

**LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY**

STANDING COMMITTEE ON HEALTH

(Reference: Aboriginal health)

Members:

**MS K TUCKER (The Chair)
MS K MacDONALD
MRS J BURKE**

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 21 February 2003

**Secretary to the committee:
Ms S Leyne (Ph: 6205 0490)**

By authority of the Legislative Assembly for the Australian Capital Territory

The committee met at 11.35 am.

THE CHAIR: Thank you all for coming and giving us your time. I want to put on the record that I know that you have very often come and spoken to committees of the Assembly, and we've had lengthy reports produced with recommendations. I'm equally frustrated with the fact that we haven't seen things change very much. That's why I'm wanting to get this feedback from you all right now, rather than going into a whole new committee process. The reason the committee is doing this is that we want to keep a watching brief on what's happening.

At the beginning of this term of the Assembly, I put a motion to the Assembly, which was supported. That will now require the departments to produce, in their annual reports, an update on progress—how they've progressed and recommendations of the committees of the Assembly that they have agreed to. That is an attempt to keep the spotlight on the committee work, and recommendations the government agrees to, so they don't just drop off. That happened for the first time in the annual report for this year that we've just looked at. That was on Aboriginal health. I asked them, and they responded to that. Even though it was the last government which responded to the recommendations, this government also has responded—and therefore it now has to be reported in the annual report.

The Health Committee wants to keep a watching brief on what's happening. We weren't happy with how the report was represented—how the progress report in the annual report was done. It was broad and vague, and that wasn't the point of the motion the Assembly passed. The point of the Assembly motion was that we have clear updates on what they've done. It's an accountability measure that's really important.

In light of the fact that we didn't get that, I've invited you here today for you to tell us how you think. I'm not asking you to refer specifically to each recommendation—just that you give us your sense of what's happening. I open it up now for you to tell us.

JULIE TONGS,

PETER SHARP and

ROBERT ERNEST HUDDLESTON

were called.

Ms Tongs: Thanks, Kerrie, for inviting us here to meet with you and the committee. Firstly, I'd like to introduce Dr Peter Sharp, our medical director; Glyniss Church, the team leader for the substance misuse team at Winnunga; Pippa Duncan, from Plan Health consultancy; Bob Huddleston, board member, Winnunga; and Dr Ben Bartlett from Plan Health consultancy.

I'm conscious that Bob has to leave at 12 o'clock. I was wondering if Bob wanted to say anything, before we get going, as board member of Winnunga.

Mr Huddleston: Perhaps I can just speak generally?

THE CHAIR: Sure.

Mr Huddleston: I've been with Winnunga before. I was with Winnunga in the early days when we were at the Griffin Centre. We found that the Griffin Centre was inadequate for our permanent place, so we moved over to Ainslie. Ever since we've been at Ainslie, we've grown out of proportion to expectations.

Our major problem now is that we need other facilities. We've approached government on that issue. That's the basis of what I have to say—that I think the ACT government should give consideration to the future of Winnunga Nimmityjah. We've met everything the ACT government has expected of us in respect of accountability, including our accounts and all those things—and especially our service to the Aboriginal community.

That is a service which cannot be met by mainstream services. We've proven that over the years, not only with our organisation but with every other medical organisation in Australia. I've been to the Northern Territory, Queensland and New South Wales, and they all have similar problems. It is a service which should be independently met by Aboriginal people.

We thank the ACT government for giving us the opportunity to do that, but we need support. We need support from this moment on. We need to be more independent—we need a facility of our own. We're sick and tired of rhetoric, and we're sick and tired of promises. We need something substantial from here on in.

THE CHAIR: Do you have a preference? In which area do you want to be accommodated? Is Ainslie good, or would you rather be in the city? What is the feeling?

MRS BURKE: Do you need a split facility—north and south?

Mr Huddleston: We've been offered the facility at Narrabundah.

Ms Tongs: It doesn't matter where we go—the location doesn't matter. We don't want to be out in the sticks somewhere. We don't want to be at the back of Belconnen or the back of Tuggeranong. Narrabundah is fairly central now. If we were able to secure the premises we've been offered, that would be really good for us.

THE CHAIR: What have you been offered?

Ms Tongs: Part of the Narrabundah Health Centre—not the whole lot.

THE CHAIR: Is that still not definite?

Ms Tongs: There hasn't been an official announcement, as yet.

THE CHAIR: When was it offered to you?

Ms Tongs: Probably in August last year.

Dr Sharp: It was in July.

MRS BURKE: Have they given you an indication that they may be formally making an offer? Is that on the table?

Ms Tongs: We haven't had anything in writing, other than to say that it is progressing. With the bushfires, accommodation is scare now. We always seem to get pushed back every time something happens. It impacts on us. Where we are at the moment, there are serious occupational health and safety issues. I'm sure that if occupational health and safety people came to Winnunga, they would close us down—and then our community would suffer. Mainstream would never cope with our clients. It would be a real dilemma for everybody.

