AUSTRALIAN SENATE

SELECT COMMITTEE ON THE ADMINISTRATION OF INDIGENOUS AFFAIRS

Submission of the Aboriginal Health and Medical Research Council of NSW

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10th September 2004

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Introduction

On April 15, 2004, Prime Minister John Howard said, when announcing the abolition of ATSIC,

> "Our goals in relation to Indigenous [sic] affairs are to improve the outcomes and opportunities and hopes of Indigenous [sic] people in the area of health, education and employment. We believe very strongly that the experiment in separate representation, elected representation for indigenous people has been a failure … programs will be mainstreamed." Hansard 29382

As ATSIC did not have portfolio responsibility for "*health, education and employment"*, it was an astonishing and inherently erroneous announcement that dismayed the Aboriginal Community. The words of one Aboriginal leader appear most poignant. The late Mr Djerrkura responded

> "For me as a former chairperson, but also in my capacity as an Aboriginal leader, one of the most disappointing aspects of Mr Howard's decision was the manner in which it was made and the language with which it was delivered. In ... classic imperial fashion, without negotiation, without understanding and with little empathy, the great white leader announced that Aboriginal people had, yet again, been a 'failure'. ATSIC would be abolished." Hansard 29382

This was not entirely unexpected in light of Prime Minister's Howard's comments in 1989 when, as opposition leader, he opposed the introduction of ATSIC, stating

> "I think it a very bad step for the long term unity of this country to establish the structure envisaged under the ATSIC legislation. The ATSIC legislation strikes the heart of the unity of the Australian people." Hansard 29384

It would, therefore, be plausible to infer that it has been a long term goal of this government to dismantle ATSIC, irrespective of its performance and potential to achieve positive outcomes. This is borne out by the preferred utilisation of the Office of Indigenous Affairs within the Department of Prime Minister and Cabinet, where its intentions, policies and agenda were often at variance with those of the Board of Commissioners of ATSIC.

The underlying presumption that Aboriginal people are not entitled to self determination is the main contributing factor to the demise of ATSIC. It is this presumption, this attempt to quash the national voice of Aboriginal people, rather than the mere dismantling of an administrative structure, that has stunned the Aboriginal community and creates the unsavoury precedent for the continuing, unfettered dismantling of Indigenous rights. It represents a return to the assimilationist policies of a previous century and an absolute reversal of the progress towards a more enlightened nation seeking to improve its relationship with Aboriginal people. It contradicts the gravity and sincerity demonstrated by the millions of Australians nationally who walked in support of this objective and constitutes an absolute betrayal of the stated sentiment of those who expressed sorrow for regrettable chapters in Australia's past.

This action portrays all the hallmarks of autocratic leadership, not only blatantly dismissive of Aboriginal aspirations and expectations, but also unresponsive to the highest aspirations of the Australian electorate. A perfect illustration of this very point is to be found, again in the insightful words of the late Mr Djerrkura,

> "… the PM walks early and often, but he has never walked for reconciliation. Nor has he been able to bring himself as the leader of our nation to say 'sorry'". Hansard 29384

Clearly, this is the ultimate causative factor in the demise of ATSIC and for the concerted attempts to disenfranchise the Aboriginal voice of this nation, negating any national representation. For as Mr Gibbons, the CEO of Aboriginal and Torres Strait Islander Services (ATSIS), said on June 29, 2004,

> "… there is no intention on the part of the government … to recreate a national representative body."

Confronted by such formidable attitudes, pre-determined conclusions and the reality that ATSIC has effectively been dismantled with the Government's proposed substitute structures for the administration of Indigenous Affairs already in place, we accept the invitation of the Senate to provide a submission on the Administration of Indigenous Affairs, to support the right of Aboriginal people, yet again, to comment on the decision making processes that exclude Aboriginal people determining their own destiny.

a) PROVISIONS OF THE ABORIGINAL AND TORRES STRAIT ISLANDER COMMISSION BILL 2004

Role of ATSIC

ATSIC was championed as the ultimate body enabling genuine self-determination for Aboriginal people, ensuring maximum participation and decision making by Aboriginal and Torres Strait Islander people. There were expectations for it to administer the responsibilities of preceding government structures while ensuring representation and proactive initiatives in Aboriginal affairs.

Ostensibly, it was to provide Aboriginal and Torres Strait Islander representation nationally and to advise the Commonwealth Government on all matters affecting Indigenous peoples. Its functions under the ATSIC Act included, among other things, monitoring the effectiveness of government and agency programs; advising the Minister for Aboriginal Affairs on relevant matters; formulating and establishing Aboriginal programs; regional planning and to provide advice in the development of policy to meet needs and priorities of Aboriginal people at regional, state and national level; **to assist, advise and co-operate with Aboriginal communities, organisations and individuals.** ATSIC also had a role in funding Aboriginal organisations under programs within its responsibility.

Despite the well intended purpose of ATSIC to manifest self-determination for Aboriginal people, this ideal did not endure the rigours of legislative process which further diminished the role of ATSIC to one of mere self-management with an advisory capacity. In more recent years even this advisory role was further undermined by the competing status of the emergent

Office of Indigenous Affairs within the Department of Prime Minister & Cabinet upon which the government became increasingly reliant.

Without executive power, ATSIC was placed at a distinct disadvantage when conflicting positions and advice were being asserted or sought. However, the position of ATSIC has always been vulnerable due to the inherent conflict of being a provider of advice to governments whilst at the same time being an independent advocate for Indigenous peoples' interests with the inevitability that these roles were not necessarily synonymous.

Lost Opportunities

ATSIC was often unfairly *scapegoated* for program delivery deficiencies for which it had no responsibility. The *National Aboriginal Health Strategy Evaluation 1994* also made this point, and, although ATSIC did have responsibility for Aboriginal health at the time, the implementation of the NAHS required a much broader and comprehensive intersectoral effort than was forthcoming from the parties to the Joint Ministerial Forum that endorsed the National Aboriginal Health Strategy recommendations in June 1990. In any event, to dismantle ATSIC on the pretext of improving service delivery is a flawed argument given governments have always had these obligations and the responsibility and capacity to meet any deficiency rather than have ATSIC unfairly lambasted as the agency responsible.

However, one important role that ATSIC was empowered to fulfil was monitoring the effectiveness of all Government agencies and departments. This, regrettably, was either minimal or totally absent and precluded the opportunity for ATSIC to be at the cutting edge of all Aboriginal programs across the broad spectrum of services to Aboriginal people.

There would appear to have been no comprehensive and adequate internal administrative structures and processes in place to effectively enable the Board and Regional Councils to undertake this legislated requirement. It would appear that government departments exploited this undeveloped capacity of ATSIC and avoided any monitoring of their program deficiencies in Aboriginal Affairs.

This was compounded by the absence of functional relationships with state and territory governments apart from limited scope in formal agreements relating to specific areas of responsibility. For example, the Aboriginal and Torres Strait Islander Health Forums in each

jurisdiction where ATSIC had, by and large, forfeited their opportunity for regional planning which required practical working relationships with Aboriginal organisations and peak bodies from which ATSIC chose to distance itself. Where such agreements were entered into these often reflected, at best, mere token involvement and in some instances exclusive and adversarial practices.

This distancing often resulted in elected ATSIC regional and national office holders being without professional advice and expertise in crucial areas of service delivery, leaving them vulnerable to bureaucratic reliance and recipients of ill considered advice, devoid of vital expertise.

Belatedly, in NSW at least, there were encouraging dialogues created between ATSIC and the State Government in recent attempts to co-ordinate service delivery to Aboriginal people across all government departments and agencies. Even in this COAG related initiative, it was at the expense of any contact with or involvement of peak Aboriginal organisations. Seeing themselves as the sole adviser to government, and the overriding Aboriginal community representative structure, many ATSIC Regional Councils still circumvented involvement of Aboriginal specialist organisations in their regional planning process. The only time that the involvement of this peak body was sought was after ATSIS had assumed responsibility for service delivery and discussions were being held in relation to the latest Primary Health Care Access Program (PHCAP) funding allocation.

Ironically, as the writing on the wall appeared for the demise of ATSIC these exclusive practices were fading but, unfortunately, probably too late for ATSIC to assume its rightful monitoring and co-ordinating role.

Service Deliverer

One of the crippling factors that weakened ATSIC, both in its operation and in public perception, was that of service delivery. There has been criticism that preoccupation with service delivery eroded the effectiveness of ATSIC's role in 'policy advice'.

Whilst policy and service delivery are not mutually exclusive it has to be understood what actual roles ATSIC had in policy advice and development and in service delivery. Concerning the former, it should be noted that ATSIC was only an advisor for government

policy whilst it had the capacity for internal policy development. The complementary role of monitoring departmental and agency service activity in Aboriginal programs could have been instrumental in providing consistent informed opinion for Commonwealth policy across the divide of portfolios.

With regard to service delivery, the original function of ATSIC was, in effect, to support Aboriginal service organisations, allocate funding, ensure positive outcomes were being realised in each area of service delivery, whether through governments or Aboriginal organisations. However, program responsibility is quite separate from actual service delivery. The legislation empowered ATSIC to seek advice from Regional Councils about service need, preferably through their regional plans. However, this did not mean that existing Aboriginal organisations and service providers which had current comprehensive local, regional and state/territory health plans and processes had to be ignored or their initiatives duplicated. In some states these initiatives were incorporated into the planning process within Aboriginal Health Forums. From our particular perspective in the Aboriginal health field there was considerable expertise and experience within the Aboriginal community that was ignored and dispensed with.

