Supplementary Submission No 38a

INQUIRY INTO OVERCOMING INDIGENOUS DISADVANTAGE

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SUMMARY

Since the AHMRC prepared its initial submission to the Committee in November 2007 and updated it for the revised deadline in January 2008, there have been significant developments at the national level, notably the signing of the *Statement of Intent* in relation to *National Health Equity Targets* in March 2008, and the signing of the renewed *NSW Aboriginal Health Partnership Agreement* for 2008-2013 at the end of April. In addition, of course, we have had the opportunity to consider the Committee's Interim Report and the issues raised in it, together with the transcripts of the public hearings and the other submissions that have been made.

In the light of all this, the AHMRC view can be summarised as follows. The need for provision of health services in proportion to the burden of illness is immediate and essential on equity grounds, over and above all the things that need to be done to deal with the underlying causes of ill-health that may eventually reduce that burden over future generations. Too often this has been presented as an either / or argument between health services versus services to address underlying causes, as if there is no evidence that health care actually alleviates illness. Such an argument would be unacceptable if it were applied to any other community in Australia where there was such a gap between rates of illness and the health services provided. Adequate health services are needed now simply to save and extend life and reduce disability. They will continue to be needed until such time as indirect interventions have actually demonstrated that they have the health benefits that are claimed for them.

To that end, we believe the following specific steps should be taken

- Noting that the NSW Government has already signed up to the COAG health targets in relation to child mortality and life expectancy, the AH&MRC will be approaching the Government requesting it also sign the *Statement of Intent* and commit to the National Close the Gap targets, and work out what it is going to do, explicitly, to play its part in achieving those goals. Importantly, this should be done through the NSW Aboriginal Health Partnership.

- The NSW Government should develop and spell out a funded long term action plan to develop and report on the quantity and type of specific Aboriginal health services that are to be provided by 2013 and 2018 in each local geographic area, with an explicit statement of which are to be provided directly by NSW Health, and which by ACCHS's, and which by other providers, and agree this plan with the Commonwealth under the COAG processes currently in train.

- Noting that the NSW Government, through the NSW Health Department, has renewed the *Partnership Agreement* with the AHMRC, we believe it is essential for this to be agreed and specified in terms of funding and service provision in each of the following areas of Aboriginal health:
    - Health promotion and illness prevention, especially programs addressing SNAP factors (smoking, nutrition, alcohol, physical activity)
    - Primary Health Care (including mental health and wellbeing)
    - Acute hospital services and how access issues are to be addressed
    - Rehabilitation and extended care

The purpose of requiring an explicit statement of quantities and times and funding for each party is simply to ensure that it is clear who is responsible for dealing with each health issue in each area of the state, and who is to be held accountable for achieving the desired improvements in each, so that any future Inquiry into these matters is not confronted with the mysterious gap that one of the Committee members described as: *"...the words are brilliant but the outcomes are appalling*".

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In addition to the above, we have provided a number of things in this supplement which we trust will be of use to the Committee in assembling the Final Report.

We have provided a response to each of the 42 specific issues in the Interim Report, since we felt it would be useful to the Committee to have the views of the body representing the Aboriginal Community Controlled Health sector in NSW, even on matters where the relationship to health is indirect. Within that, we have focused most of our comments on issues of health care that did not seem to be well covered by the information thus far provided to the Committee. We regret that the public hearing most directly relevant to state-wide health issues coincided with the Apology by the Commonwealth Government to the Stolen Generations on 13th February, and we have done what we can here to provide the Committee with answers to a number of questions that were asked of the representative of the National Community Controlled Health Organisation (NACCHO) on that occasion, especially those that Dr Couzos referred to the AHMRC.

Though it might be argued that now is not the right time to introduce extra material unless it is recent and pertinent and has not previously been included, a concern we had with the Interim Report is that it seemed mainly to outline the views put to the inquiry and neither NSW Health nor the AHMRC was asked for that general background, while information from the Commonwealth Department of Health and Ageing was entirely absent. Thus to some extent the

health-specific issues moved into the background, and more general issues that contribute to health - the so-called "social determinants of health" - tended to dominate the report. We assume that the Final Report will contain a more comprehensive background on the health issues themselves, and the role of those who fund and/or provide health care services to Aboriginal people in NSW. We assume also that much of this will be assembled by the support staff for the Committee. To assist them, we have provided some analyses of issues in this area.

The main point that arises out of those analyses simply puts a number on things that were already identified by the Committee at Issue Numbers 4 and 16: the undervaluing of Aboriginal community controlled organisations, and the under-funding of health and wellbeing services for Aboriginal people. We have tried to make this more concrete by providing an analysis of the main findings from the Australian Institute of Health and Welfare (AIHW) report on Aboriginal Health Expenditure for 2004-05, with special reference to the available data for NSW. This demonstrates that only about 5% of expenditure goes through the Aboriginal Community Controlled Health Services, and that the documentation of how the other 95% is planned and spent by State and Federal government agencies is poor.

To clarify the role of AHMRC members in health care, under Issue 16 (funding) we have provided tables for every Local Government Area (LGA) in NSW that show AHMRC member services and other services funded by the Commonwealth Office of Aboriginal and Torres Strait Islander Health (OATSIH), and the Aboriginal population of the LGA in which they are located. These are arranged under the NSW Area Health Services who have overall responsibility for the health of the whole population in that region of the State. For each, we have given an indication of how many potentially avoidable deaths of Aboriginal people under the age of 75 would need to be prevented each year, simply to close the gap to the rate of premature preventable death that is already achieved for other Australians by those same Area Health Services. We believe that this is the most direct and graphic evidence of the gaps in services and their consequences for health, expressed in a way that anyone can understand. Ideally, we would have identified the specific Aboriginal health care resources provided by NSW Health and by Commonwealth-funded primary care providers at the same level of detail, but such things are not publicly available. We hope the Committee may be able to obtain and present information of that kind in the Final Report. It is very important to know this, because while we are waiting for the underlying causes of ill health to be addressed, it is health services that carry the responsibility for promoting and maintaining the health of those who are alive now but may not otherwise live to benefit from these longer-term indirect changes. If the services exist and are not achieving the result, that is one thing. If they do not exist at all, or not in sufficient quantity, or are not accessible, that is quite another. This simply underlines the points about resources that Dr Couzos explained to the Committee at the hearing on 13th February.

