Hunter, that what I am talking about puts you out of a job—

**Dr Hunter**—I would be put out of a job if you do that.

**Mr HAASE**—but I want you to accept that I accept that. I want you to answer this, if you will, in a practical manner. In 50 or 100 years down the track, should we still be belting our heads against a brick wall trying to get funding for specifically culturally sympathetic and appropriate health services independent of the mainstream, or should we have been addressing discrimination on the basis of race, if you like, and making public health accessible to all people?

**Dr Hunter**—There are probably a few points to make on that. The sad part about Aboriginal people is that we were not even allowed to vote until very recently. The reality is we have been with the state and territory governments before and we have suffered under those circumstances before because money has been given to the states and territories. The reason we are alive today is that they have failed. If they were doing their job before and the Commonwealth had put measures and penalties on them before, then we probably would not be having this conversation. But the Commonwealth has never done that. Like I said now, they are still not doing it today. What is going to change—

**Mr HAASE**—Can I interrupt, please. Could you be more specific about whom they are and what it is they have not done?

**Dr Hunter**—You are saying that somehow we are going to get a service off the states and territories. I always say that we live in the states and territories and that is what the whole thing about the framework agreement is, but then you have to think about how come. How come Aboriginal people were left 100 years behind white people? Not me. I have not done that. You have to ask: who made that decision or who made that decision not to bring us along at the same time as everybody else? That was white people. So you want me now to believe that somehow along the road that is going to change and that white people are going to actually take control of this and we will be all happy. It just does not happen, Barry. Those things will never happen. The system had an opportunity of doing that with us and we have the worst stats in the world, considering we are the lucky country. With those sorts of stats in mind and going the way we are going, something has got to change, mate.

We are the ones dying out here, not you fellas. We are dying, so we want to see change. I am sick of going to funerals. I am sick of burying people up the road. I am sick of seeing young fellas die. I had three suicides over three days in the Kimberleys, so that is the sort of stuff that we live with. No white person is going to come along and fix that up. It is us that have to do this with the white person. If we were all looked after from the very beginning, we would not be 100 years behind. Why would someone leave two per cent of the population 100 years behind? Because of racism. That is all I see it as—pure racism. They thought we were going to die off. They were going to breed us out. They tried to poison us. They tried all those tricks but we are still here. This is our country. Why shouldn't we have a say on how our health is handled? It is

our health. We are the ones that are dying, mate. If your mob were dying at our rate, you would probably have the biggest strategy in the world.

**Mr HAASE**—I take that to be an answer—

**Dr Hunter**—No.

**Mr HAASE**—that, no, there will not be an integrated health service.

**Dr Hunter**—No, because we cannot trust anybody. It is up to us.

**Mr Ritchie**—Can I make a comment in relation to that as well. It is an interesting question but it assumes that the only reason that community controlled health services exist is as an alternative to mainstream services that were provided in a culturally inappropriate way, which is not the case. Community controlled health services exist because Aboriginal people, like any group, have a right to exercise self-determination and control their own affairs. Community control in health service delivery in our medical services is an expression of that. So, unless we are going to pursue an Aboriginal affairs policy that is returning to some sort of assimilative process, the answer is no. The reason that the answer is no is that Aboriginal people will remain Aboriginal people who will remain Aboriginal people. They have a right to their own culture and to express their culture in every aspect of their life, including their health service delivery.

**Ms Kehoe**—Also, it is important to bear in mind that when we talk about separate culturally appropriate services we are talking about a small part of the overall health needs of Aboriginal people. We do not have Aboriginal community controlled hospitals and we do not have Aboriginal community controlled operating theatres and hearing centres and everything else. Obviously, it is stating what is apparent to all of us that Aboriginal community controlled primary health care services are a link in a chain and it is important to work with mainstream services as much as we can to ensure that they do meet their obligations to provide appropriate care for all Australians. That is important. But I do not think that can be at the expense of the survival and the absolute imperative to properly resource community controlled primary health care for Aboriginal people. That has been shown to work. It is what Aboriginal people want and it is what Aboriginal people have struggled for and have put in place over the last 30 years, with or without government funding. So I think we need to recognise that for the valuable contribution it makes to the overall health care of Aboriginal people.