ATSIC and Aboriginal Health

The *National Aboriginal Health Strategy 1989 (NAHS)* - the first attempt by governments anywhere to formalise an approach to Aboriginal health - resulted from extensive consultations within Aboriginal communities throughout Australia. In fact, the consultations were the most extensive ever undertaken and far in excess of those preceding the establishment of ATSIC. The consultation reports emanating from each jurisdiction could not be printed due to lack of resources with the exception of a report for Queensland which reflected the extent and thoroughness of the process. The NAHS sought to establish much needed partnerships to eliminate the uncoordinated and fragmented efforts that prevailed in Aboriginal health. For the first time it envisaged dialogue between governments and the Aboriginal community, this was both historically and politically significant.

It was with optimism that the NAHS working party recommended that the proposed new ATSIC would be the most appropriate location for the secretariat of the National Council for Aboriginal Health, not envisaging the obstacles that could arise from ATSIC's limited knowledge of health. ATSIC would later assume responsibility for distribution of the first

NAHS health funding allocation of $232million over four years. Around 75% of this amount related to environmental health and was to address these issues through the intersectoral collaboration of government departments through State Tripartite Forums and the National Council for Aboriginal Health (NCAH). Unfortunately, the NCAH did not meet until two years later at which time the ATSIC bureaucracy announced that the Council was due for review. State tripartite forums had varied success in influencing the allocation of funding consistent with the processes and principles recommended in the NAHS and were subject to the same review (Codd Report). Consequently, the NAHS was barely implemented; the intended partnership between governments and Community did not eventuate; and indispensable intersectoral collaboration between governments and their departments, essential to successful implementation of the NAHS, was not evident despite a whole chapter having been devoted to this very subject in the NAHS (1989). Consequently, much of the *ad hoc* characteristics of government programs continued unaffected. Had governments taken their obligation seriously fifteen years ago, the upheaval and uncertainty in the current restructuring in Aboriginal Affairs could have been avoided. In the meantime, the health and wellbeing of Aboriginal people could have been more effectively addressed by now with the present effort and expense being directed towards more constructive processes of ongoing improvement.

Following the review, the National Council for Aboriginal Health was replaced with a far less representative structure, having only two representatives elected by the Aboriginal community and a majority of ministerial appointments. State Tripartite Forums, which included ATSIC, were replaced following the transfer of Aboriginal health with Aboriginal Health Forums pursuant to *Aboriginal Health Framework Agreements*, with ATSIC as a signatory.

Whilst this initial carriage of health by ATSIC was encouraged, it became quickly apparent that confidence in this responsibility was misplaced. This was not from any perceived sole mandate or monopoly in a specialist field now within the responsibility of ATSIC but, rather, an ethical and moral obligation to ensure sustainability of appropriate health services to Aboriginal people.

One of the main factors that created negative criticisms of ATSIC was the process through which funding of Aboriginal programs was effected. The ATSIC structure was vulnerable in that responsibility for funding allocations for individual projects was vested in the elected

arm. Not only was this open to perceived conflict of interest in some cases, but the decision makers were often lacking expertise in the areas under consideration with little fiscal experience.

In the area of Aboriginal health, ATSIC administrative deficiencies were exacerbated when recurrent Aboriginal health funding applications, supported by evidence based needs analyses, were totally disregarded through the regional council approval process. Urgent health requirements for indispensable additional equipment or medical positions had to compete for funding within a global budget process against the entire range of service provision and projects. The only response of the ATSIC bureaucracy to this dilemma was to decree that regional councils should simply apply a blanket CPI increase to all projects regardless of merit. Aboriginal health needs were clearly stifled with grave ramifications. ATSIC Regional Councils remained unfamiliar with NAHS and its importance. In an attempt to correct this the AH&MRC and NACCHO both wrote on numerous occasions to the Chair of ATSIC offering assistance to facilitate workshops with all ATSIC Regional Councils (65 at the time) on the importance of the NAHS 1989 and its implementation. No response was forthcoming for two years and this contributed inevitably to the necessity for remedial action.

The whole process concerned the Aboriginal Community Controlled Health (ACCH) sector so seriously that it had no alternative than to advocate for the transfer of health responsibility to the Minister for Health.

The eventual transfer of responsibility for health from ATSIC to the Commonwealth Department of Health hinged upon the vital consideration that the health of Aboriginal people could not be placed in further jeopardy through experimentation with service delivery models or administrative systems, without substantive justification. To do so would have been unethical and unconscionable.

Admittedly, at the time of the transfer there was a mere handful of administrative staff within the health unit in ATSIC, grossly inadequate, with no foreseeable major funding allocation to engage appropriate staffing levels to cope with the anticipated work load. Whilst program responsibility was transferred to a government department this should not be viewed as *mainstreaming* as such because the effect was only to replace one administrative agency with another. The actual delivery of health services was still through Aboriginal Community

Controlled Health Services and a Memorandum of Understanding between ATSIC and the Office of Aboriginal and Torres Strait Islander Health (OATSIH), within the Department of Health, was entered into to formalise this arrangement. Significantly, when this MOU was recently renewed all reference to NACCHO as a peak body responsible for Aboriginal primary health care was deleted, contrary to the NAHS. At the same time ATSIC was still a member of Aboriginal Health Forums with Commonwealth and State Governments and the ACCH sector State/Territory affiliates which could have enabled ATSIC monitoring role in health service provision.

It was only in the final years of ATSIC that interface with State and Commonwealth governments in health became evident. Despite the failure of Commonwealth governments to implement the NAHS, the NSW Minister for Health, who himself has worked as a doctor in an Aboriginal Medical Service, and the ACCH sector had the insight to acknowledge that there was no justification for a polarised stance between the mainstream and the ACCH sectors. Each was considered complementary to ensure maximum delivery in health services to Aboriginal people. This indispensable role for partnerships between both health sectors was addressed in NSW in 1995 with the establishment of the *NSW Aboriginal Health Partnership*, between the NSW Government and the Aboriginal Health and Medical Research Council of NSW, consistent with the NAHS 1989.

The Partnership aimed to introduce parity between the public health sector and the Aboriginal Community Controlled Health sector which would enable tangible health benefits. Numerous health initiatives were achieved through polices developed, including the *NSW Aboriginal Health Policy 1998* and the *NSW Aboriginal Health Strategic Plan 1999* which are applicable throughout the state. It catered not simply for state and regional priorities but evolved through robust health needs analyses of each Aboriginal community on a trajectory through local Aboriginal communities, regional Area Health Services, to the State Health Department. AH&MRC has advocated for many years that the Commonwealth Minister for Health follow the recommendations of the NAHS and establish a comparable arrangement with the NACCHO.

This critique has been inserted to indicate that any proposal for the administration of Aboriginal affairs with regard to regional emphasis, implicit in the ATSIC Amendment Bill,

can benefit greatly from what has already been successfully accomplished in the health field within this state, and may, conversely, be doomed to revisit past mistakes if not heeded.

However, as alluded to earlier in the context of the necessity to transfer program responsibility of Aboriginal health to the Commonwealth Department of Health, there are some serious qualifications and dangers within the new Australian Government Indigenous Affairs Arrangements and the proposed amendments and in the exclusive pursuit of a model *per se* without due consideration of the history and merits of the Aboriginal community's involvement in the delivery of health services and representation. This fundamental principle applies equally in all specific program areas affected by these changes.

Understandably therefore, it is of serious concern to the Aboriginal community controlled health sector that in spite of the crucial need to ensure that the health of Aboriginal people remains outside any regional experimentation in global service delivery, a senior staff member from the new Office of Indigenous Policy Coordination (OIPC) within DIMIA has recently conveyed at a public meeting in Northern NSW that within 2 years all ACCHS would be de-funded and their services mainstreamed.

Importantly, the NAHS is still as relevant for the health and wellbeing of Aboriginal people as it was in 1989 as acknowledged this very year by the National Council for Aboriginal & Torres Strait Islander Health (NCA&TSIH) in its *National Strategic Framework for Aboriginal and Torres Strait Islander Health* 2004 which states:

> "Although never fully implemented (as indicated by its 1994 evaluation), the NAHS remains the key document in Aboriginal and Torres Strait Islander Health. It is extensively used by health services and service providers and continues to guide policy makers and planners."

It is unfortunate that ATSIC did not likewise comprehend the significance of the NAHS 1989 and understood its application solely in relation to the area of Aboriginal housing and infrastructure.

b) PROPOSED ADMINISTRATION OF INDIGENOUS AFFAIRS

Guiding Principles

As mentioned previously, and notwithstanding the demonstrated position of this current government, the fundamental principle at stake in the current debate is that of self

determination for Aboriginal people. Again, the astute perception of the late Mr Djerrkura is relevant.

> "The Prime Minister has long refused to accept the fundamental difference of Aboriginal people in our community. He was never sympathetic to the principles on which ATSIC was based and founded. He has always rejected any suggestion of indigenous autonomy and self determination." H29384

Self determination is pivotal in any understanding of Aboriginal communities and must underpin representative structures or proposed administrative arrangements in Indigenous affairs, in whatever form that may eventuate.