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The remainder of the material provided here in Appendices may be more or less useful to the Final Report depending on the direction the Committee chooses to take. They were not prepared specifically for the Inquiry, but for other purposes. The AHMRC is not an academic organisation that publishes in journals, nor a Government Department with a media unit and in-house data analysts and report production facilities. Nevertheless, plain English explanations of things that appear in elaborate reports are useful to members, and it may be that the same is true of a busy Committee.

It is very easy to become confused by the profusion of details in reports about the Aboriginal health "problem". The basic issue are actually very simple. There is not, and never has been, enough money spent on Aboriginal health services, or on other things that contribute to health. The figures that are quoted on expenditure are based on very crude estimate in many cases. Most illness statistics are probably minimum estimates of the gaps because of under-identification of Aboriginal people in routine health administrative data collections, even where they exist. Even so, they are usually so large that this hardly matters.

In these circumstances, it is grossly inequitable to demand better evidence before taking action, especially when such evidence has not been required for investment in the health and wellbeing of other Australians, but this is not obvious when the simple facts are obscured by quibbles over data and other details. We have tried to clarify that here.

In addition, we have tried to summarise the history of the last 230 years in a way that captures the sense of realistic hope that can be gained by touching on the high points of the last few years. We believe that the Committee has an opportunity, and also a responsibility, to make the Final Report a statement of practical things that can actually be done, relatively quickly, to begin to undo the legacies of the past, and to indicate who should do them, and with what resources. These are not complicated technical issues in the ACCHS sector. They only become complicated when they are 3% or less of the priorities of large complex organisations with other things on their minds. We hope that message is clear enough.

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ISSUES IN THE INTERIM REPORT

The AH&MRC appreciates the opportunity to make a supplementary submission to the NSW Legislative Council *Inquiry into Overcoming Indigenous Disadvantage.*

This submission was authorised by the Chair and Board of the AH&MRC after its meeting on 26th-28th August 2008. As previously, we have concentrated on the issues of health care and especially those where the role of our member organisations is most important.

Questions from the Public Hearing on 13th February 2008

We note that the hearing attended by Dr Sophie Couzos from NACCHO was held on the day of The Apology in Canberra, when, for obvious reasons, many people from the AHMRC were in Canberra and unable to attend the hearing.

Thus we would like to begin by stating that The AHMRC endorses the remarks of Dr Couzos on that occasion, especially the following exchanges in the uncorrected transcript.

Question on Responsibility for Outcomes in Aboriginal Health

> **The Hon. TREVOR KHAN:** Yesterday we met with a number of people who gave evidence to this inquiry. I do not wish to generalise too far, but it would be safe to say that virtually everyone who came before the Committee told us their projects and programs are doing a wonderful job. Whilst clearly that evidence was given genuinely, we are confronted today with the knowledge that—notwithstanding all the evidence that these programs are doing a wonderful job—there are huge gaps in social inequality, life expectancy, infant mortality, unemployment or employment rates, and educational outcomes.
>
> My impression is—and I intend to say this to every witness who appears before the Committee—if everyone is doing such a wonderful job, it does not appear to be reflected in what you could call the performance indicators. I make that comment, and I hope you understand I say it passionately. It seems to me that what we have heard from so many people was akin to a public service speak: the words were just brilliant but the outcome to me seems to be appalling. I am not being rude when I say this to you, and I am not being personally critical, but in the context of what we know the outcomes are, how do you say that essentially the organisations that you represent are producing an effective outcome?

Dr COUZOS: If there were no Aboriginal community controlled health services, there would be a massive explosion of costs in the hospital-healthcare sector. This has been demonstrated in an independent analysis of the cost effectiveness of Aboriginal community health services, particularly in the Northern Territory. They are already saving upstream—that is, in the hospital sector—tertiary level costs with the preventive and primary health care they are delivering. In terms of the results, there would be no question that the health outcome indicators would be a lot worse if there were no Aboriginal community controlled health services. Despite the fact that these services are doing a very good job—a much better job than any other primary health care provider in Australia—there is still a need to drive health outcome results to close the gap.

That is a manifestation of a number of factors. Of course, there is also social disadvantage. Even though services act to mitigate social inequalities, there is obviously a need to address them through housing, education, employment and so on. That goes without saying. You will never close the life-expectancy gap unless those things are addressed. Nevertheless, you will make a significant contribution to health outcomes if there are appropriately resourced primary health care services. The question then follows: Are they functioning to their optimal effectiveness and are they meeting community and health sector needs? The answer is no. That is because they are underresourced. There is tremendous evidence showing that; inquiry after inquiry has demonstrated it.

The Commonwealth Grants Commission inquiry into indigenous funding demonstrated it; the Health is Life report by the House of Representatives also demonstrated it; and there is no question that independent analysis has demonstrated it. Access Economics recently calculated the shortfall in funding for indigenous-specific primary health care to the order of $460 million per annum. An Australian Institute of Health and Welfare analysis of health expenditure shows that for every dollar expended through the Pharmaceutical Benefits Scheme for a non-indigenous person, only 30¢ is expended on an Aboriginal person. That is regardless of whether they are in a remote part of Australia or an urban environment. In fact, access to pharmaceuticals for urban Aboriginals is far worse than for remote area Aboriginals because there is no equivalent to the section 100 access scheme operating in remote Australia, which has revolutionised access for indigenous peoples living in those regions. We have an unusual situation wherein we have a very effective policy that has boosted medicine access in remote areas, but disadvantage continues in urban areas. That is evident in the expenditure statistics.