**Mr Ritchie**—That, in fact, would constitute an integrated health care system.

**Mr HAASE**—It strikes me, and I recognise the point, that when it comes to specialist care, the mainstream service is quite adequate. Do you see in that the fact that the primary health care is an area that you can, with the basic funding that you receive, readily provide? Do you see yourself going into a specifically indigenous specialist care circumstance in the future?

**Ms Tongs**—I am talking ACT now. Urban Aboriginals have difficulty accessing specialist services and a lot of what we actually do is support people to access those services. They would never be able to go into one of those services on their own. They do not feel comfortable. They get treated badly. They have got no transport. A lot of them have not even got a telephone. I have actually asked doctors to change referrals because the receptionist has been rude to my

staff when they ring up to make an appointment for the client and if they are rude to my staff on the phone, how are they going to be when that client actually gets there? I do not have a problem doing things like that but it is about us being able to support and look after our people and make sure that they are getting properly treated when they do get there.

**Mr HAASE**—I think that has been adequately answered, Mr Chairman.

**CHAIR**—Thank you very much. I think it would be appropriate, at this stage, for Mr Barry Wakelin, the Chair of the Family and Community Affairs Committee, and Mr Quick, a member of that committee, to move and second a resolution that the government response to the House of Representatives inquiry into indigenous health, *Health is life*, be accepted as an exhibit and received as evidence to the inquiry into the needs of urban dwelling Aboriginal and Torres Strait Islander peoples. Agreed? It is so ordered. I have not read it yet but we are looking forward to it. That will become part of the public record for this inquiry. It was made part of the public record yesterday when it was tabled in parliament.

I will quickly come to a couple of questions and then defer to Mr Snowdon. Time is getting on. We have a number of questions that our secretary has suggested the committee members might give consideration to. I am anticipating we are going to run out of time on those. Would you help us, if we write to you with those questions, by providing us with written responses?

**Dr Hunter**—Yes.

**CHAIR**—Thank you. That will cover a number of areas that I know members would like an answer on. I have probably spent about 30 years of my life in trying to foster and develop in regional Australia community primary health care services so I am fascinated to hear the discussion of all of that. Certainly I subscribe to the view, and I can prove it beyond doubt, that the more the community owns, controls and develops community services, the more efficient and beneficial they are. It takes goodwill, partnership and recognition of the priorities that have to be set but it can be done and it works.

**Dr Hunter**—It does.

**CHAIR**—You are not going to have much difficulty persuading me that community primary care services particularly have a huge potential if they are developed. Michael Wooldridge, the doctor in charge of health under the Howard government—which I am a part of so I may be a little biased, but please bear with me—has developed a regional community health policy. I had a little bit to do with that and it is being well received by local communities in my own electorate. One design does not fit all and communities are invited to put their ideas forward. Through a process of consultation the funds will start to flow hopefully, and they are starting to flow. Are you familiar with that policy?

**Ms Tongs**—The regional rural—

**CHAIR**—Yes.

**Ms Tongs**—No, I am not.

**Mr Ritchie**—Is that the measure in last year's budget?

**CHAIR**—Yes, pretty well.

**Mr Ritchie**—Yes. I have some familiarity.

**CHAIR**—That policy is available for all Australians.

**Dr Hunter**—Let me tell you about that.

**CHAIR**—You are not going to disillusion me, are you?

**Dr Hunter**—I had a meeting last week with the Commonwealth. Because I am also the chair of the Kimberley medical services, I called a meeting with our framework partnership in the Kimberley and we had a planning session. We engage with ATSIC, OATSIH and another player we brought in in our area—AAD, which is the Aboriginal Affairs Planning Authority in Western Australia. We brought them in because they also have a lot of say on blocks of land in our area. I can honestly tell you I had a long drawn out argument with the state health department, OATSIH, about that money when it first surfaced. I actually rang my office in Canberra. It was getting rolled out in Western Australia. We never heard about it. We knew about it in the budget. There was no talk with us at the national level on how to go about it. Then I saw a book on Western Australia getting access to that money.