It would also be highly presumptuous for any one Aboriginal organisation or sector to speak on behalf of Aboriginal people nationally as self determination has its origins in local Aboriginal community process which ensures culturally appropriate representation. Nor is it appropriate for a third party outside of the Community to look beyond the realms of the local Aboriginal community for suitable or adaptable models on behalf of Aboriginal people. Whilst cross fertilisation of ideas is to be encouraged and information about such models might be adopted by Communities, the decision rests ultimately within rights of local Aboriginal people. Any representative Aboriginal structure must incorporate local Aboriginal communities and by definition be independent of government.

Accordingly, it is an aim of this submission to defend the right of the Aboriginal community to elect its own representatives and for a model to be developed that utilises existing vital Aboriginal community structures and, wherever possible, to provide complementarity to departmental structures and arrangements.

The ultimate and indispensable structure that will incorporate all Aboriginal nations independent of government control and influence, with spiritual and cultural criteria to determine appropriate representation without any oversight by the Australian Electoral Commission and external to any government legislative process, will await the initiative of the Aboriginal community itself.

For practical purposes the delivery of programs and projects will require some immediate interim structure, however, this need not intrude upon local Aboriginal decision making and

can be inclusive of all levels of representation yet still provide sufficient structure for governments to distribute funding for essential services.

With regard to Aboriginal health, irrespective of the overall model or structure adopted for Aboriginal Affairs, it is obligatory that recommendations apply from the *National Aboriginal Health Strategy 1989* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Framework for Governments 2004* (NSFATSIH), just recently endorsed by all State and Commonwealth Ministers.

Key Result Areas of the NSFATSIH include Group A - Towards a more effective and responsive health system, which describes its program for comprehensive primary health care as the centrepiece of the health care system for Aboriginal and Torres Strait Islander peoples.

Further it states:

> "ACCHSs are the best practice model for the delivery of comprehensive primary health care to Aboriginal and Torres Strait Islander communities. In many circumstances, other provider groups (for example, general practitioners and State/Territory government health services as well as private specialists, private hospitals and organisations such as the Royal Flying Doctor Services) provide primary health care services to Aboriginal and Torres Strait Islander peoples. However, while acknowledging that such providers have delivered technically competent health services, only ACCHSs currently provide culturally appropriate health services to Aboriginal and Torres Strait Islander peoples.
>
> "ACCHSs are fundamental to delivering health services to the local community in a holistic and culturally appropriate way and can assure that a range of primary health care services are available. However, it is important that mainstream services do not defer to the existence of ACCHSs as a reason to ignore their responsibility to provide culturally sensitive services to Aboriginal and Torres Strait Islander peoples. Given the complex health needs and multi-factorial causes of poor health amongst Aboriginal and Torres Strait Islander peoples, an approach is needed that fosters the complementarity of both ACCHSs and mainstream services working together, taking into account local circumstances and capacity.

The document also defines an Aboriginal community controlled health service as:

- An incorporated Aboriginal organisation;
- Initiated by an Aboriginal community;
- Based in a local Aboriginal community;
- Governed by an Aboriginal body which is elected by the local Aboriginal community; and
- Delivering a holistic and culturally appropriate health service to the community which controls it.

"A service that contains these elements represents true community control and best practice."

The first *Key Result Area*:

> "… aims to continue support for adequately resourced, well planned ACCHSs. It advocates partnerships between community controlled health services and mainstream services to ensure that Aboriginal and Torres Strait Islander communities have access to the full range of services expected within the comprehensive primary health care context. It supports the fundamental principles of community decision making, influence and control over the way health services for Aboriginal and Torres Strait Islander peoples are managed and delivered."

Its objectives are:

- Strong community controlled primary health care services that can draw on mainstream services where appropriate.
- Improved community decision-making influence and control over the management and delivery of health care services
- Improved capacity of individuals and communities to manage and control their own health and well being

Action Areas:

- Continue to fund ACCHSs
- Identify costings and core services for rural, remote and urban ACCHSs
- Acknowledges Framework Agreements' aim to improve co-operation and coordination of current service delivery by both ACCHSs and mainstream and by all government jurisdictions. To this end, planning forums established under the Framework Agreements should link with:
    - Mainstream health sector regional and area health plans and where possible ATSIC regional plans
    - Local community planning
- Commit to and resource the regional planning structures established under the Framework Agreements as the primary mechanism by which local priorities are determined and implement existing regional plans
- Support capacity building for ACCHSs to respond to emerging health problems; … resources for appropriate training, including epidemiology, primary prevention, program development management and technical support.
- Optimal resourcing for provision and maintenance of health service buildings and equipment
- Resourcing of optimal patient information systems
- Provide training and support for community members on Boards of Management
- Etc.

In light of the foregoing, for any government to ignore the NAHS and NSFATSIH or even contemplate partial or implicit revocation in any restructuring of Aboriginal affairs, would epitomise the historical neglect and abrogation of responsibility which has lead to the continuing ill health of Aboriginal people.

The nebulous construct now being implemented by governments cannot be allowed to override extant policy which has been comprehensively developed in consultation with Aboriginal and Torres Strait Islander communities, based on sound principles, medical and

scientific best practice and agreed to at all levels of governments. To do so would be extremely irresponsible and retrograde. Such an outcome would be an insult not only to the Aboriginal community but also a slight to the competence of those Ministers who are signatory to the document and to those within the bureaucracy and the medical and scientific fraternities who would distance themselves from any negation of their contribution and commitment.

Appropriate Service Delivery

In formulating structures that will provide effective and achievable goals in service delivery there are lessons to be learnt from past exclusive practices. Often governments arbitrarily turn to unrepresentative groups without expertise in areas of specialist service delivery. Once again, attempting to channel all service provision into one complex structure that ostensibly provides economies of scale and transparency can in reality be a potential diminishment of actual meaningful services to Aboriginal people and confines political and financial power to an ever diminishing number of unrepresentative people with increased power over Communities.

The only models that will withstand the test of time as functional and responsible will be those that embrace existing expertise within the Aboriginal community and encourage transparency and democratic representation with the capacity to correct any deficiency or necessary amendment.

The role of Aboriginal Community Controlled Health Services

The NAHS anticipated that not only were Aboriginal Community Controlled Health Services, which predated ATSIC by decades, the most efficient and effective means of providing comprehensive holistic primary health care for Aboriginal people. This acknowledgement can also be found in the *Report of the Program Effectiveness Review* which examined spending on Aboriginal health and the effectiveness of funding mainstream in the 1970's. The Report was initiated following the disparaging findings of the *National Trachoma Program (1973-1978) Report* in 1978 but was never published. In the same decade, the House of Representatives Review into Aboriginal Health, chaired by the Hon. Mr Philip Ruddock, recognised a marked decrease in hospital admissions as a direct consequence of the establishment of Aboriginal Community Controlled Health Services.

Contemporary proponents of this view that endorse the value of ACCHS can be found amongst many recognised scholars and practitioners at the cutting edge of medical and social and emotional well being research, including from Western Australia Professor Fiona Stanley, Dr Sandra Eades and Dr Helen Milroy, the only Aboriginal psychiatrist in Australia; from New South Wales Professor Marie Bashir, Professor Beverley Raphael, Professor Brian Layland, Professor Brien Holden, Professor John McDonald, Professor Bruce Armstrong and Dr Neil Phillips; from Queensland Professor Ian Wronski and Dr Mark Wenitong; and from the Northern Territory Professor Robert Parker and Professor Kerin O'Dea.

It also important that ACCHSs, through their Community elected process are represented at the local, regional, state and national levels. This submission expressly defends the integrity of this process in the development of any model relating to Aboriginal representation or service delivery.

The argument that Aboriginal service delivery and Community representation are separate is flawed. Dismissive claims by some that service delivery within the Aboriginal community is restricted to merely 'citizens' rights', requires qualification. Naturally, Aboriginal people are entitled to access health services as Australian citizens not by virtue of any practical reconciliation.

Far from mere 'citizens' rights' that can be tendered out to all and sundry, service delivery within Aboriginal community controlled organisations is different in kind not degree. For the purpose of this submission, may we refer to the specialist responsibility of this Aboriginal health organisation to demonstrate the profundity that service delivery is an integral part of the Community, inextricably entwined within Community processes and not merely the aggregation of individual services. Health is viewed within the holistic context of the Community where the health and well being of the Community overall indicates the adequacy of health service delivery. The following definition used by the ACCH sector is adapted from the W.H.O. Alma-Ata Declaration in 1978

> **"Primary Health Care"** is essential, integrated care based upon practical, scientifically sound and socially acceptable procedures and technology made accessible to Communities as close as possible to where they live through their full participation in the spirit of self-reliance and self-determination. The provision of this calibre of health care requires an intimate knowledge of the community and its health problems, with the community itself providing the most effective and appropriate way to address its main health problems, including promotive, preventative, curative and rehabilitative services.

Social and Emotional Wellbeing

The ACCH sector further locates primary health care delivery within the

> " … holistic health provision of an ACCHS as it provides the sound structure to address all aspects of health care arising from social, emotional and physical factors. It incorporates numerous health related disciplines and services, subject to its level of operation, available resources and funding. In addition to the provision of medical care, with its clinical services treating diseases and its management of chronic illness, it includes such services as environmental health, pharmaceuticals, counselling, preventive medicine, health education and promotion, rehabilitative services, antenatal and postnatal care, maternal and child care, programs and necessary support services to address the effects of socio-somatic illness and other health related services provided in a holistic context. Socio-somatic health is specifically defined to incorporate the context in which health care delivery is provided." *(AH&MRC Constitution)*

It removes health as a mere service delivery that can be contracted out to the most convenient service provider.