The other aspect with regard to indicators relates to how Australia measures its responsiveness to the needs of Aboriginal people. In many respects it is flawed. We tend to look at health status indicators as a measure of progress. However, we do not look at indicators of action. The human rights terminology for this is that the Australian Government's obligations are twofold; that is, obligations of conduct and obligations of result. We tend to look at the result side of things without assessing as a nation whether we are fulfilling the obligations of conduct in terms of service provision to meet community needs. That is where we are failing. There are insufficient measures with regard to the obligations of conduct. We have statistics showing that primary health care expenditure is insufficient to meet those needs. They need to be boosted according to appropriate need so that services across Australia can boost their capital infrastructure. That is part of the Close the Gap campaign

We have met with the Office for Aboriginal and Torres Strait Islander Health, which provided this information. At least $150 million is needed just to boost clinic infrastructure within these services across Australia. That is just infrastructure. How can a service move forward to meet the needs of the community if it does not have enough clinic space and is experiencing difficulty employing doctors because there is no room in their clinic? Many infrastructure issues need to be addressed. While they do a good job, they are not supported enough to provide the optimal support necessary to meet the needs of the community.

The AHMRC believes that in considering the health outcomes of existing services, it is appropriate to allocate responsibility for "outcomes" in proportion to the resources available to each sector.

In broad terms these are the "mainstream" health services provided (and largely funded) by State / Territory Governments, the "mainstream" fee-for-service private practice funded by the Commonwealth via Medicare and the associated Pharmaceutical Benefits funding, and the private sector funded by private contributions subsidised by the Medicare rebate. This last component obviously connects health funding to general economic disadvantage, since in fact very few Aboriginal people are in a position to benefit from it.

Alongside that there is the specific funding of what OATSIH refers to as "Aboriginal Health Organisations", only about half goes to Aboriginal Community Controlled Health Services who are members of the NACCHO affiliate in each State. This special purpose funding is only about 10% of the total, however, so that the vast majority of Government funding is applied to Aboriginal health through Government services.

Since February, when Dr Couzos presented her evidence on behalf of NACCHO, the Australian Institute of Health and Welfare has produced a new analysis of estimated expenditure on Aboriginal health for 2004-05, which changes the figures to some extent, but not in any very material way.

Since the report is very detailed, it is easy to get lost in the figures, so we have simplified it down to the findings that are of most interest.

See Appendix : Money in the Mainstream, 2004-05

The work was not done specifically for this Inquiry, so it deals with national and between-jurisdiction comparisons. It is also written in plain English in a flow diagram, so it may be that this will be helpful to the Inquiry also. There is nothing informal about the analysis itself.

The most immediately relevant finding for the question asked about the gap between "wonderful" programs and "appalling" outcomes is that more than 90% of funding is spent by "mainstream" services, and about 66%-67% is spent by State/ Territory services. Thus responsibility for the current health outcomes rests largely with Government.

In relation to NSW, the main finding of the interstate comparisons on 2004/05 data is that even when inpatient data are adjusted for under-identification and the community health estimates for each State/Territory are taken at face value:

- NSW spent $530 per person less than the Australian Average on Aboriginal people
- NSW spent $85 per person more than the Australian average on other people

We have also made an attempt to look at the more recent data from publicly available sources, namely the "Murray Motion" reports by Commonwealth agencies. This is given in another Appendix:

See: Appendix : Open Government and Commonwealth Aboriginal Health Funding: An Analysis of 'Murray Motion' Reports for 2007

The key message for NSW in this case is that, next to Tasmania, NSW received the least per capita funding, by a considerable margin.

Relativities by State, Dissection of OATSIH Murray Motion Reports 2007

$ per capita	STATE	Relativity
$ 511	ACT	2.29
$ 223	NSW	1.00
$ 643	NT	2.88
$ 335	QLD	1.50
$ 515	SA	2.30
$ 206	TAS	0.92
$ 595	VIC	2.66
$ 484	WA	2.17
$ 14	other	
$ 401	AUS	1.73

In 2007, 96% of the $401 per capita in funding from OATSIH could be assigned to a State/Territory, the rest being best regarded as national (other, in the Table). The per capita rate was much higher in the NT ($643), Victoria ($595), SA ($515), the ACT ($511), and WA ($484) than in Queensland ($335), NSW ($223) or Tasmania ($206).

There are several points to make about these data. While it would no doubt be possible for OATSIH and other Commonwealth agencies to dissect their grant data and actual annual expenditure by jurisdiction and type of organisation funded - and OATSIH should be thanked for providing much more detailed information than other agencies - this is not done. Thus, since it is necessary to apportion multi-year funding evenly across years to arrive at an estimate for a particular year, these results could be said to be "wrong" in detail for any particular year, though they can hardly be wrong by very much in the averages. Similarly, it is technically possible that a large amount of money in grants below the Murray Motion threshold of $100,000 might go to a particular State/Territory and change the relativities, though this seems unlikely. Again, it might be that funding channelled through Medicare or the PBS flows in unusually high proportions to one State/Territory and compensates for less grant-based funding. However, the problems of estimating the Aboriginal share of Medicare funding are so great even at the National level that it would be many times worse at a jurisdiction level.

Remembering that these funds are only about 10% of the total, while it is no doubt reasonable that the Northern Territory receives considerably more per capita (a small part of which was the leading edge of the finding for the Northern Territory Emergency Response), there is no obvious reason why NSW is so poorly funded relative to Victoria, for example.