Dr Sharp: One of the other problems at the current place is that it's a lovely suburban house, but a suburban house isn't suitable for a medical service. There are no rooms and there is no privacy—it's just impossible.

MRS BURKE: I remember that issue from when I was there last time. The walls are paper thin. It was difficult to have consultations with clients.

Mr Huddleston: It's met our needs sufficiently until now, hasn't it?

Dr Sharp: It was a great step forward from where we were—yes.

THE CHAIR: I thought you were using part of a building above Bernadette's.

Ms Tongs: We are. We run a diabetes clinic monthly. We have some services from ACT Community Care come in—a diabetes person and a podiatrist. There are fairly steep steps. Some of our people are on dialysis. It's difficult for people to make it up those steps. It's really unfair.

THE CHAIR: Yes, I know those steps.

Dr Sharp: We've got several patients in wheelchairs, for whom we do our consultations outside, under the trees. We can't get them into the doctors' rooms.

MRS BURKE: That is not appropriate.

Dr Sharp: No, it's not.

MRS BURKE: Is there anywhere else, Julie? Earlier on, I mentioned a split site—keeping Ainslie and then maybe southside. The last time we talked, you said you had a lot of people coming to you from southside areas. Would that be a possibility?

Ms Tongs: We have a 99-year lease on Ainslie, so that is our facility. Ideally, what we'd like to do in the future—and maybe we could in the interim, until people get used to it, or until we see what sort of impact the move would have—is operate an outreach from Ainslie maybe a couple of days a week. But it does need to have work done to it. Ideally, we'd like to turn that into a training facility.

MRS BURKE: So you would stay there and hopefully keep somewhere like Narrabundah going.

Bob, I know the facility down at Erindale is the business-type centre and the youth centre. Is there any possibility of converting some of the facilities you have down there?

Ms Tongs: They're already overcrowded in there. We have thought of that option.

Mr Huddleston: We've got the CTP out there too.

MRS BURKE: Yes, I'm aware of that.

Mr Huddleston: And also the Gugan Gulwan.

MS MacDONALD: Location would be an issue, too—it may not be central enough for people on the northside.

MRS BURKE: I was just thinking of southside clients that you have. I know they have to travel.

Mr Huddleston: We've got a large community out in the Tuggeranong area. But we've also got a large community in the Belconnen area, you know. I think anywhere in the ACT is central to everybody—they can get there without much trouble. The ideal thing would be to give us a purpose-built building.

MRS BURKE: What would that look like, and where would it be? I think that's what we're trying to ask.

Mr Huddleston: We don't know whether there is any spare land around. We don't know the geography of the country—as to whether there is any land.

THE CHAIR: Sure. You're saying that, ideally, you would like a purpose-built building.

Mr Huddleston: Ideally, we would like a purpose-built building. We have 41 staff in that little place up there, and it's like a rabbit-warren at the moment—like people are sitting on top of one another. They've got no facilities—they've got no independent surgeries. Dr Pete hasn't got a place where he can do his surgery. He just has a little box—a little office.

MRS BURKE: Have you got an idea—a sketch in your minds—of how many rooms you would need? What sort of area; what size of building; what sort of land size are we looking at?

Ms Tongs: We'd need to have an architect come in and do that for us, you know.

THE CHAIR: That's a bit too much detail for the moment.

Ms Tongs: Yes, it is,

MRS BURKE: I was talking about rooms. I suppose it's appropriate. If we're looking at what your needs are now, we need to look down the path. We need to know what the outcome is and work towards it.

Ms Tongs: For a start, we have two full-time doctors, three sessional doctors, a psychiatrist who's there three days a week and nine Aboriginal counsellors—the social health team. Glyniss is the team leader of the substance misuse team, and Leanne is the team leader of the social and emotional wellbeing team. For the staff out the back, there are three to one desk. They do not have any space, as it is. There is no specific counselling room.

The walls of the doctors' rooms are paper-thin. If you're having a consultation with one doctor, you can hear what the doctor in the other room is saying to the other client. So there are real confidentiality issues. We've got over 5,100 clients, so obviously that's not a deterrent for them. We had 80 new clients in a three-week period, before Christmas.

MRS BURKE: I was going to ask how that compares to this time last year—the numbers.

Ms Tongs: It's increasing daily. Part of that is because many doctors are no longer bulk-billing.

MS MacDONALD: I was about to ask you about the bulk-billing issue—how you dealt with it.