> **"Socio-somatic illness"** means those physical ailments, bodily disorders and psychological or mental conditions which impair the health of Aboriginal people and the well-being of Aboriginal communities resulting directly or indirectly from sociological disadvantage; economic deprivation; racism; assimilationist legislation, policies and practices, unemployment; lack of housing; dispossession, alienation from land, forced separation from parents, children, families and communities; and other traumas, which impinge and have impinged upon Aboriginal people since dispossession." *AH&MRC Constitution*

It is important to acknowledge here the valuable insights of those working in Aboriginal mental health and social and emotional well being. Conscious of the onerous task in delivering appropriate health care in this crucial area of need the recent publication *Social and Emotional Well Being Framework – Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Well Being 2004 – 2009* is a valuable contribution in the health field.

One Key Strategic Direction expressly addresses the indispensable role of the Aboriginal community controlled health sector in Aboriginal mental health and is entitled *Strengthening Aboriginal Community Controlled Health Sector* and the stated "Rationale" is as follows:

> "Aboriginal Community Controlled Health Services (ACCHS) deliver a range of services required to meet the complex and interactive health needs of Aboriginal and Torres Strait Islander peoples (Health Council 2002).
>
> "ACCHS provide a central role due to the religious, cultural, spiritual and social needs they address. They provide culturally appropriate primary health care that is specific to the needs of their communities. For many people, services that are offered by ACCHS provide a sense of belonging. ACCHS provide:

- Community ownership as the Community has developed and shaped the service;
- A built in health care complaints system;
- A service that is consumer driven and everyone is a consumer;
- A Community elected ACCHS Board. These board members are consumers of the service, many of whom are elected to represent the Community at a regional, state and national level. All associated responsibilities are met unpaid;
- A constant memorial of Community members past and present who have worked tirelessly to develop services;
- A meeting place, teaching place, learning place – its our place;
- A place to go when you feel crook;
- A place to go when you need food or to make an urgent phone call;
- Emotional support and a place to cry;
- A place to heal;
- A supportive place to track and contact family members;
- Assistance when family and friends pass away; and
- Culturally respectful support and assistance, wherever possible, including assistance with funeral preparations and the return of loved ones back to country for burial. (NACCHO Consultation Report 2003)"

ACCHS - Pivotal to Representation, Service Delivery and Partnership

Accordingly, when we consider appropriate structures for service delivery to Aboriginal people, to exclude Aboriginal community controlled organisations in effect diminishes the quality and social benefits of health care itself and this principle applies across the whole gamut of service delivery. Regrettably, ATSIC failed to embrace this important distinction. As it considered itself as the ultimate representative structure of the Aboriginal community on all matters it, in effect, removed itself from the Community process and became a mere dispenser of programs rather than seeing primary health care as an all inclusive, integrated health process determined by the Community. It is this context that determines the quality and efficacy of health services. This comprehensive approach to health is in accordance with the Aboriginal holistic definition of health and arises out of the practical experience within the Aboriginal community itself having to provide effective, accessible and culturally appropriate health services to its members.

It was in the face of dire neglect that the Aboriginal community during the 1970's developed and embraced a process of service delivery that was imbedded within the calibre of the Community itself and accepted as culturally safe and appropriate. Without any initial government subsidy the Aboriginal organisations established during this period developed means by which service delivery reached its intended target. Any criticisms of the continuing health of Aboriginal people, as with any other portfolio responsibility in Aboriginal service

delivery, must be seen in the context of gross under resourcing and other external determinants outside the control of the Aboriginal community, for example, the plethora of unimplemented recommendations from numerous reports are cause for concern. More recently, the *Deeble Report* recommended an immediate additional $250 million just to reach parity in health service delivery while the Australian Medical Association (AMA) recently recommended that $440 million was necessary to redress Aboriginal ill health. To address the external factors will require sustained action and complementary resolve by successive governments to attain the intergenerational improvements required.

The following diagram illustrates that the relationship between service delivery and representation within the Aboriginal community controlled health service context is not mutually exclusive. Further, that self determination is not only possible in such structures but also enhances the management and operations of mainstream from the policy development level to that of service delivery.

	Aboriginal Community	**P A R T N E R S H I P**	**Mainstream**
Representation			
▪ Local	ACCHS		Area Health Services (Local Area Aboriginal Health Partnerships)
▪ Regional	ACCHS Consortia		Area Health Services
▪ State	AH&MRC		NSW Health Department (NSW Aboriginal Health Partnership)
▪ National	NACCHO		OATSIH /DOHA (Aboriginal & Torres Strait Islander Framework Agreement)
Service delivery			
▪ Local	ACCHS		Area Health Services, Community Health & Hospitals
▪ Regional	ACCHS Consortia		Area Health Services
▪ State	AH&MRC [special projects]		Centre for Aboriginal Health
▪ National	NACCHO [special projects]		

This diagram further serves to illustrate the partnership relationship which facilitates the bringing of Aboriginal health expertise to the health care processes. In the state of NSW the

AHMRC and ACCHS are party to Partnership Agreements replicated at the Local/Area Health Service level. This NAHS recommended partnership fulfils all the recommendations outlined in the NSFATSIH. There are also many additional productive and unique partnerships with ancillary bodies such as Divisions of General Practice (GP), Universities, Non-Government Organisations (NGO's) and other specialist health bodies.

Alternative Representative Structures

1 National

Government proposed structure

With the proposed legislation so radically departing from the ATSIC structure that facilitated national representation it is an onerous task to formulate an alternative within such a short timeframe that would adequately meet the disparate needs of Aboriginal communities. Considering the statement of the former ATSIS CEO, current Director of the Office of Indigenous Policy Co-ordination (OIPC), Wayne Gibbons, that

> "… there is no intention on the part of the government … to recreate a national representative body"

it would appear futile to attempt any definitive solution at the national level.

The proposed National Indigenous Council (NIC) which will be appointed by Government, based on its own assessment of appointees' skills, background and experience to facilitate better outcomes for indigenous Australians. They will be expected to promote dialogue and engage between Government and Aboriginal and Torres Strait Islander people, communities and organisations. The proposed NIC provides yet another example of governments' reneging on previous commitments to the Aboriginal community for meaningful engagement and participation at this crucial level of policy advice and prioritisation of programs. The absence of elected indigenous representation at the national level will militate against the dialogue and engagement anticipated in the terms of reference. As Council delegates will not have a decision making role and

> "… will not provide advice on specific funding proposals or specific planning or program matters related to individual communities or regions."

- the inherent criticism of the ATSIC Board - there is no plausible reason why Indigenous elected representation should be excluded as the scope for this to occur has been removed. In fact, the scope for such problems had already been removed through the establishment ATSIS and the separation of 'powers' earlier this year.

Aboriginal Community Initiative

Whatever form national Aboriginal representation may take, legislators would benefit to consider that at the National Aboriginal Strategic Summit, held in July 2004, it was unanimously agreed to set up a National Council of Aboriginal Peak Bodies, including the following national organisations:

- National Aboriginal Community Controlled Health Organisation (NACCHO) representing Aboriginal and Torres Strait Islander health.
- Secretariat of the National Aboriginal and Islander Child Care (SNAICC) representing Aboriginal and Torres Strait Islander children and families.
- National Aboriginal Justice Advisory Council (NAJAC) representing social and justice issues for Aboriginal and Torres Strait Islander peoples.
- National Aboriginal and Islander Legal Services Secretariat (NAILSS) representing Aboriginal and Torres Strait Islander Legal Services.

It should be borne in mind that this national meeting was held in response to the government's announced changes to ATSIC and in the context of dispensing with the recommendations of the ATSIC Review. Any national representative administrative structure to be developed that excludes this important national Aboriginal coalition will do so without mandate and in the face of consensus amongst the leading Aboriginal organisations of this country.

As it is the actual health and well being of Aboriginal and Torres Strait Islander peoples that is the subject matter under consideration, the imposition of extraneous structures on Indigenous communities, which exclude the Community's acknowledged national leaders in each portfolio area, will ultimately be counter-productive to any improvement. It is hoped that wisdom shall prevail and those in government and bureaucracy with ultimate decision making authority will assume a collaborative approach with the Aboriginal community,

utilising the expertise and unique contribution of its national peak bodies replacing the membership on the NIC.

At the national level, we recommend that:

- a representative elected national body be incorporated into the new *Australian Government Indigenous Affairs Arrangements*;
- that such a body be known as the *National Assembly of Aboriginal Regional Councils;*
- that its composition be elected from Regional Councils within the 29 former regional boundaries of ATSIC where ICCs have been established;
- that the membership of the National Indigenous Council (NIC), established with government appointed members be replaced by a joint committee comprising solely of the:

    1. *National Assembly of Aboriginal Regional Councils*
    2. *National Coalition of Aboriginal Peak Bodies*

In the event that there is no immediate provision for a representative elected national body being incorporated into the *New Australian Government Indigenous Affairs Arrangements* it is recommended that the elected representatives from the *National Coalition of Indigenous Peak Bodies* alone replace the NIC membership until such a joint elected representation is possible. This modelling can be seen at Appendix 1 (page35).