The overall result seems to be that, to the extent that it has been possible to estimate Aboriginal health expenditures in NSW, it is below national averages.

In our original submission we drew attention tho the fact that Australian Health Care Agreements do not attach any specific conditions to funding in relation to Aboriginal health. These analyses suggest that the absence of monitoring in real time has led to funding being driven by factors other than relative need.

And certainly, it shows that the extraordinary accountability requirements imposed on Aboriginal Community Controlled Health Services who spend 5% of the funding stand in marked contrast to the lack of accountability of Government services that spend more than 90%. The AHMRC therefore wishes to emphases its support for Dr Couzos' answer to the following:

> **CHAIR:** What kind of support do Aboriginal community controlled organisations want from the Government?
>
> **Dr COUZOS:** What is required is increased funding for capital infrastructure and for recurrent costs. That is to employ a workforce of the level required to meet need. These services have established and completed regional plans across the country with the support of the Office for Aboriginal and Torres Strait Islander Health, and these plans indicate what needs to be done, where are the gaps, where is the growth that is needed to support these, but there has never been Federal level expenditure to fully implement these plans and deal with those needs.
>
> **CHAIR:** So the amount of funding that is needed, we are talking about $150 million for infrastructure. I think there has been some indication from your organisation of funding of about $350 million. Can you comment?
>
> **Dr COUZOS:** Yes. The $460 million is the estimate that Access Economics has calculated, which refers to the cost required to deliver primary health care. Of that there would be capital infrastructure as well as recurrent costs for workforce and additional costs. Seventy per cent of the cost in running an Aboriginal health service is in workforce, employment, which is pretty standard.
>
> **CHAIR:** And ongoing skills and training?
>
> **Dr COUZOS:** Skills, training, and additional costs with regard to equipment, and so on.
>
> **CHAIR:** And culturally appropriate training?
>
> **Dr COUZOS:** Definitely, yes.

The location of ACCHSs across NSW is given in the discussion on Issue 1 Funding Issues in general

Questions about Cooperation between the AHMRC and NSW Health

On a different matter, we note that Dr Couzos referred some questions to the AHMRC.

> **The Hon. GREG DONNELLY:** Could you please explain to the Committee how your organisation interfaces with New South Wales Health?
>
> **Dr COUZOS:** Yes. Being a national body we also have State bodies. In the State of New South Wales the Aboriginal Health and Medical Research Council is the affiliate of NACCHO. We call the State bodies affiliates. So, it is the membership, the formal relationship we have with the Aboriginal Health and Medical Research Council.
>
> **The Hon. GREG DONNELLY:** On an ongoing basis, on a day-to-day, week-to-week, month-to-month basis, how are the workings with and cooperation with New South Wales Health and vice versa?
>
> **Dr COUZOS:** Representatives from the AHMRC attend all NACCHO board meetings and we have quarterly board meetings. Day-to-day interaction is usually through the usual mechanisms, electronic communications, telephone communications, as required, and vice versa. The AHMRC back to NACCHO for advice and assistance, and the other way around.
>
> **The Hon. GREG DONNELLY:** Is the ongoing level of dialogue and cooperation with New South Wales Health, in your view, at a satisfactory level?
>
> **Dr COUZOS:** Absolutely. By New South Wales Health you mean the New South Wales health government or are you referring to the Aboriginal Health and Medical Research Council, that NACCHO is an affiliate of?
>
> **The Hon. GREG DONNELLY:** No, the Government, the department?
>
> **Dr COUZOS:** I cannot comment on the department. I misunderstood your question. Relationships between the AHMRC and NACCHO are optimal because they are our members, but between NACCHO and the New South Wales Government we do not have a direct relationship in that way in delivering our programs and policies and activities. We work through the New South Wales State affiliate. It is the affiliate that engages with the New South Wales Government.
>
> **The Hon. GREG DONNELLY:** But, as far as you know, that working relationship with the affiliate is a satisfactory one?
>
> **Dr COUZOS:** I cannot comment on that.

The simplest answer is to refer the Committee to the Appendix we have added that deals with the NSW Aboriginal Health Partnership Agreement signed at the end of April 2008:

Appendix : NSW Aboriginal Health Partnership Agreement

This also contains the media release of the Minister for Health about the intentions of the NSW Government in relation to the Agreement.

Clearly, the terms of the Agreement are very broad, and its success depends on good will and good faith on both sides. For its part, The AHMRC assures the Committee that it is committed to the Guiding Principles stated in the Agreement.

Question on the Outcomes of "spectacular things" done by NSW Health

There was a question in relation to "spectacular things" that NSW Health is doing in relation to care for mothers and babies, which was referred to the AH&MRC.

> **The Hon. MARIE FICARRA:** I have a quick question about two areas of concern. Yesterday we heard from NSW Health that it is doing such great things with antenatal care, pregnancy health, postnatal care, maternity care and early childhood care. We know how important that is for the future—not just for one generation but multiple generations—in terms of social impact and education. Are you seeing that on the ground? Is your service organisation seeing those positive things that are so important? Are the strides or the improvements that we heard about yesterday being seen by your organisation? The second area is dental and oral health.

.....

> **The Hon. MARIE FICARRA:** That is a lack from the Federal Government. I acknowledge that. It should be an area that the new Federal Government looks at. But the point is that NSW Health told us that it is doing spectacular things in this area that it acknowledged was so important and so neglected. I would love to know—even if you could get this information to us—whether we are seeing this on the ground. It is so vital. Are we seeing any improvements delivered? We are a State Government and we can do only so much to influence the Feds—that is your job. But we want to know whether we are seeing an increase in resources from NSW Health. If you do not know offhand perhaps you could get back to the Committee with that information, and also about oral and dental health.
>
> **Dr COUZOS:** No, I cannot unfortunately. It is a very good question but I think the Aboriginal Health and Medical Research Council would be best placed to answer it.