Dr Sharp: We have to bulk-bill, obviously. We provide services to anybody who comes. Whilst they are mainly Aboriginal people, we'll certainly help anybody who needs help. There are a lot of people out there who are having difficulty accessing medical services now, because of the drop in bulk-billing. They know each other. They say, "Go to Winnunga—they'll look after you." We're happy to do that, but it stretches our resources further and further—every time.

Mr Huddleston: When you look at it in the context of the number of people that we service, it's really big. There are over 5,000 people. It's a great big drain on mainstream community services. We're doing that job for them.

Ms Tongs: Primarily, we are funded by the Commonwealth to run an Aboriginal health service. The ACT needs to start looking at how they're going to resource us to pick up the slack for the non-Aboriginal people who access our service.

MRS BURKE: How many would that be? I know you have spoken to me about that before.

Ms Tongs: Probably about 500—maybe more.

Dr Sharp: About that.

MS MacDONALD: About 10 per cent?

Ms Tongs: Yes. They are marginalised people—disadvantaged people—who have drug or alcohol problems and complex health needs. They fall through the cracks of mainstream. People in mainstream were advertising our doctors' services. It is pretty poor, when we're under-resourced as it is, to be referring more people to us. There is nowhere else for these people to go. We're happy to do it, and I'm proud to say that we don't discriminate. That's why people feel comfortable coming to Winnunga.

THE CHAIR: On the accommodation issue, basically would the facility at Narrabundah be adequate, more than adequate, or still difficult?

Dr Sharp: I think it would be adequate. A purpose-built place would be ideal, but let's be realistic.

THE CHAIR: It would be adequate?

Dr Sharp: It would be a great step in the right direction—yes.

MS MacDONALD: Have you heard recently about what is happening with that? You were talking about it before, and discussions were to take place in August. Have you heard much about that lately?

Ms Tongs: No.

THE CHAIR: We can move on from the accommodation question.

Ms Tongs: Ben is going to do a presentation about what we do as a comprehensive primary health care service. With holistic health, people just don't seem to be able to get a handle on what we actually do at Winnunga,

BEN BARTLETT was called.

Dr Bartlett: As to who I am, I work with Pip. We've both worked in Aboriginal health generally for 15 to 20 years, in different parts of the country. Last year, we had the privilege of doing a strategic plan for Winnunga. One of the interesting things which highlights some of the sorts of problems with Aboriginal health generally is that, in doing the strategic plan, there was a lot of pressure on us, in a sense. Nothing could be done—no new resources could go to Winnunga until the strategic plan was done. The strategic plan was completed in August last year, yet there has still been no movement in addressing any of the issues. It's frustrating.

MRS BURKE: Was that last year—August 2002?

Dr Bartlett: Yes.

MRS BURKE: That was 12 months after this report?

Ms Tongs: Yes.

Dr Bartlett: What I've tried to do here is look at Aboriginal health a bit more generally, and what sort of strategic approaches are appropriate. Although this applies to Winnunga, it is a more general look at the situation. The first thing is to briefly revisit Aboriginal health status. There is a popular view that all this money has been thrown at Aboriginal health, but nothing has changed over the last 20 or 30 years.

I think that is an erroneous view—things have in fact changed. Infant mortality has fallen from eight times to around three times the Australian average, which is a major achievement. However, at the same time, young adult mortality is now the highest in the world, outside a war zone, in the Aboriginal community generally. That's also a new situation. That wasn't the case 20 or 30 years ago. Plus there are high levels of chronic disease now. That is also a relatively new situation compared to the 60s and 70s.

The current situation is that there are high levels of hospitalisation and longer average lengths of stay. That is where a lot of the Aboriginal health money is going. A lot of what the government is spending on Aboriginal health is at that end stage. Part of that is because of the lack of adequate primary health services in communities to prevent hospitalisation, and to provide better after-care—those sorts of things.

The factor that hasn't changed is that life expectancy remains around 20 years less than that of other Australians. The cause of that used to be high infant mortality, and now it tends to be high adult mortality. However, I think it's important to realise things have changed. It's not as if there has been no impact of policies over the past 20 or 30 years.

An important question is, why are Aboriginal people sick? If we can't answer that question, we're not going to develop strategies to address it. There are no simple answers or explanations. It's clear that one factor is that the histories of communities is a major contributor to the current situation the communities find themselves in.

There has been massive depopulation. If you look back over the history, just on the most conservative figures, Aboriginal people probably faced a depopulation of something like 80 per cent. It is hard to imagine—I certainly find it difficult to imagine—the impact that has on a society. Of course, there was conflict and massacres, but much of that depopulation was due to the introduction of infectious diseases that Europeans tended to be immune to, to which Aboriginal people hadn't been exposed to before.

So there is this process of fragmented families, as well as marginalisation. I think that's largely the situation in the Aboriginal community today. They continue to be marginalised. Owing to those histories, there are enormous levels of grief, stress and powerlessness, which we'll come back to. Also, as part of the marginalisation, their living conditions are poor. After the fires, the housing situation in the ACT is going to get worse for Aboriginal people. It's already tight and difficult.