2 State

The ATSIC Act made no provision for any official capacity at the jurisdictional level. Although unofficial bodies which included constituent regional councils were established in different States and Territories they had no status for appropriation or negotiation with their administrative counterparts. This omission affected tangible interface with governments and hindered attempts to monitor effectiveness of programs or establish meaningful partnerships. This omission was compounded by ATSIC making no attempt to enter into partnerships with peak Aboriginal bodies, further isolating Councils and councillors from proactive programs at the coalface. It will be a recommendation within this submission that the initiative of

Aboriginal peak bodies to enter into proven substantial partnerships with State government departments provides the path out of the complex labyrinth that now confronts the management of Aboriginal Affairs.

In the state of NSW, such a rigorous process is in place in the health portfolio with solid and constructive partnerships and this positive direction could be extended to other portfolios. The health of Aboriginal people cannot be laid bare to the continuing uncertainties of experimentation in Aboriginal program delivery. Important as it is to witness the combined efforts of NSW departments and agencies to improve reporting on a collective basis in Aboriginal affairs with the intention to achieve a co-ordinated effort in redressing deficiencies in service provision to Aboriginal communities, there are certain cultural caveats that require acknowledgment. It is crucial that the expertise of the Aboriginal community itself is not excluded from the process. Regrettably, this was exactly the case in NSW until Aboriginal peak bodies were eventually included in the collective planning process within the *New Ways of Doing Business – Two Ways Together* initiative. However, there is still no provision for any Aboriginal community organisation to be involved in decision making for the delivery of services within the proposed new regional and local structure. The stated objective of combined strategic planning to meet identified needs; equitable allocation of funding; reporting on positive and negative indicators; and highlighting outcomes are all essential ingredients for a successful state wide program but if it is at the expense of dispensing with Aboriginal community organisations, whether, local, regional or State, the process is incomplete and potentially ineffective.

The primary fault with the national OIPC and its regional and state ICC counterparts is the conspicuous absence of elected Aboriginal representation. *Mainstreaming* has proven in the past to be ineffective and the proposed administrative experimentation is cumbersome and unproven; without parallel in the wider community; with no evidence to show that it will work and with no basis in best/better practice.

Accordingly, it is recommended that provision for an elected representative Aboriginal body being incorporated into the *New Australian Government Indigenous Affairs Arrangements* within each jurisdiction. We suggest that such an advisory body be known as the *Chairs of Elected Regional Councils* and that it be elected in each jurisdiction from the Regional

Councils within the former boundaries of ATSIC where *Indigenous Coordination Centres* have been established.

At the State level it is recommended that a *State Framework Agreement* be established, comparable to the proposed *Regional Partnership Agreement* and that the *Coalition of Aboriginal Peak Bodies* be included as a vital part of this structure. The parties to the *State Framework Agreement* would be as follows:

- *Coalition of Aboriginal Peak Bodies*
- *Chairs of Elected Regional Councils*
- *NSW State Government*
- *Office of Indigenous Policy Coordination*

This modelling can be seen at Appendix 2 (page 36).

3 Regional

At the regional level, for practical purposes, it makes sense to utilise the former geographical boundaries of the regional council structures of ATSIC. Ideally, some form of representation chosen by the Aboriginal community itself is required.

This raises the question as to how elections would take place to ensure proper representation within regions. There are no details whether the former process that incorporated the *Australian Electoral Commission (AEC)* will be retained and if not, how any degree of appropriate representation is achievable.

In the absence of definitive information it would appear that a rather loose aggregation of proposed regional *Indigenous Coordination Centres* would operate nationwide with the emphasis upon regional projects and programs.

There is no plausible reason why former ATSIC Regional Councils could not be elected to recommend regional policy and have oversight for the implementation of policy and priorities across the whole divide of service activity within their respective regional boundaries. As so many projects involve cultural and traditional values the proposed amalgam of *Indigenous*

Coordination Centres is bereft of Aboriginal representation and the antithesis of Aboriginal self determination, which may well be the intention of this significant reversal of service delivery. At the same time, *Indigenous Coordination Centres*, if they are to remain on the landscape of Aboriginal Affairs, working in association with elected regional bodies, could well provide an administrative capacity to work neutrally to implement regional policy through recommended specific projects.

This may well be a workable model without too radical a departure from the proposed structure and process that demands transparency, accountability and Community scrutiny. Elected Regional Councils, together with regional consortia or regional representatives of Aboriginal Peak Bodies, could easily meet the role and criteria for the proposed *Regional Indigenous Representative Networks (RIRN)*. This amendment would thereby remove any scope for divisiveness through the external imposition of yet another tier of control by *Indigenous Coordination Centres* otherwise working merely with clusters of Aboriginal people competing for projects rather than meaningful overall dialogue with the elected representative bodies from the Aboriginal community itself.

It is disconcerting and ironic that the recent House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs *Report of the Inquiry into the capacity building of service delivery in Indigenous communities (June 2004)* was undertaken just prior to the demise of ATSIC. Together with numerous Aboriginal community organisations, the Aboriginal community controlled health sector participated in this Inquiry in good faith and commented upon the extensive capacity building of Aboriginal people through its sector. Nationally, there are some 130 ACCHS with over 1,000 Aboriginal board members of these organisations providing governance oversight and experience, all without pay or sitting fees. In addition, the ACCH sector is the largest non-government employer of Aboriginal people in Australia with 67% of its 2,500 workforce being Aboriginal or Torres Strait Islander peoples.

With Aboriginal unemployment in general being so high, even with CDEP 'work for the dole programs' considered actual employment for statistical purposes, there is a blatant contradiction in the current attempts to regionalise services. This will only further reduce opportunities for capacity building and employment of Aboriginal people. Local Aboriginal services are neither duplicative nor redundant and cannot be rationalised. What is

fundamental here is that, in effect, the very essence and structure of Aboriginal society - the local Aboriginal community - is dispensed with or minimised through regionalisation.

It is noted that attempts to regionalise services without local Community input reflects a basic misunderstanding of Aboriginal societal structure and culture. Centralisation and regionalisation are important components of representative structures but if they do not embrace and accommodate **local Aboriginal communities** they have ignored the basic building block of Aboriginal representation.

It can be recalled that overnight one stroke of the pen reduced 65 ATSIC Regional Councils to 36, with many expressing angst at the reconfiguration of their boundaries. One of those gravely affected at the time was the vast current Murdi Paaki ATSIC Regional Council in the state of NSW which had two distinct entities prior to this amendment. Even here, the current combined boundary, conveniently drawn to facilitate administrative efficiencies, service delivery and manageable funding processes, is not necessarily drawn upon traditional boundaries as numerous Aboriginal nations and language groups are incorporated, some a thousand kilometres apart.

In some States/Territories relevant clusters of local Aboriginal communities are appropriate; however, without the local Communities being an essential component in these structures this process can be potentially detrimental to the Community. Even structures having Aboriginal names may not necessarily reflect traditional boundaries as they incorporate many different language groups whose participation and involvement in any decision making is essential. In some instances local Aboriginal land council boundaries coincide more accurately with traditional boundaries and should be incorporated into this process.

From the health service perspective at the regional level, consortia of autonomous local Aboriginal Community Controlled Health Services within former ATSIC regions have developed regional representative incorporated networks that can assist in providing valuable and timely specialist health advice and assistance to *Indigenous Coordination Centres*. It is considered essential that any additional regional health initiatives to the health program administered by the OATSIH be undertaken within and consistent with the health service provision of the ACCH sector. Its experience and expertise need to be utilised and not

marginalised and any injection of additional funds be applied to meet identified health needs, thereby avoiding unnecessary duplication and waste of scarce resources.

It is hoped that whatever semblance of ATSIC survives at the regional level it includes the capacity for partnerships with the Aboriginal Community Controlled Health sector and Aboriginal Community Controlled Health Services so that there will be no regression or unnecessary duplication in the delivery of appropriate primary health care services.

In all relevant discussions and planning it is assumed that *Indigenous Coordination Centres* and their counterparts at the state and national level will give heed to the recommendations of the *National Aboriginal Health Strategy (1989)* and the Recommendations of the *Royal Commission into Aboriginal Deaths in Custody (RCIADIC)*.

At the regional level it is also suggested that the *Regional Indigenous Representative Network* be replaced by a genuine elected body stemming from elected Regional Councils and regional consortia of Aboriginal organisations within peak Aboriginal bodies. Such an amendment would provide considered advice and a transparent process through which service delivery within each region can be prioritised. In NSW, in the health area, there are regional consortia like Bila Muuji Aboriginal Health Service, with some 15 ACCHSs and 3 Aboriginal Community Controlled Health Related Services (ACCHRS) constituent members, enabling potential for economies of scale and support for each local community. There are similar consortia throughout the State within each of the former ATSIC boundaries in which *Indigenous Coordination Centres* are established.

It is the recommendation of this submission that at the regional level the appropriate party with which the *Indigenous Coordination Centres* seek considered advice, as well as enter into various *Regional Funding Agreement*s, include representatives from Regionally Elected Aboriginal Councils and regional consortia or regional representatives of Aboriginal peak bodies.