It is probably important to explain that the AH&MRC has a very different role in relation to the member organisations than the NSW Health Department has in relation to Area Health Services. The simplest way to describe the governance explained in our initial submission is that it is almost the reverse: bottom-up rather than top-down. The member services deal directly with the bodies from whom they receive funding, and they elect representatives on a regional level to form the Board that directs the operations of the Secretariat of the AHMRC. A key role of the AHMRC secretariat is to provide services to support the members, but it has no directive role. Nor is the AHMRC Secretariat funded to perform a data collection and analysis service.

That said, there are substantial programs, for example the Eye Care program, where other NGOs have worked with the AHMRC and members to develop and manage programs that have been very successful indeed, based on screening and where relevant referral to mainstream services provided by NSW Government. In fact this program might reasonably be called a "spectacular thing" and is a good example of the things that can be done by the ACCHS sector in providing an essential and trusted point of contact with local Aboriginal communities to address access issues that had obviously not been addressed previously, even though in theory services were available from Government agencies.

Aboriginal Eyecare: A Review of Services in NSW

GERD SCHLENTHER NINA TAHHAN SERINA STRETTON BRIAN LAYLAND

International Centre for Eyecare Education, Sydney NSW Australia
Vision Cooperative Research Centre, Sydney NSW Australia

According to the 2001 National Health Survey, eye or vision problems are reported by three out of ten Aboriginal people and by nine out of ten Aboriginal people over 54 years [1]. One of the leading causes of vision problems in Aboriginal people is uncorrected refractive error, or more simply, the need for a pair of spectacles. This seems unacceptable when refractive error is not difficult to diagnose, measure or treat, and when spectacles are an extremely cost-effective and immediate solution. In 2003, Vision 2020 Australia, a national partnership comprising more than forty Australian-based eyecare organisations, made identification of refractive error a priority within Aboriginal communities [2]. Yet despite this recognition many of the current eyecare services are not meeting the needs of Aboriginal people, particularly those living in rural and remote areas [3].

One of the main reasons for the prevalence of uncorrected refractive error in Aboriginal communities is a lack of physical access to appropriate eyecare services. In rural areas most Australians are more likely to see an optometrist rather than other medical specialists for their eyecare [4]. In 2002, the number of patients per optometrist in Australia was more than 12,700 in remote areas and 2,700 in rural areas, compared with a national average of 1,180 [4]. Although limited availability and long distances to eyecare facilities have always been barriers to accessing health services in rural and remote areas, limited availability of culturally-sensitive eyecare services compound these barriers in Aboriginal communities [5].

What is needed for Aboriginal communities is a self-sustaining system of eyecare that provides locally available, culturally sensitive personnel for eye examinations and immediate interventions combined with an effective low-cost spectacle service.

Barriers to access

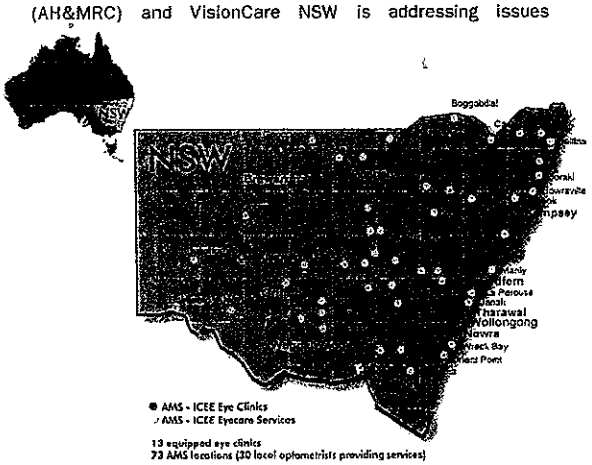
Several studies now show that the establishment of Aboriginal community controlled health services are associated with improvements in the health of Aboriginal people [6] and that accessible, appropriate and affordable eye and vision care services, delivered to Aboriginal Australians through community-controlled health centres, can help to overcome some of the existing barriers [7]. Indeed a study by Ivers and her colleagues [8] found that in Aboriginal communities, financial cost is relatively less important than cultural barriers and that as a consequence, individuals are often prepared to travel substantial distances to receive more culturally appropriate services.

Some of the cultural barriers that have been encountered when Aboriginal people access mainstream medical services include a lack of health professionals that they can relate to, a perceived unfriendliness of health centre staff, inappropriate body language, long waits and an appointment system that is difficult to adhere to, and a lack of understanding about the way indigenous people construct reality, their knowledge and values [9]. These difficulties are reflected in the reluctance of Aboriginal people to visit mainstream hospitals and community health centres, optometrists and ophthalmologists in private practice [3] and are part of the reason why Aboriginal people underutilize the state and territory spectacle schemes that were established to provide free and/or low cost spectacles to all Australians in need [10].

Current eyecare services accessed by Aboriginal people in NSW

While full-time, part-time or visiting optometrists supply much of the eyecare to rural and remote locations in NSW, many of these services are not tailored to Aboriginal communities, and because they rely on individual service providers are not sustainable. For instance, in the previous year an individual optometrist provided spectacles to over 2000 Aboriginal people through the VisionCare NSW spectacles program, mostly in the form of reading glasses. The success of this individual provider relies on the relationship of trust he has built with the communities he services, the relationship he has built with health workers to arrange the clinics, make appointments and manage the patient recall system, and the Medicare consultation payments that fund his services. However, although this is a good example of community-coordinated eyecare, it is not sustainable. The optometrist is essentially a 'one man show'; he sees about 12 to 15 patients a day, spends long hours working and incurs considerable costs travelling to each location.