The community has low levels of education—again that is part of that marginalisation—and there is generally poor access to services. That relates back to the high levels of hospitalisation. This view is now strongly supported by international research in an area generally known as the social determinants of health.

There is no time to go into great detail, but I want to refer a little to the Whitehall study—UK-based research. An overview of the evidence, which is fairly strong, is that one factor of good health relates to education—especially the education of women.

The second factor is the autonomy of women. To some extent, that is related to the education of women, but there are some differences. If a mother doesn't have the autonomy to act on concern about a sick child, for instance—if they have to wait for the paternal grandmother, or something like that, to give permission, then that has an impact on people's health.

There is a great deal of evidence to suggest that what happens in early life, including intra-uterine life, is at the core of a great deal of chronic disease in adult life. Obviously, employment—or economic activity more generally—is a major determinant, as is access to good quality food. Then there is the physical environment, such as housing, water, waste disposal, et cetera—and access to health services. There is evidence that, where there are strong social networks, that is a positive for people's health. Certainly the Aboriginal community has those. Within the Aboriginal community there are strong social networks. Those networks are critical for people dealing with their problems.

Overall, there is the problem of social exclusion. That, of course, is a negative. Addictions are a major determinant—and chronic stress. I'll come back to the stress question. There is also this notion of a social gradient—and the UK study particularly looked at that.

This graph shows what we mean by “social gradient”. The UK study was looking at UK civil servants. Public servants were divided into four categories. The admin category is the senior executive and the professional group is clearly made up of people like lawyers. That is still a fairly high level. Then there is the clerical level, which is the bottom of the heap. It was not so surprising that people at the bottom had poor outcomes.

It was fairly surprising that the professional group had twice the mortality experience over the 10-year period over which the study was conducted than the top executive group. The professional group includes people with high levels of education, high incomes and high levels of resources—that means they can do their job properly—and yet they still had this high mortality experience. This is significant information. We’re not talking about minor effects, we’re talking about major outcomes.

In the study, they looked at risk factors such as cholesterol levels, blood pressure, smoking and obesity. They allowed for those sorts of things. I don’t want to go into too much detail with this table. It shows that, if you look at the current smokers at the highest grade, their death rate from coronary heart disease is much less than that of non-smokers.

That illustrates that smoking is only part of the story. In fact, the evidence suggests that, if you approach this question looking at ischaemic heart disease, only 30 per cent of ischaemic heart disease can be explained by any of the known risk factors. The rest of it is the other effect that this study has exposed.

We will come back to Aboriginal health. The evidence suggests that this effect is about stress. There is a common attitude—which I believe is driven, to some extent, by who has the money and who can pay for stress management programs—that it’s people in high positions of authority who suffer the most stress.

Stress is a natural phenomenon. It is a healthy phenomenon, provided the conditions are such that the stress can be resolved. People in positions of high authority have the resources to deal with the problems they confront. They have the stress reaction physiologically, but they are able to relax completely because they’ve been able to deal with it. People at the bottom of the heap have chronic, unresolved stress. That is very unhealthy—that’s the killer.

To bring it back to a broad view of the situation in Aboriginal communities, we have what could be called the grief-anger-despair cycle. If you look back in history, you’ve got massacres, infectious diseases, dispossession, forced settlement and the taking away of children. The natural human response to those things is grief, anger and despair.

The problem is that—a Sydney writer, whose name I can’t recall, has done some work about this—people who experience these horrors tend not to talk about them. I’m sure we all know people who have been in wars who have come back and not talked about them. The woman I’m referring to is in Sydney and has written a book about “the silence”. She’s mainly focusing on people who went through the Holocaust in Europe.

People don’t talk about it. What they pass on is not the detail of why they’re stressed or depressed or why their behaviour might be erratic. What they do pass on are the emotional impacts. Then people personalise it and blame themselves—so they feel bad

about themselves. Alcohol abuse, for instance, becomes almost a self-medication. That then produces other nasty things—violence in the community, et cetera. That produces more grief, anger and despair. A lot of people are locked into this cycle of grief, anger and despair which is self-generating and is dislocated from the things that started it in the first place.

This isn't just a mental health issue—this also relates to people's physical health. This stress is a physical phenomenon; it's not just a thing in your head. It causes high blood pressure, which damages your arteries.

THE CHAIR: Thanks for coming, Bob.