Specifically, in the area of Aboriginal health it is recommended that at the regional level the appropriate advisor to *Indigenous Coordination Centres* and a necessary party to any *Regional Partnerships Agreements* be the regional consortia incorporated health organisation associated with the AH&MRC.

It is also imperative to ensure that at the regional level important specific agreements and arrangements remain. In health, the extant *Local/Area Aboriginal Health Partnerships* between local Aboriginal Community Controlled Health Services and NSW Health Area Health Services are necessary to ensure that the collaboration between agencies and service providers continues enabling vital service delivery. The local health forums operating under these instruments enable a whole of community participation in health issues and prioritisation of health initiatives. This modelling can be seen at Appendix 3 (page 37).

4 Local

Mention has already been made that self-determination has its origins in local Aboriginal communities. This necessary process ensures culturally appropriate representation and it is unnecessary to look beyond the realms of the local Aboriginal community for the basis to develop appropriate models on behalf of Aboriginal people. Any truly representative Aboriginal structure must incorporate local Aboriginal communities and be independent of extraneous control.

However, there are some conflicting claims about actual representation of local Aboriginal communities. In short, any regional or representative appointed process that denies local Aboriginal community autonomy or control over administrative procedures cannot claim to be local Aboriginal community control. For the ACCH sector the rights of the local Aboriginal communities provide the crucial building block upon which the whole organisation is built. Any local, regional, state/territory or national administrative structure or aggregation of Aboriginal communities or organisations that diminish the rights and importance of the local Aboriginal community itself to control its own destiny is unacceptable. It is against this fundamental determines this response to the proposed *New Australian Government Indigenous Affairs Arrangements* and against which any structure understanding consideration must be measured.

The much championed *Community Working Party (CWP)* process is highly dubious. From numerous complaints to the Council there is considerable scepticism of this process within the Aboriginal community particularly due to its regional non-representative basis and that it provides a means by which local autonomous organisations and Communities forfeit their right to negotiate directly with government and in effect are over ridden.

Because the *CWPs* are not necessarily initiated, elected or appointed by the Community and can be chosen or appointed by select groups either within or extraneous to the local Community, with the potential to be non-inclusive of Aboriginal organisations or Community groups, the structure is viewed as an imposition and as such potentially divisive and a barrier to effective Community decision making.

In addition, there is no opportunity for Communities to question the validity of such a structure and such questioning or non-participation may be at the risk of exclusion in the decision making process about priorities and project allocations. Hence, the *CWP* process is presented to the local Community as virtually obligatory to any participation at that level and therefore perceived as duress. While in the short term it may satisfy those seeking 'quick fix' solutions to Community involvement, extreme caution should be taken when assuming that such structures reflect or enhance genuine Community representation.

This is not to say that local Aboriginal organisations cannot initiate their own local committees to better co-ordinate their combined effort in service delivery, nor is it to say that those local Aboriginal people already participating in *CWPs* are not genuinely motivated or achieving outcomes for their Communities.

There may be merit if similar representative groups were designed within the former Regional Council electoral system as local elected groups might provide more transparent representation. However, as the proposed and operating *Indigenous Coordination Centres* are constructed outside of the local Aboriginal community, unaffected by its principles and cultural imperatives, involving *Indigenous Coordination Centres* with *Community Working Parties* would heighten the irrelevance of the former in any genuine Aboriginal community process. The *Indigenous Coordination Centres*, as substitute decision making structures, in effect have the potential to disenfranchise the Aboriginal community and need to be linked with elected personnel and operate under partnerships with regional consortia of Aboriginal peak bodies. This is particularly so in the health field.

The proposed *Shared Responsibility Agreements* are also a pale reflection and certainly no substitute for overall Community planning and reflect similar inadequacies not being anchored to regional council representative bases. The *New Australian Government Indigenous Affairs Arrangements* state that "SRAs may be negotiated with family groups

through to larger community groups". Whilst they may ostensibly reassure some that immediate and local issues are being addressed they have the capacity to perpetuate polices of dividing and conquering Aboriginal communities with the inevitability of groups competing for projects with non-Aboriginal administrators having unfettered discretion with no local knowledge of the issues or understanding appropriate Community representation.

In any regionalisation of Aboriginal Affairs in this State, it would be imperative to ensure that each Community has access to the decision making process as several Communities have already experienced disenfranchisement through the very current structures now being imposed through government mechanisms.

At any level or jurisdiction, inappropriate representation is glaringly conspicuous when 'leaders' for the Aboriginal community are chosen or appointed by politicians and administrative bureaucrats without appropriate Community endorsement. The ACCH sector is conversant with the cultural imperative of the Community nominating and appointing its own leaders at each respective level of its structure.

In each ACCHS within a local community membership is open to all adult Aboriginal people. The organisation elects an Aboriginal board to govern its affairs. It annually elects delegates for state and national meetings at which delegates are elected by the members in a truly representative process. The state affiliate bodies of NACCHO, in NSW the AH&MRC, comprise delegates from member organisations so that they can authoritatively speak on behalf of their Communities. Consensus is a crucial criterion in deliberations.

Whilst this relates solely to Aboriginal health this structure has been included in the present submission to demonstrate the importance of including the ACCH sector in any meaningful dialogue in service delivery to the Aboriginal community. This modelling can be seen at Appendix 4 (Page 38).

c) RELATED MATTERS

Summary of Recommendations

1. This submission defends the right of the Aboriginal community to elect its own representatives and for a model to be developed that utilises existing vital Aboriginal community structures and, wherever possible, to provide complementarity to departmental structures and arrangements.

2. The recommendations of the *National Aboriginal Health Strategy (1989)* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health – Framework for Governments (2004)* (NSFATSIH), just recently endorsed by all State and Commonwealth Ministers, should be observed.

3. The only models that will withstand the test of time as functional and responsible will be those that embrace existing expertise within the Aboriginal community and encourage transparency and democratic representation with the capacity to correct any deficiency or necessary amendment.

4. This submission expressly defends the integrity of Aboriginal Communities', including ACCHS, elected representative processes at the local, regional, state and national levels in the development of any model relating to Aboriginal representation or service delivery.

5. The relationship between service delivery and representation within the Aboriginal community controlled health service context is not mutually exclusive.

6. The absence of elected indigenous representation within the *New Australian Government Indigenous Affairs Arrangements* at the national level will discourage the dialogue and engagement anticipated in the terms of reference of the NIC.

7. Any national representative administrative structure to be developed that excludes the important national *Coalition of Aboriginal Peak Bodies* will do so without mandate and in the face of consensus amongst the leading Aboriginal organisations of this country.

8. At the national level, we recommend that:
    - a representative elected national body be incorporated into the *New Australian Government Indigenous Affairs Arrangements*;

- that such a body be known as the *National Assembly of Aboriginal Regional Councils;*
- that its composition be elected from Regional Councils within the 29 former regional boundaries of ATSIC where ICCs have been established;
- that the membership of the National Indigenous Council (NIC), established with government appointed members be replaced by a joint committee comprising solely of the:
    - *National Assembly of Aboriginal Regional Councils*
    - *National Coalition of Aboriginal Peak Bodies*

9. In the event that there is no immediate provision for a representative elected national body being incorporated into the *New Australian Government Indigenous Affairs Arrangements* it is recommended that the elected representatives from the *National Coalition of Indigenous Peak Bodies* alone replace the NIC membership until such a joint elected representation is possible.

10. The initiative of Aboriginal peak bodies to enter into proven substantial partnerships with State government departments provides the path out of the complex labyrinth that now confronts the management of Aboriginal Affairs.

11. It is recommended that provision for an elected representative Aboriginal advisory body be incorporated into the *New Australian Government Indigenous Affairs Arrangements* within each jurisdiction and be known as the *Chairs of Elected Regional Councils*, elected from the Regional Councils within the former boundaries of ATSIC where *Indigenous Coordination Centres* have been established.

12. At the State level it is recommended that a *State Framework Agreement* be established, comparable to the proposed *Regional Partnership Agreement.* The parties to the *State Framework Agreement* would be as follows:
    - *Coalition of Aboriginal Peak Bodies*
    - *Chairs of Elected Regional Councils*
    - *NSW State Government*
    - *Office of Indigenous Policy Coordination*

13. There is no plausible reason why former ATSIC Regional Councils could not be elected to recommend regional policy and have oversight for the implementation of

policy and priorities across the whole divide of service activity within their respective regional boundaries.

14. Local Aboriginal services are neither duplicative nor redundant and should not be rationalised or minimised through regionalisation.

15. Whatever semblance of ATSIC survives at the regional level, in the area of health it should include the capacity for partnerships with the Aboriginal Community Controlled Health sector and Aboriginal Community Controlled Health Services so that there will be no regression or unnecessary duplication in the delivery of appropriate primary health care services or intrusion into existing *Local/Area Aboriginal Health Partnerships*.

16. In all relevant discussions and planning it is assumed that *Indigenous Community Centres* and their counterparts at the state and national level will give heed to the recommendations of the *National Aboriginal Health Strategy (1989)* and the Recommendations of the *Royal Commission into Aboriginal Deaths in Custody (RCIADIC)*.

17. At the regional level it is also suggested that the *Regional Indigenous Representative Network* be replaced by a genuine elected body stemming from elected Regional Councils and regional consortia of Aboriginal organisations within peak Aboriginal bodies.