The program currently run in collaboration with the International Centre for Eyecare Education (ICEE), the Aboriginal Health and Medical Research Council of NSW (AH&MRC) and VisionCare NSW is addressing issues



surrounding the sustainability of eyecare services in NSW. This program [11] is a joint collaboration between a range of State, Federal, community and professional organisations (Table 1) and individuals that was established to improve Indigenous people's eyecare as well as their access to spectacles, thereby reducing the incidence of uncorrected refractive error. The program is conducted and controlled by local Aboriginal communities with support from the AH&MRC and is organised and delivered through Aboriginal Community Controlled Health services (ACCHSs) using regional Aboriginal eye health coordinators (EHCs) and health workers. Patients usually access the program directly but may be referred by medical practitioners or the Aboriginal health workers.

Visiting optometrists (provided by ICEE) staff the eye clinics and provide spectacles through the VisionCare NSW spectacle scheme. These optometrists conduct eye examinations and prescribe spectacles if appropriate. They also advise patients on other aspects of eye health and refer patients to specialist medical services at regional hospitals if for example cataract, diabetes or glaucoma are detected. In general, most patients seen by optometrists do not require specialist care and are referred to their local AMS or general practitioners for a range of health or eye related reasons. In most cases, consultations are directly billed to Medicare, and spectacles are generally supplied at no cost. Where possible, the use of relatively local optometrists has provided a high degree of continuity which ensures good quality of service, appropriate follow-up, and good practitioner/patient relationships.

The program's spectacle delivery program was initiated in 2000 and over the last six years there has been a gradual increase in the number of outreach clinics, organised by eye health coordinators and conducted by optometrists at the invitation of each participating AMS. The program is now delivering local and ongoing eyecare to Aboriginal communities in 73 rural and metropolitan locations around NSW (Figure 1). As of September 2005, there have been about 12,500 consultations, and in very many cases the patients coming to the clinics have never been seen by an eyecare practitioner before. There are no comparable programs in NSW that conduct eye examinations solely for the benefit of Aboriginal people within community-controlled health services.

When the program began in 2000, less than 20 Aboriginal people were known to have received spectacles through the VisionCare NSW spectacle delivery program each year (11). In the year ending June 30 2005, 2340 Aboriginal people were provided with spectacles through the scheme, and up to 13,000 pairs of spectacles have been provided since the program was initiated (Figure 2).

Discussion

The experience of delivering eyecare in NSW shows that the main barriers to access are related to socio-economic factors, in particular culture and transport. The ICEE/AH&MRC Aboriginal Eye and VisionCare Program has attempted to overcome these barriers by creating a strong collaboration of government stakeholders, service providers, community-controlled health services and the local communities themselves. The benefits of the program are that more and more Aboriginal people now have access to regular and ongoing eyecare as well as spectacles for those in need.

Outreach eyecare program: no. of spectacles authorised

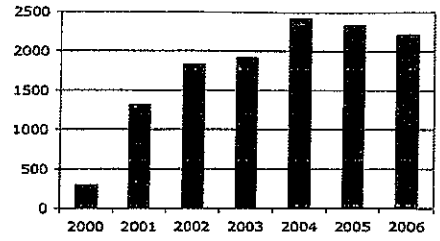


Table 1.
NSW Aboriginal Eye and VisionCare Program Collaborators

Aboriginal Community Controlled Health Services (ACCHSs)
Aboriginal Health and Medical Research Council of NSW (AH&MRC)
Aboriginal Medical Services (AMSs)
Commonwealth Government
International Centre for Eyecare Education (ICEE)
NSW Department of Community Services
VisionCare NSW
Office of Aboriginal and Torres Strait Islander Health (OATSIH NSW)

References

1. Australian Indigenous HealthInfoNet. Summary of Australian Indigenous health, November 2005 [cited 2006 May]; Available from: http://www.healthinfonet.ecu.edu.au.
2. Vision 2020 The Right to Sight - Australia. Aboriginal eye health: an overview of partner activities. Melbourne, Victoria, Australia; March, 2003.
3. Hecker R. A Review of Eye Health Services for Aboriginal Communities in NSW: Office of Aboriginal and Torres Strait Islander Health, Commonwealth Department of Health and Family Services; 1998.
4. Madden A, Simmons D, McCarty C, Khan M, Taylor H. Eye health in rural Australia. Clin Exp Ophthalmol. 2002;30:316-21.
5. Wildsoet C, Wood J. Primary eyecare needs and services to Aboriginal and Torres Strait Islander populations across Queensland: a user's perspective. Clin Exp Optom. 1996;79:188-201.
6. McDermott R, O'Dea K, Rowley K, Knight S, Burgess P. Beneficial impact of the homelands movement on health outcomes in central Australian Aborigines. Aust NZ J Public Health. 1998;22:653-8.
7. Thomson N. The Health of Indigenous Australians. Victoria, Australia: Oxford University Press; 2003.
8. Ivers R, Palmer A, Jan S, Mooney G. Issues relating to access to health services by Aboriginal and Torres Strait Islander people. SPHERe Discussion Paper. Department of Public Health and Community Medicine: University of Sydney; 1997 April. Report No.: 1/97.
9. Walsh W. Cardiovascular health in Indigenous Australians: a call for action. Cardiovascular mortality has been significantly reduced in New Zealand Maori and Native Americans, so why not Indigenous Australians? [Conference Report]. Medical J Australia. 2001;175:351-2.
10. Taylor H. Eye Health in Aboriginal and Torres Strait Islander Communities: Commissioned by: Commonwealth Minister for Health and Family Services; 1997.
11. Layland B, Holden BA, Evans K, Bailey S. ICEE/AHMRC NSW Aboriginal Eye and Visioncare Program, Australia. Rural and Remote Health. 2004;4 (online):no. 247.

This program has been backed up by training of workers through the AHMRC Aboriginal Health College, which was funded by the International Centre for Eyecare Education at UNSW.