Dr Sharp: It has physical effects. Part of the strategy for trying to overcome this has to be what I've termed a hope-optimism-confidence cycle. For the dysfunctional communities, families and individuals caught in that grief-anger-despair cycle, there needs to be something to break out of that. That is the point at which I think we need to focus, and it is difficult. It means that simply providing high quality medical care—I'm not saying that shouldn't be provided—is not going to break the cycle. In fact, it can perpetuate it because it can potentially leave people in quite passive situations where they are not making any advances themselves, they're just receiving the immunisations which Winnunga, I understand, is very good at.

There are other aspects of what places like Winnunga are on about. They are community action, solidarity, building up networks, being supportive in the community and providing services in that context. That is what I think we mean by comprehensive primary health care.

Going back to Winnunga, I put this in because I think the main thing you have to realise is that it is about people, yet we've been talking about a building. Despite the problems in the building, we were extraordinarily impressed with the quality of Winnunga's work. People are incredibly committed to working with these enormously difficult problems.

The hours people work, their availability, their responsiveness—all these things stand a little—with all due respect to the mainstream—in contrast with the way mainstream tends to operate. That is that, "I look at eyes. I set up my little room and people come to me. This is what I do." That's how we experience it.

If you're a fairly powerful person in your own right in society, that's probably all you want. You don't want to be messing around with anything else anyway, so that may be appropriate. But the problems are complex. Most of the adult and child clients of Winnunga would have multiple problems at physical, emotional and spiritual levels.

How Winnunga operates is quite different from mainstream—and I don't think the mainstream understands that. In the work we were doing, when we said that, we got some negative reactions. One example was, "Oh, yes, there is a comprehensive primary health care service in Canberra—it's the Junction youth centre."

We went and talked to the coordinator, and it's a dog's breakfast. The funding doesn't go to the Junction youth centre. The division gets some of the funding for the doctors, there are contributions made from ACT Health, and community care for nurses. If someone

can't come to work, they don't contact the coordinator of Junction, they contact the division or whatever, and then they try to get through. It's not comprehensive at all—it's a management nightmare. So there are many issues about people understanding the phenomena of Winnunga. I don't think there is any example of that in the mainstream.

The other area where I think there is a clash is that several people said to us that, in the work we're doing, Winnunga staff are not qualified. In fact, these staff are highly qualified to work with Aboriginal people because they are, themselves, from the community. They've often experienced the same sorts of problems as their clients.

Think of most non-Aboriginal professional staff. They come from reasonably well-off and secure middle-class backgrounds. Those backgrounds don't prepare them for the issues faced by Aboriginal clients, regardless of their academic qualifications. It's not that academic qualifications aren't important, but there needs to be a recognition that there are two types of qualifications operating. The knowledge of the community, being part of the community and understanding all that sort of stuff is an essential qualification for doing the sort of work Winnunga does.

I think the challenge is, given the poor access Aboriginal people have had to educational opportunities, how do we provide some catch-up for people to gain more formal qualifications? I believe strategies need to be worked out about that, as well as dealing with the continuing educational disadvantages Aboriginal people have generally, for schooling and that sort of thing.

MS MacDONALD: Does Winnunga link with CIT's Aboriginal centre—the Yurauna Centre—doing joint sorts of things with them, with regard to education and so on? I'm not sure if there is an equivalent to the Yurauna Centre at the University of Canberra or the ANU.

Ms Tongs: The dilemma we have is that we're so under-resourced that it's really difficult. We've got two staff members doing the Redfern Aboriginal mental health counselling diploma at the moment. When those two go out, we don't have resources to backfill that space. That puts more pressure on the staff who are already there. Primarily, all my staff are employed to deliver a service to the people in our community. There has never been any consideration given to backfilling positions. That puts the staff left behind under more and more pressure.

We need to be looking at how we can get our staff qualifications. But that's not the be-all and end-all for our people. It's about being able to relate to the people and understand their issues. We've lived it. It doesn't matter whether you live in Canberra, the Northern Territory or in a remote community somewhere—there are more similarities than differences when it comes to Aboriginal health.

GLYNISS CHURCH was called.

Mrs Church: We can also understand that you need a bit of paper—a certificate is fairly relevant these days. But the fact is that, when you live the lifestyle, you know your people, you relate to them, you know and understand their needs. That’s more important than a piece of paper.

We can go and do certificates after certificates, but that’s purely to support a health organisation because you need to have a certificate in a particular area. But having the life experience and dealing with your people all the time—because you’ve lived the lifestyle, understanding their issues is so important.

Whilst we’re out there working, we’re linking-in with a lot of non-Aboriginal organisations—purely because we understand that they provide their services, too, and we like to work with them. We have to bring the other government organisations up to scratch on how to sit down and listen, and support our clients in the way they need to be supported. Sometimes it’s not about giving them medication. I can take you through many cases where we’ve got clients in different organisations—they are rehabs and things like that—who need spiritual healing.