One of my arguments constantly is that, by the time our services get to the trough, the money is all gone. The issue for us was when we thought this money was going to come out for rural areas we put our hands up and rang them up. They said to us, 'Don't you AMS mob get excited about this. This is not for you mob; this is for white people.' I said, 'All right.' This is what we have been told.

**CHAIR**—Dr Hunter, before you go on, can you reveal the name of that person and the position of that person?

**Dr Hunter**—No. We get told lots of things. I can give you a whole book on things that they tell us out there.

**CHAIR**—It is not a trap question.

**Dr Hunter**—I do not want to kill someone off. He is gone.

**CHAIR**—What you just said to me is a very serious matter.

**Dr Hunter**—I understand where you are coming from, but I can honestly tell you that we get told things like this constantly. My argument was: in some areas 20 to 30 per cent of our clients are non-Aboriginal people in the Kimberley. We get the tourist bus pull up and they send them down to us from the hospital.

**CHAIR**—Actually I was going to ask you some questions after Mr Snowdon on that issue.

**Dr Hunter**—We get all these people because someone else does not want to bulk-bill. We are the only bulk-billers in town. We get them all.

**CHAIR**—Time is getting on.

**Dr Hunter**—That is what we were told.

**CHAIR**—Before I hand over to Mr Snowdon, I want to see if I have understood you correctly. You are aware of the Wooldridge Commonwealth—

**Dr Hunter**—I must say there is a change now—sorry; I am interrupting you. They came to me last meeting and told me it is for everybody.

**CHAIR**—That is what I was going to say to you.

**Dr Hunter**—Nearly a year.

**CHAIR**—I will keep this hearing going and I will ask the department to come over urgently and in your presence tell this committee whether what you were told by someone is right or not—I happen to know it is not right.

**Dr Hunter**—I know that it is not right.

**CHAIR**—I was not going to close this hearing today without someone senior from the department testifying before this committee on that allegation.

**Dr Hunter**—Yes. I raised that issue with the Perth office.

**CHAIR**—I do not want to dwell on it. What you are now saying is that you know that that is not the policy—

**Dr Hunter**—I knew that from the beginning because Minister Wooldridge told me so.

**CHAIR**—And that it is available to all Australians?

**Dr Hunter**—Yes.

**CHAIR**—I will hand over to Mr Snowdon.

**Mr SNOWDON**—I have a couple of quick questions. I think what you have been saying is proof positive of the importance of community based health services. I do not think there is an argument there. I am interested in the relationship between primary health care and environmental health and how your organisation and the community based health services based in urban areas relate to questions of housing, infrastructure and other issues.

**Dr Hunter**—That is a longwinded question, but I will answer it the best I can. I am aware of the environmental health stuff. We are well aware of that. In most states environmental health is

that state's responsibility. So it is here and there, honestly. Some of them are mainly on CDEP. So you have got someone running a whole sewerage system, someone who works and gets CDEP. That is not good enough. Those are the sorts of things related to environmental health. Some of us were lucky enough to receive funding through the Commonwealth to cover some of the environmental health funding, but not all of us, no way. The other thing that was annoying for us was that there was the council set up on environmental health. We do not even know who is on it. To do with my argument about environmental health I went off and argued with the new Public Health Partnership. I now chair the indigenous committee on Public Health Partnership.

When we went into this I was tired of arguing with states and territories and local government about environmental health issues. What I did was go back through the public health and looked at the rules and regulations. There is an Ian Bidmeade report, there is a John Scott report. We are all working on the Queensland forum. The sad thing about what I have discovered—I have come back to my executives on this—is that I went there to actually make some laws about public health medical officers, public health in general, and we have got sewage running back on our communities constantly. In the Kimberleys, I have documents about this on my table constantly and in every other place I go where the housing, sewerage and water is not working. There is somehow this belief that ATSIC is going to fix all that with its magic wand—I do not know how.