This program also demonstrates that developing collaborations is a process that would be unlikely to occur in a context where a service is simply tendered out by Government in the usual way.

The program was reviewed alongside others some years ago (2003) in the report:

- Taylor V, Ewald D, Liddle H, Warchiver I. *Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program.* Centre for Remote Health, October 2003.

It was one of two "successful" models:

> MODELS OF SERVICE DELIVERY
>
> Two models of service delivery were presented as successful models of delivery. The service model described by ICEE relies on REHCs being trained in vision screening and being provided with a vision screening kit. The REHCs visit small and remote communities, pre-schools, schools and other locations, and those who are screened and fail one of seven items are referred to an optometrist, the referrals being sent to an optometrist during their regular visits to the ACCHO. If ophthalmic or other specialist medical care is required, the local networks that are established between optometrists and ophthalmologists ensure that Aboriginal people are seen as private patients by the ophthalmologist under free-to-patient bulkbilling arrangements. Arrangements negotiated between HIC, the New South Wales health system and RANZCO allow a nominated ophthalmologist to carry out procedures on an Aboriginal client in public facilities at Medicare bulkbilling rates.
>
> The service model described by the Outback Eye Service Healthcare unit relies on a range of strategies to review patients. Feeder centres from Walgett, Lightning Ridge and Brewarrina refer patients to a visiting ophthalmologist in Bourke, where surgery is performed twice a year. Where possible, patients are treated within their local community so that they do not have to travel long distances for treatment. This model uses tele-ophthalmology links to the Bourke hub and a rural ophthalmology registrar program, both of which are run by the Prince of Wales Hospital.

Case study: The role of a champion — ICEE

The International Centre for Eyecare Education aims to eliminate avoidable blindness and impaired vision due to uncorrected refractive error by developing sustainable solutions for communities in serious need of eye care. ICEE identified Aboriginal eye care as a priority and has been instrumental in linking local or ICEE optometrists to AMSs in New South Wales. ICEE was also commissioned to provide training to the AHWs and REHCs in New South Wales under the NATSIEHP. At the outset, ICEE developed a memorandum of understanding with the ACCHO representative body, the Aboriginal Health Research Council. This MoU details the role and support that ICEE provides to AMSs in New South Wales, facilitates ongoing dialogue with AMSs, and reduces the need for separate negotiations with each service. ICEE now conducts programs at 50 locations throughout New South Wales, including a regular eye clinic at the Redfern AMS. Since February 2000 these programs have provided over 4,000 eye examinations and over 3,000 pairs of spectacles*. Thirty optometrists have participated in the program, including a community optometrist employed by ICEE for Aboriginal communities in remote areas. Regular clinics have been established in the Sydney metropolitan area at Tharawal AMS, Campbelltown and Durak AMS, Mount Druitt. Optometrists have made intermittent visits to La Perouse.

Training has also continued for the New South Wales Aboriginal eye health coordinators. This training focuses on aspects of patient care and health service such as clinical management, the logistics of eye care delivery, patient communication, the maintenance of patient records, screening techniques for eye disease, and vision correction. Basic information for health workers such as diseases and disorders of the eye, and anatomy and physiology of the eye is also included. In 2002 training courses were held at Walgett, Kempsey, Bourke, Broken Hill, Nowra, Narooma, Wagga Wagga and Wellington. A three-day training program was held in Sydney in October, and a three-day program related to ocular problems associated with diabetes was held in July in cooperation with the Australian Centre for Diabetes Strategy.

During 2002 ICEE entered into an agreement with RANZCO (NSW) to improve Aboriginal people's access to eye surgery and to prompt the treatment of eye disease in Aboriginal people. ICEE's support for the program has enabled AMSs to take advantage of the extensive network of optometrists in New South Wales and to receive ongoing support and training, an aspect of the program that has not been possible in other states.

* Revised figures from ICEE indicate that at 30 June 2003 in excess of 7355 examinations have been conducted by ICEE optometrists, 5475 pairs of spectacles have been supplied and services are provided at 66 locations.

Since workers have to be backed up with training, this has been developed and delivered by the AHMRC's Aboriginal Health College:

SPECIFIC ABORIGINAL HEALTH WORKER SKILLS SETS

Eye Care Skills Set

Overview

This course focuses on the key skill and knowledge requirements for Eye Care Co-ordinators or Aboriginal Health Workers involved in running and/or co-ordinating Eye Clinics. Successful completion leads to a Statement of Attainment – The Eye Care Skills Set covers 4 units of competence from the recently endorsed Aboriginal Health Worker qualifications.

Target group

Enrolment within this course will focus on recruiting students from the following in order:

1. New and existing Aboriginal Health Workers working as Eye Care Co-ordinator's or conducting Eye Clinics
2. Students needing to gain an Eye Care qualification or whom have an interest or need to study in the area

The competencies aligned to this Skills Set are:

Unit of competency	Nominal course hours
HLTAHW304A Undertake basic health assessments	120
HLTAHW305A Plan and implement basic health care	120
HLTAHW417A Provide information and strategies in eye health	40
HLTAHW403A Plan and implement health care in a primary health care context	140

Nominal course hours

200 hours

AH&MRC Aboriginal Health College.
Course Information Brochure Version 1.4 January 2008
30

Expected face to face hours

70 hours plus site visits and potential online/teleconference connection.

Delivery mode

Delivery mode: face to face – block release (2 x 5 days); site visits; e-learning support; study groups; tutorials; and email.

When offered?

This Skills Set is offered on a continuing enrolment basis in distance education mode. Educational blocks are run for students on a periodic basis.