Now who’s educated in spiritual healing? I’ve got clients who need to have that spiritual healing. They’ve come to me and said, “Look, I’ve got some spiritual problems. How do I deal with them? How can I get some help?” Within our community, smoking is a spiritual healing for us. To have someone out there in a rehab not know about that is upsetting for us because we know what our clients need. We sit down and talk to our clients who have lots of spiritual problems. When we try to sit down and talk to the workers about this, it’s a case of where do we start?

There are a lot of issues on which we like to deal with our people ourselves, because we know the community. Like I say, it’s not always about medication, sometimes it’s just about listening—going there, being there and supporting them. Just being there is enough.

THE CHAIR: I need to know where we’re going with this. I think we have until 12.30 pm. Have you finished your presentation?

Dr Bartlett: Not quite. There are a few other things I want to emphasise. We’ve talked about the physical space. I won’t talk about that again, except to say that it wouldn’t be tolerated in mainstream. The core operational budget for Winnunga represents about 30 per cent of its activities. The rest of the funding is fragmentary—bits and pieces. I think that puts them at potential risk, financially.

It tends to represent a problem to do with lack of cohesive and consistent funding arrangements by both the Commonwealth and ACT governments. An example of that is that, last year, there was a proposed three-year funding from Healthpact, which amounted to a total of \$100,000, so it was \$33,000 a year. But, for that, they wanted their own strategic plan. That is bizarre for such small amounts of money. There needs to be some process that starts to be much more strategic in how Winnunga is seen and how it is supported, to do that job.

I'll quickly slip this in to try and get some sort of structural idea about what comprehensive primary health care is. Basically, it is the clinical work. It's the acute care, the preventative care such as immunisations and Pap smears—and there is the management of chronic disease and disability. There are social preventative programs, which require community agencies. Many of the problems the community have are not going to be dealt with through immunisations or medical intervention. Winnunga is very strong on that side.

There is a serious weakness in the support that primary health care needs to function. The support can roughly be put into the categories of management and administration. Julie does not have a personal assistant or a policy officer. Any mainstream person in an equivalent position would have support staff to help deal with the wads of paper that come through, et cetera.

Then there is education and staff development. People pick that up on the fly. People were talking earlier about the current premises—and what if new premises were found. One possibility is to set up the existing premises as an education centre, maybe regionally—taking in some parts of New South Wales as well—so there can be a more systematic approach to filling some of the educational gaps which currently exist.

Program development and evaluation is an area Winnunga has trouble with, which is partly a resource question. People want data about the programs but if there is not the support to set up the systems, then it's very difficult to get that data. That relates to IT stuff generally, as well.

The other area is policy and advocacy. Sometimes people have been anxious that Winnunga is stepping outside its core business. But because Winnunga is the main community development agency for the Aboriginal community in Canberra, it inevitably gets caught up in having to advocate for housing needs—for a whole range of needs.

Julie talks about holistic health care, which I don't think is well understood. There is a difference. Winnunga is a health service, so overall it provides comprehensive primary health care, but it doesn't provide housing or fix the roads. The holistic practice of people in the service is that they don't deal just with the diabetes. They're dealing with the diabetes, the attempted suicide of the son, and with the problems with housing. That's what holistic practice is at that level.

What needs to be done? That is what this is all meant to be working up to. There is a framework agreement between Commonwealth, state, and territory health ministers, ATSIC and NACCHO. These tend to operate around the country, but the ACT one is not signed. The purpose of this framework agreement was to overcome what had been identified as a major barrier in addressing Aboriginal health problems, which was cost shifting, and buck-passing between the Commonwealth and the states.

In some jurisdictions, the framework agreement has worked reasonably well. The different players, at a higher level, have sat around the table and started to work out how to provide services that don't duplicate each other—how to get away from some of those problems. The issue is that people come up with another proposal about how to break some of the problems that exist, or to get the framework agreements working properly.

In order to do that, that must be signed. Winnunga has to be provided with the resources to participate equally, and the commitment has to be such that senior people sit around the table. Sitting around the table with junior people who can't make decisions is hopeless—it just wastes everyone's time. So it has to either be taken seriously or a new framework developed about how to deal with it. Of course, one player can't do that, it does need the players to do it.

MRS BURKE: Where is the agreement up to? Why isn't it signed?

THE CHAIR: We can pursue that, as a committee. Unless you have a quick answer, I think we need to keep going or we're not going to get through.

Dr Bartlett: I've nearly finished. The other thing, which is more internal ACT government, is an all-of-government approach, which I understand is being pursued. That all-of-government approach is part of the recognition that Aboriginal health problems are not solved by the health sector—it involves other sectors. There needs to be some accountability from the housing authorities, et cetera, as to what they're doing about Aboriginal health in the more general way. Having some sort of forum of departmental heads who provide some reporting against performance indicators for their departments I believe is critical.