As to the conditions that I have come across, it is a bit annoying for me again that there are laws out there that govern public health, made by the Commonwealth and the states, but at the end of the day no-one enforces the laws. Those laws are there. There are laws there about water, sewerage, housing, and disposal. I wondered why we could not get these laws enforced. That is really the bottom line. We have come to that now.

**Mr SNOWDON**—Who looks after the advocacy of those environmental issues as they impact upon primary health care?

**Dr Hunter**—We have to take them up separately as we go. We talk to ATSIC, we talk to the Commonwealth, and we talk to the state. We know for a fact that the state is responsible, but—

**Mr SNOWDON**—Each state and territory gets money from the Commonwealth for these purposes.

**Dr Hunter**—We know that as well, yes.

**Mr SNOWDON**—Has there been any effort by the central agencies here—like PM&C, the office of whatever it is called these days—or the minister to bring together those parties who are responsible for implementing environmental health to marry up with the priorities of primary health care?

**Dr Hunter**—No, never.

**Mr SNOWDON**—So there is an essential conflict between primary health care objectives and the maintenance of environmental health?

**Dr Hunter**—Yes, major. We are trying to fix people and they are living in conditions that are just not right.

**Mr Ritchie**—In fact, Warren, one of the things that we found most difficult in the process of revising the National Aboriginal Health Strategy was to get some of the major players involved in the delivery of those environmental health programs at all districts and all levels engaged.

**Dr Hunter**—That is my argument.

**Mr Ritchie**—One of the things that we have strongly put is the question, 'When a health minister for a state signs off on an agreed national strategy, does he sign off and does he bind his government or just his department?' If he is just binding his department, that is well and good, but with some of these problems, the responsibility lies outside health portfolios.

**Mr SNOWDON**—Similarly in terms of education, one of the issues obviously is youth. I know the answer to this but I will ask you anyway. What is the relationship between your primary health care objectives and the educational institutions or the bodies responsible for education services?

**Dr Hunter**—I have tracked it myself by actually getting involved with the education minister and I have chased that through my own area. We actually engaged with the education system, which is something new again—as NACCHO did with our ear trials by convincing them that ears and learning are together. So they committed to support us. They have given us some money to do the trials. But it is just me.

I have raised this at the state level and I have raised our concerns with the federal minister for health—which is why we have stepped, in a sense, off the health council in the national health strategy. Apart from some of the issues about how the thing is written up, I said to the minister, 'Listen mate, I have been sitting on the health council for how many years and I have not once seen a bloke from the water authority come and tell us how we are going to fix the water problem out in Australia with us mob. I have not seen anybody from housing come along to the health council and tell me about how they are going to fix housing. I have not seen anybody talk about education at the health council. I have not seen anybody talk about sewerage and all this sort of thing. Is this the national health strategy for the health department of the Commonwealth, because it is not making any difference to the rest of my mob, and it has not affected how the state brings the housing up to scratch'—none of these things such as sewerage, water and education. It is not a national health strategy.

**Mr SNOWDON**—So there is no national forum which brings all those players together, even at a national level, to coordinate the Commonwealth's responses to these issues?

**Dr Hunter**—As far as I was concerned, that is what the health council was supposed to do.

**Mr SNOWDON**—But is the health council bringing in the department of education?

**Dr Hunter**—No, not once.

**Mr SNOWDON**—Or does it bring in the people responsible for housing?

**Dr Hunter**—No.

**Mr SNOWDON**—Does it bring in the people responsible for roads?

**Dr Hunter**—No.

**Mr SNOWDON**—So clearly it is not working.

**Dr Hunter**—That is my argument. That is why I said: I do not want to do another strategy which looks good. That is why NACCHO stepped off the health council, and we got beaten around the head for that.