18. It is recommended that at the regional level the appropriate party with which the *Indigenous Community Centres* seek considered advice, as well as enter into various *Regional Funding Agreement*s, include representatives from Regionally Elected Aboriginal Councils together with regional consortia or regional representatives of Aboriginal peak bodies.

19. It is also imperative to ensure that at the regional level important specific agreements and arrangements remain.

20. Regional and local health initiatives, additional to the health program administered by the OATSIH within the Department of Health and Ageing, should be undertaken within and consistent with the health service provision of the ACCH sector to meet

identified health needs, thereby avoiding unnecessary duplication and waste of scarce resources.

21. Any local, regional, state/territory or national administrative structure or aggregation of Aboriginal communities or organisations that diminish the rights and importance of the local Aboriginal community itself to control its own destiny is unacceptable.

22. Because the CWPs are not necessarily elected or appointed by the community and can be chosen or appointed by select groups extraneous from the local Community, the structure is potentially divisive and a barrier to effective Community decision making.

23. *Indigenous Coordination Centres*, as substitute decision making structures, in effect have the potential to disenfranchise the Aboriginal community and need to be linked with elected personnel and operate under partnerships with regional consortia of Aboriginal peak bodies.

24. The proposed *Shared Responsibility Agreements* are certainly no substitute for overall Community planning and are inadequate if not anchored to regional council representative bases or, in the area of health, existing plans, policies and partnerships.

Closing Remarks

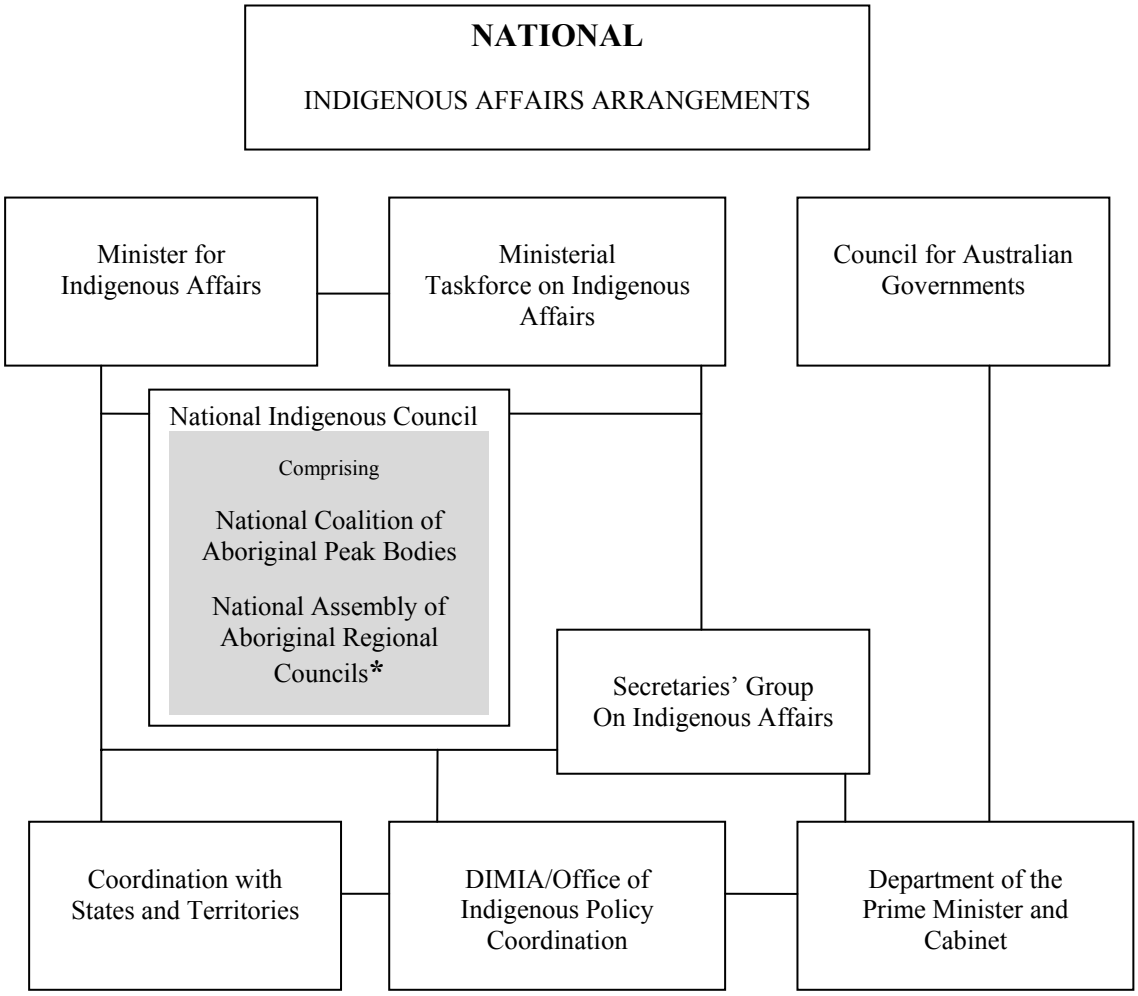
Finally, it should be stated that the Aboriginal community controlled health sector has watched for many years as the passing parade of successive governments, departments, agencies, bureaucrats and legislators, perennially flounder in their well intended attempts to formulate administrative systems to contain the full breadth and depth of Aboriginal needs and aspirations within a culturally incompatible context. This is further characterised by the abundance of unimplemented recommendations from costly reports which have provided more than sufficient evidence of needs and priorities, but which continue to be shelved until considered in need of review.

Yet the demand for Aboriginal people to attend meetings, provide submissions, give evidence, write critiques, make press statements and generally respond to the overwhelming expectations places a virtually impossible burden upon those least resourced to comply. Not only does this unmet demand cause distress, it is often misconstrued as acquiescence in governments' agenda. Hence, with every passing phase, the Community becomes more

cynical and disillusioned, having little confidence in governments to actually deliver, knowing that this experience is bound to resurface in some other form. However, the reticence of Aboriginal people in this disempowering process should not be construed as concurrence, but often reflects resignation to the inevitable. Not only is silence deemed to be acceptance but when programs fail it would seem that the Aboriginal community is ultimately held responsible.

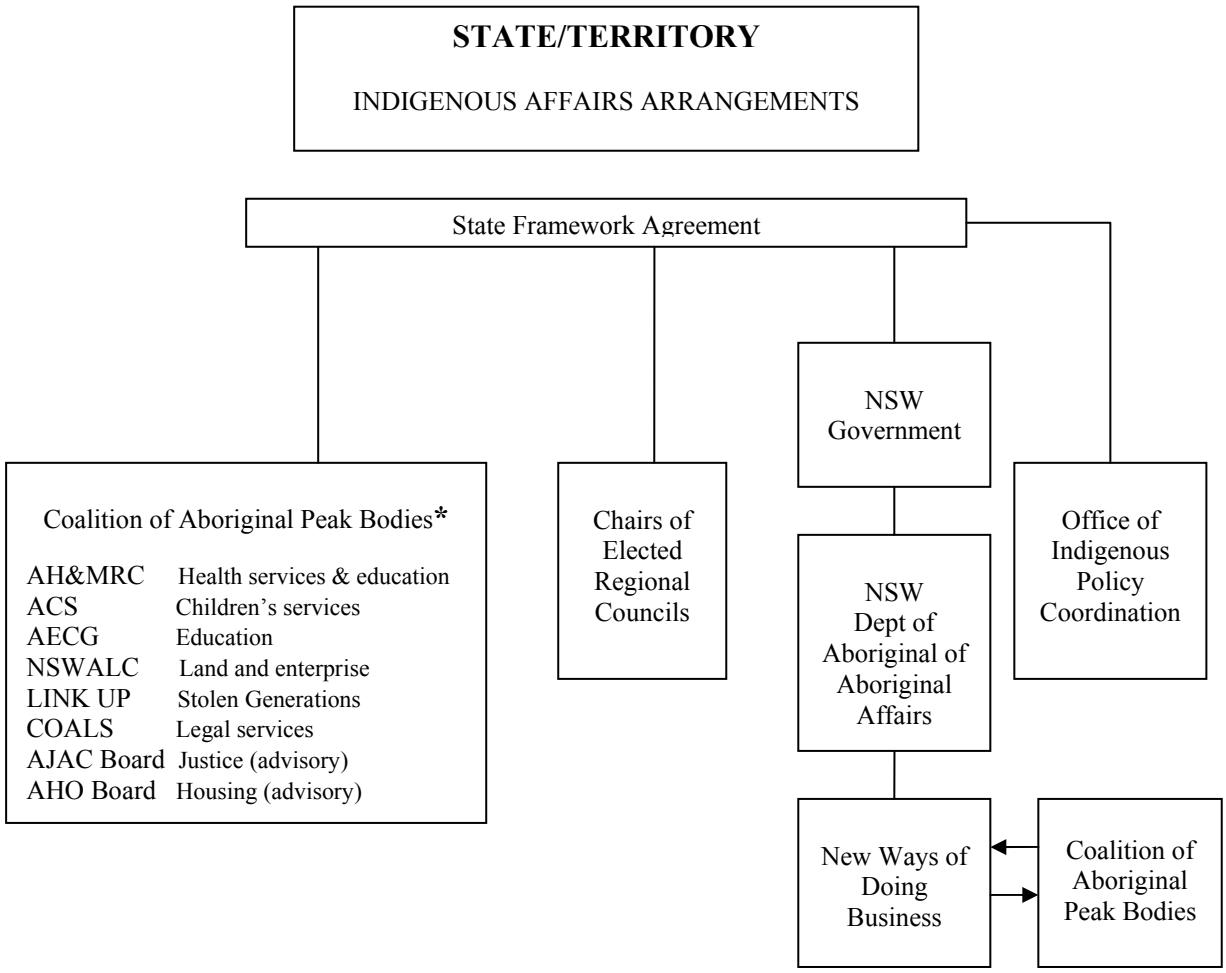
Regrettably, the Aboriginal community has been systematically excluded from the entire decision making process in the *New Australian Government Indigenous Affairs Arrangements,* which epitomises the very experience of dispossession, disempowerment and disinheritance which has characterised relationships between Indigenous peoples and governments of this country since occupation.