Accountability goes two ways. Of course, Winnunga has to be accountable for the public dollars it gets. However, if we're serious about addressing Aboriginal health, governments have to start developing their mechanisms for accountability. I take note of your introduction. I think there is some intent about that.

THE CHAIR: Sure.

Dr Bartlett: I believe part of it is also recognising that a community development approach is a difficult thing to operationalise at times. You can do an immunisation program—bang, bang, bang—it's quite simple. It seems to me that we're in a learning curve here—and departments will be in a learning curve about how to operate better. That requires an approach that is still focused on outcomes, but which recognises that there is a long strategy about some of this stuff and that it doesn't fit the electoral cycle of three years. Governments always want to get the runs on the board in three years but sometimes that undermines the longer-term strategy.

Ms Tongs: This is why I've always said that we need bipartisan support for Aboriginal health. We've got very sick people and we need to have a whole-of-government approach if we're serious about addressing these problems.

THE CHAIR: Is that the finish of your presentation?

Dr Bartlett: Yes, thank you.

THE CHAIR: Thank you very much. Are there any other comments you want to make?

Ms Tongs: Yes. The Labor government put out some commitments before the last election. One of those commitments was to allocate \$140,000 to create two new

positions for dual diagnosis outreach workers to be co-located at Winnunga Nimmityjah Aboriginal Health Service and Gugan Gulwan Aboriginal Youth Service, to assist the services in the long-term management of complex-needs clients. This hasn't been forthcoming.

We have clients with complex needs who need intensive support work. Because there are many clients with complex needs, staff are getting dragged in different directions. We could have, say, another eight people on the ground. These clients are barred from Centrelink, so that takes my staff out. They need to go down to Centrelink, double-park or park however; run in to tell the Centrelink people that they're there and that the client is in the car, and the Centrelink officer comes out to the car, to the client. The staff member has to sign a consent form.

MRS BURKE: Surely you must be some way down the track with that—aren't you?

THE CHAIR: Jacqui, can we just let them make the presentation? We've got five minutes—and I don't want important information to not come out.

Ms Tongs: It's a real dilemma for us. I've spoken with Centrelink staff and also the funding body—Department of Family and Community Services. If they're not going to let our clients into Centrelink, they should come to Winnunga and see our clients. They need to do the outreach. Our dilemma, again, is our building. Where do we put people? How do we get people from Housing, Centrelink, Family Services, and drug and alcohol—all those other places? You name it—there are issues.

My staff are expected to be sitting in with these people. A lot of these things can be addressed through mainstream but, as soon as it's an Aboriginal person, they refer them to Winnunga regardless of what it is. I had a client who rang Lifeline from Winnunga, only be told to ring Winnunga. She said, "I'm already at Winnunga."

THE CHAIR: The \$140,000 is one thing that's outstanding.

Ms Tongs: It is, yes.

THE CHAIR: That's the dual diagnosis, which would deal with a number of those clients.

MS MacDONALD: You're raising a bigger issue in that too, when it comes to cooperation with other agencies and their understanding of the needs of your clients. They should not necessarily be flicking them straight to you but possibly coming to some understanding of what your clients need, and doing some work with you as to how they should deal with your clients.

Ms Tongs: Then it comes back to the resources. I'm on the health directions board. This is just one example. I'm the CEO of the Aboriginal Health Service; we have Rosemary Follett, who is the chair of that committee; James Ryan, the head of corrections; there is the director of family services, director of drug and alcohol; a mental health person—and then there is me. They've all got specific areas to look after, but I've got to be across all the areas—one person.

Then everyone wants a piece of me. When I don't turn up to their meetings, I'm the worst in the world. I'm only one person—I can't be everywhere. If my staff start running off to meetings—we could be in meetings every minute of our day—who looks after our people?

Dr Bartlett: There are also examples where arrangements are that a mainstream service will get funding for an Aboriginal program, then go to Winnunga to work out how to do it, and Winnunga doesn't get the resources.

MS MacDONALD: I don't want to take up your time, but I'm chair of the Education Standing Committee. We're currently conducting an inquiry into vocational education and training. I'd like to have a chat with you at some stage about getting some information from you—and some ideas have just come into my head. I might pop upstairs, before I go, and grab some cards, if that's all right.

Ms Tongs: That would be fine.

THE CHAIR: Yes. Do you want to make some comments?

Ms Tongs: Yes. Dr Pete, do you want to talk about what you do and how long you've been there?

Dr Sharp: It's not so much what I do, but what we do. There is a lot of talk about holistic care and health care teams working. There is lots of talk and not much action—except at Winnunga. We do what we do extremely well, under extraordinary stress. We work as a team. Glyniss and I work together and talk together constantly. It's not a matter of the doctors running the show, as it shouldn't be. Aboriginal health must be in Aboriginal people's hands.