**Mr Ritchie**—But we are back on now.

**Dr Hunter**—We are back on. But there are still issues. As I said to Minister Wooldridge: 'How come this mob does not turn up and answer?' When John Howard's mob told us about the whole-of-government approach, I said to him, 'You are not Wayne Carey, you can't kick all the goals. We need all the other players as well,' and there are millions of other players. I went to the state and told them the same thing. How can we talk to the health department and expect the housing mob to talk to them? I used to be on the housing board in WA and I know that they do not talk to one another. They are trying to tell us that they talk to one another. I know government systems do not talk, but they are expecting me to believe that. That is why, going back to Barry's question, I do not trust them. We have got to go in there; we have to make those decisions.

**Mr SNOWDON**—But what you have illustrated is a dysfunctional relationship between the administrative units of Commonwealth government and state and territory governments because clearly if this report, which I have just flipped through—it is a good report with good recommendations—is not picked up by government as a whole and implemented as a whole, then you may as well just put it in the bloody bin.

**Ms Kehoe**—That is right. It is also particularly ironic to see that lack of coordination between government areas, because for Aboriginal communities it is almost an incessant cry that we must have intersectoral collaboration.

**Dr Hunter**—We must be partners; we must be friendly.

**Ms Kehoe**—Aboriginal communities must demonstrate the partnerships. Yet, in terms of modelling that behaviour on the government side, it leaves a lot to be desired.

**Mr SNOWDON**—The issue becomes, though, that if there is no political will—

**Dr Hunter**—Nothing is going to happen.

**Mr SNOWDON**—It will not happen.

**Mr Ritchie**—Recommendations 5 and 6 in *Health is Life* go to that issue. Recommendation 6 goes to how it might be progressed through COAG and all those sorts of things. The response, in my view—not that I am here to particularly criticise the government's response—tends to just give it the flick.

**Mr SNOWDON**—But the point is that you cannot set up NACCHO to be the fall guy for the failure to deliver primary health care and coordinate the environmental, health and education services—you cannot do that.

**Mr Ritchie**—Absolutely.

**Mr SNOWDON**—So there is a fundamental issue here about the structure of the policy, the way in which the policy is implemented, and the integrity of the policy in terms of the coordination effort of the federal government and every state and territory government.

**Mr Ritchie**—There is a point of disjunction when you have portfolio responsibility for environmental health in Aboriginal communities resting with ATSIC and a primary health responsibility resting with the Commonwealth department of health, and it depends on the liaison there.

**Mr SNOWDON**—ATSIC should be at the table every time these people breathe. If they are going to suck in air and talk about Aboriginal health or Aboriginal infrastructure, ATSIC needs to be there, and if it is health, you need to be there. So when they are discussing and deliberating these issues, there is no question that ATSIC is going to take the responsibility for the failure of the Northern Territory government, for example, to put one of its own dollars into housing. But that is what happens.

**Mr Councillor**—That was agreed upon with the framework agreements, and the framework agreements are not working.

**Mr QUICK**—The framework agreements do not have any teeth. If Aboriginal and Torres Strait Islander Health does not have any sanctions, you are wasting your time.

**Mr Ritchie**—We have spent a lot of time working on the performance indicators that state and territory governments sign off on in terms of being in receipt of Commonwealth money. We, as a funded organisation, have performance indicators. If we do not meet our performance indicators, we are breached and our money is stopped.

**Mr SNOWDON**—But not state and territory governments.

**Mr Ritchie**—What happens there? They say, 'We could not implement it because we didn't have sufficient resources' and they get more money.

**Mr SNOWDON**—Not only that, they say, 'We got money from the federal government for the general purpose of health. We will decide where the money goes and how it is spent.' A bit of carrot and stick, direct funding, withdrawing funds from state and territory governments when they are not doing their job would be a bloody good thing.

**Dr Hunter**—The other thing is that local governments have a role to play as well. We try to make friends with them as well. As the chair of this indigenous thing on the Public Health Partnership I have asked for a review on their roles, working out in their areas. You do not have to be smart to go around and see where Aboriginal people live in some of these towns out there, to see the broken down roads and the broken down fences and no lighting. You do not have to go far to see that. They get more money for Aboriginal people because we are classified as a problem.