APPENDIX 1



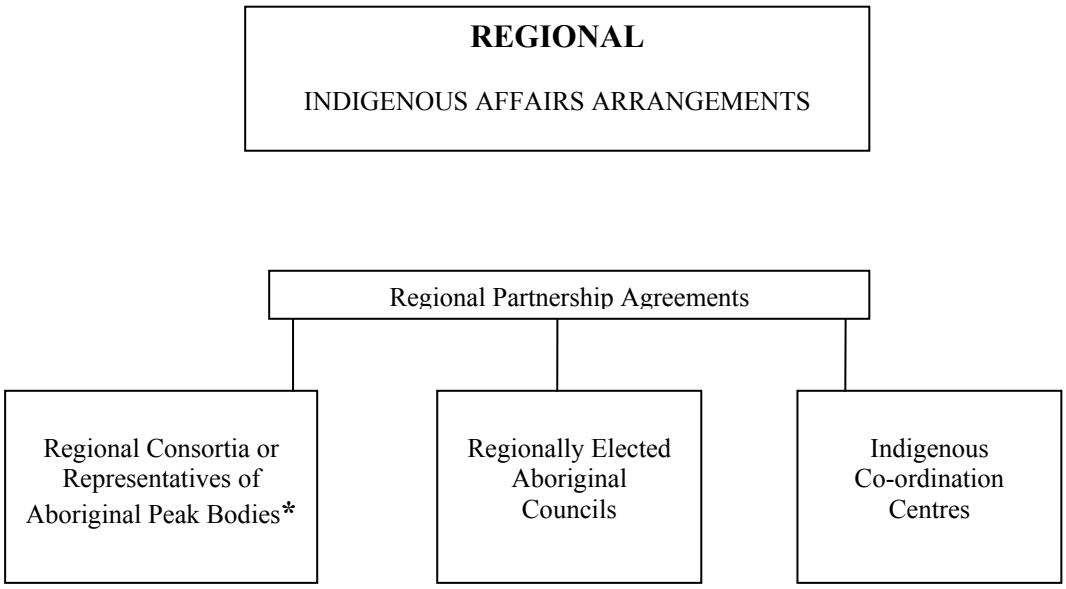
*The shaded area indicates the composition of the national representative structure as recommended in this submission and is the only change of the *New Australian Government Indigenous Affairs Arrangements* at this level.

APPENDIX 2



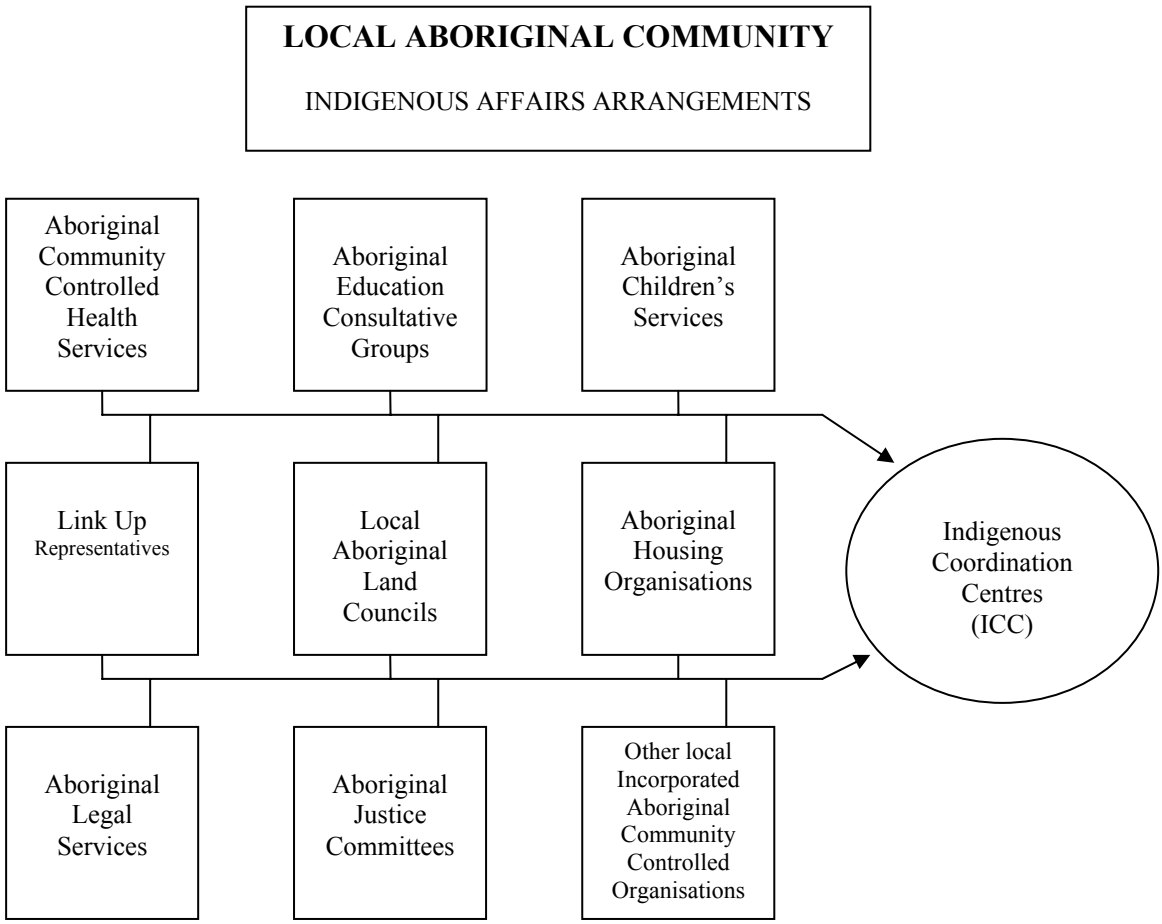
* At the State level, program specific agreements and programs with respective Departments and agencies will remain to ensure sustained provision of specialist services. For example, in health, the extant **NSW Aboriginal Health Partnership Agreement** between the AH&MRC and the NSW Government.

APPENDIX 3



*At the regional level, program specific agreements and arrangements will remain, not to be replaced with this generic structure. For example, in health, extant **Local/Area Aboriginal Health Partnership Agreements** between local Aboriginal Community Controlled Health Services and Area Health Services are necessary to ensure that the collaboration between agencies and service providers continues enabling vital service delivery.

APPENDIX 4



For *Shared Responsibility Agreements* and *Regional Partnership Agreements* outside of the above structure, *Indigenous Coordination Centres* should be advised by the Aboriginal parties to the *Regional Partnership Agreement* due to the potential issues of probity and accountability arising from funding unincorporated or non-representative bodies or individuals.

This local structure would remove the need for government initiated *Community Working Parties* as well as provide the coordinated response of local organisations.

ACRONYMNS

ACCHRS	Aboriginal Community Controlled Health Related Service
ACCHS	Aboriginal Community Controlled Health Service
ACS	Aboriginal Children's Services
AEC	Australian Electoral Commission
AECG	Aboriginal Education Consultative Group
AHB	Aboriginal Housing Board
AH&MRC	Aboriginal Health and Medical Research Council
AHO	Aboriginal Housing Office
ALS	Aboriginal Legal Service
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
ATSIC	Aboriginal & Torres Strait Islander Commission
ATSIS	Aboriginal & Torres Strait Islander Services
CDEP	Community Development Employment Program
CEO	Chief Executive Officer
COAG	Council of Australian Governments
CWP	Community Working Party
DIMIA	Department of Immigration, Migration and Indigenous Affairs
DOHA	Department of Health and Ageing
GP	General Practitioner
ICC	Indigenous Coordination Centres
MOU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy (1989)
NAILSS	National Aboriginal & Islander Legal Services Secretariat
NAJAC	National Aboriginal Justice Advisory Council
NCA&TSIH	National Council of Aboriginal & Torres Strait Islander Health
NCAH	National Council for Aboriginal Health
NGO	Non-Government Organisation
NIC	National Indigenous Council
NSFATSIH	National Strategic Framework for Aboriginal and Torres Strait Islander Health
NSW	New South Wales
OATSIH	Office of Aboriginal & Torres Strait Islander Health
OIPC	Office of Indigenous Policy Coordination
PHCAP	Primary Health Care Access Program
RCIADIC	Royal Commission into Aboriginal Deaths in Custody
RIRN	Regional Indigenous Representative Networks
SNAICC	Secretariat of the National Aboriginal and Islander Child Care