THE CHAIR: Do you want to make a comment?

PIPPA DUNCAN was called.

Ms Duncan: As part of the consultancy, to do the operational strategic plan, we had to talk to several non-Aboriginal organisations. The big thing was that they basically said, “Look, we may have an Aboriginal worker.” They had many Aboriginal clients. But as soon as that worker left to do something else, their clientele was non-Aboriginal. It’s pretty major about having Aboriginal workers.

THE CHAIR: That’s an interesting question—you want to have both. You want to have a community-controlled sort of centre dealing specifically—as much as possible anyway—with the clients, but then having the mainstream services, and also having Aboriginal workers. There seem to be concerns about how well that can work too, because that person can become very isolated within the work force. We won’t go into the details of that at the moment. Glyniss, did you want to make a comment?

Mrs Church: As a worker, it’s very full-on there. Whilst everyone has their professions and they’re all labelled professional this and professional that, I feel that, having the ordinary workers there, with the life experience that all the health liaison people have, is an added bonus. Without that, we would not be able to provide the service that we do at Winnunga.

We are people who have lived the lifestyles. Our mob out there are subjected to exactly what we’re dealing with—housing issues, Centrelink issues and schooling. It’s an ongoing thing, and always will be. The health liaison people out there, with the support of our wonderful CEO and the doctors and psychiatrists at Winnunga, make a wonderful team and they are supported. We provide a real support team effort.

Dr Bartlett: That’s one of the things about workers in mainstream agencies. It’s often the relationship with Winnunga that allows the Aboriginal worker in the mainstream agency to get the clients into the mainstream. It’s not just the fact that you’ve got an Aboriginal person, it’s more who they are and what their relationship with Winnunga is—and other parts of the community.

Ms Tongs: I find that some of these—I call them token positions, in mainstream services—aren’t effective. A lot of those workers become our clients because they’re not supported. There is no support network for them—they’re “another bureaucrat” to our people. “We don’t want to go there—we want to come here.” But sometimes we have to say no. We can’t do everything.

We even do court support. We spend half our lives in the courts supporting young people from Quamby or the Belconnen Remand Centre. Dr Sharp goes to Goulburn jail and does a clinic once a fortnight—three hours a fortnight. In a 12-month period he’s seen 272 people. That’s a huge demand. It goes to show that the service is needed and that the people in there are getting the service they deserve. Regardless of whether they’re on the inside or the outside, people are entitled to proper health care.

Some days I think I’d like to be in a remote community somewhere, because you’ve only got the flying doctor or a first aid kit. A lot of those people have still got their language;

they've got their land; they've got their traditions and their culture—all those things. What we've got is a great deal of dysfunction. We can't get access to the services that are needed. If you try to get them into detox, they say they're not using enough. The fact that people are using— isn't that enough? There are all these barriers to try and get into these services, I've got to get on the phone and ask people, "What's happening here?"

MRS BURKE: I'm sorry that we're not further on than 15 months ago. I can't believe it. At that point, Chair, I'm going to have to leave.

THE CHAIR: Yes, sure. Thank you.

MRS BURKE: I'd love to meet you all again. Julie, I'll be in touch with you.

THE CHAIR: We will have to conclude. I don't know if you're interested in doing this again. You can think about it. We could have three-monthly or six-monthly meetings. However, I'm very aware that you are being taken away from your work.

MS MacDONALD: I'm wondering whether it would be possible for us to come and meet with you at Winnunga. I wasn't here 14 months ago so I haven't been to Winnunga Nimmityjah as an MLA. I haven't been there as an ordinary person either—but I'd certainly be interested in going and looking at the facilities.

Ms Tongs: You're more than welcome to come to Winnunga. But we've got to stop the rhetoric. We're dealing with reality at Winnunga.

THE CHAIR: Do you think it would be useful for us to meet again as a committee?

Dr Sharp: Yes, I think it would be.

Ms Tongs: Definitely.

THE CHAIR: We can work out when it is going to be suitable—three months, four months or five months—what period of time.

We'll certainly follow up some of the issues you've raised again today. I'll be making a statement in the Assembly. It's a way of just keeping the issue on the agenda and hopefully seeing something in the budget. Certainly your accommodation has to be dealt with urgently. I imagine even after this hearing—or hoping—we will be hearing a definite announcement from the government.

The issues of the dual diagnosis work is among the important issues you've raised today. The overall presentation was helpful—thank you for that. I have learned some things—the social gradient stuff is interesting. It is a good way to keep people informed. If we do this again, it would be great to get more members of the Assembly to sit in on it. It would be encouraging to do that.

MS MacDONALD: As one of the government members, I'd certainly like to take up the issue of election commitments which may not have been followed through.

The committee adjourned at 12.37 pm.