**Mr SNOWDON**—Thank you very much.

**Dr Hunter**—I have a question. I know there was a review done in 1992. I would like to now what the outcome of all that was.

**CHAIR**—I am not in a position to answer that. Certainly we can convey that question through the minutes of this hearing and I think, without pre-empting it, we will talk about that in our report.

**Dr Hunter**—We never heard anything, honestly. No-one has ever talked to us. This is the first time we have had the opportunity of talking separately about urban areas.

**CHAIR**—I will draw the hearing to a conclusion now—I know we all have to go—with a note we can leave ourselves on. If I understand the position correctly, what you have told us and what you are asking us to take up on your behalf and on behalf of all Australians, is that you do not condemn but you endorse the concept of the framework agreements as further developed and pushed by Michael Wooldridge. You think that is a sound thing to do. I want to study the government's response to Mr Quick and Mr Wakelin's committee; I have not had a chance to do that. I have picked up that you are concerned that the implementation of the framework agreements requires further work and attention and direction.

**Dr Hunter**—It is only coming from us because we are the players that are suffering out of that. I read the government response to the framework agreement as well. They write a good story.

**CHAIR**—I always like to solve a problem or find a way of addressing it rather than leaving it buried. That leads me to then ask whether you agree that we should do what we can to make the framework agreements more effective and accountable to work, and that attention needs to be given to that challenge. Am I on the right track there?

**Dr Hunter**—Yes.

**CHAIR**—I want to ensure that the minister is encouraged to keep doing the things he has been trying to do and not throw out the baby with the bath water. In our report, subject to my colleague's agreement, we would like to come up with some practical ideas, picking up perhaps from the other committee's recommendations.

**Mr Ritchie**—Can I make a suggestion also? One of the things that we have flagged is that, at the national level there is no such formal articulation of partnership relationships. There is no document that defines the partnership at a national level. The framework agreements are state

based and that is right and proper, but at the same time there is the National Aboriginal and Torres Strait Islander Health Council. We are continually getting challenged on approaches that we might choose to take, where the challenge is that that is not really pursuing a partnership approach, but there is nothing that defines and articulates that at a national level. We have suggested and flagged with the minister and the department that the development of such a document at a national level would seem to me to be almost so fundament as to not require mentioning, but it does not exist and it should exist.

**Dr Hunter**—Just to carry on with that so-called framework, the point we keep trying to raise is why we cannot have a bipartisan approach to Aboriginal health. Every time there is a change of government, it does not matter whether you live in the city or the bush, we are zigzagging across the country with Aboriginal health. Honestly, we cannot afford that. With the level of death in our community and the sadness that goes on there, we are tired of zigzagging along because someone else has got another idea for us.

**CHAIR**—This committee has a great passion for addressing that. We look forward—although I will not be here—to the day when the number of inquiries and reviews are not needed. Mr Quick tells me, and I know, that the report was a bipartisan one. So there is something going wrong somewhere. I thank you for informing us. There is one other thing, Dr Hunter, in relation to our previous discussion about the very concerning statement made by some official to you. I will not press you to name that person; I respect what you said. However, I would like to establish for the record that that person was an official or a public servant of a federal or state government.

**Dr Hunter**—Federal. Those people come and go with us, and he is gone. And we will be there longer than him.

**CHAIR**—But I think I heard you correctly when you said, 'But we know that that is not the Commonwealth's policy.'

**Dr Hunter**—It is not the Commonwealth's position.

**CHAIR**—It has been clarified. I would not rest tonight if that were still up in the air, because I would be wanting to be doing something about it.

**Dr Hunter**—We were on the committee that created that thing; this is what is so crazy.

**CHAIR**—Yes. Thank you very much for your attendance here today.

Resolved (on motion by **Mr Quick**):

That the committee authorise publication of the evidence given before it at the public hearing today.

**Committee adjourned at 5.25 p.m.**