Question on Notice

There was a query whose content cannot be resolved from the transcript, namely the following:

> **The Hon. GREG DONNELLY:** Question No. 5 on notice relates, I suppose, to my question. Do I take it that the answer to that question is no; that there has been no discussion between your organisation and the New South Wales Government and that discussions take place at the State level?
>
> **Dr COUZOS:** Yes, correct.
>
> **The Hon. GREG DONNELLY:** So we need to speak to them?
>
> **Dr COUZOS:** Exactly.

If the question has not been addressed by the foregoing, The AHMRC would be happy to provide such information as the Inquiry seeks.

Measuring Outcomes

Measuring outcomes

10.2 The effective measurement of outcomes, or the success of programs and services was a key issue raised throughout this inquiry. In relation to a number of service delivery areas, the Committee heard that programs and strategies were not effectively monitored to determine if targets are being met and the life expectancy gap being closed.

10.3 These issues are drawn from Chapters 3, 5 and 9: Service delivery; Health and wellbeing; and Incarceration and the criminal justice system, respectively.

Issues for consideration – Measuring outcomes

- The need for greater clarity in who has the overall leadership and responsibility for defining the performance indicators and delivering priorities under the New South Wales State Plan and Two Ways Together Pan, and how this leadership is translated into meaningful, measurable outcomes that are accepted by the Indigenous community, will be further considered in the Final Report – Issue 2, page 52
- The Committee will examine mechanisms for improving the reporting and accountability processes for community organisations – Issue 12, page 98
- The Committee will review the methodology used to record the incidence of child sexual abuse in Aboriginal communities. The review will consider the existing arrangements used with respect to data collection and examine how it can be refined and improved – Issue 15, page 106
- The Committee believes that the measurement of health priorities and the associated programs should be a key element of the New South Wales Government's health strategy for Indigenous communities. The Committee will examine the need for more comprehensive measurement of health outcomes for Indigenous people – Issue 17, page 117

- The Committee believes that the lack of Aboriginal specific criminal justice priorities in the New South Wales State Plan needs to be addressed – Issue 38, page 235
- The successful implementation of the Aboriginal Justice Plan is being hindered by the lack of clarity surrounding its current status and relevance to the New South Wales State Plan. The Committee will consider further the status of the Aboriginal Justice Plan and its proper implementation – Issue 39, page 237
- The ability to address family violence and child sexual abuse issues is impeded by the high level of underreporting of these incidents by Aboriginal communities. The Committee will examine the reasons behind underreporting of domestic violence and sexual abuse. Consideration will be given to the level of government support for Aboriginal police officers and ACLOs. The Committee will examine the efficacy of early intervention programs targeted at male perpetrators – Issue 45, page 270

Issue 2 Implementation Responsibility Vs Accountability

3.51 The Committee believes the New South Wales Government, through the New South Wales State Plan and Two Ways Together Plan, has identified important priority areas for delivering Aboriginal services. In other areas of the Interim Report, shortcomings with performance indicators contained in the New South Wales State Plan are discussed. The Committee believes that performance indicators in F1 of the New South Wales State Plan require greater detail. In other areas, such as the area of Aboriginal involvement in the criminal justice system, performance indicators need to be created, as they are presently absent.

3.52 During the first part of this Inquiry, it was unclear whether DAA has overall leadership and responsibility for delivering these priorities. Without clear direction and leadership, it will be difficult to meet the government's priorities. This difficulty is exacerbated by the myriad national and state level plans and agreements that provide the framework for delivery of Aboriginal services in New South Wales.

3.53 The Committee believes that the role of the DAA is a critical one, and that DAA must be given every opportunity to succeed as the lead agency in implementing the New South Wales State Plan and the Two Ways Together Plan.

Issue for consideration 2 – Delivery: responsibility

The need for greater clarity in who has the overall leadership and responsibility for defining the performance indicators and delivering priorities under the New South Wales State Plan and Two Ways Together Plan, and how this leadership is translated into meaningful, measurable outcomes that are accepted by the Indigenous community, will be further considered in the Final Report.

The AHMRC wishes to emphasise "meaningful, measurable outcomes that are accepted" in the statement of this issue. So far as it specifically affects ACCHS's in their primary care role, these demand for accountability need to be made in an even-handed fashion. That is to say, they should be a condition applied to all primary care providers, with adequate compliance costs factored into funding arrangements, which is often neglected.

DAA would need a significant enhancement of funding to do the tasks envisaged. The AHMRC believes that reporting should be done by an independent body, not by the agency directly responsible for implementation. There are too many potential conflicts of interest. That said, it should be noted that agencies such as NSW Health have provided, and continue to provide, a large proportion of the evidence about the gaps that need to be overcome, even though it can be used to criticise NSW Health. We see the issue as one of possible public perception of conflict of interest, the ICAC definition, rather than one that exists in reality.

Issue 12 Reporting Burden

4.89 The Committee acknowledges the significant burden essential administrative and reporting requirements can have on community provided services. However, the Committee cannot condone the relaxing of these reporting requirements, particularly where large amounts of funding have been awarded.

Issue for consideration 12 – Environment and infrastructure: reporting and accountability

The Committee will examine mechanisms for improving the reporting and accountability processes for community organisations.

The AHMRC notes the Committee's comment on the debate over high reporting compliance costs.

There is a great deal of room for debate about how "essential" many of these requirements actually are, and whether supplementary funding for additional work of a different kind contains an adequate allowance for additional reporting requirements. The AHMRC notes that "large amounts of funding" are delivered to community-based providers of health-care in many services, most of which are operated by Government or by Medicare-funded private practitioners. Whatever the "essential" requirements are agreed to be, they should be placed on all providers, with appropriate allowance of compliance costs, and not changed arbitrarily when personnel in funding agencies decide they would like something new.

Issue 15 Child Sexual Abuse data

5.29 The Committee is also concerned that the Interagency Plan does not sufficiently address the under reporting of child sexual abuse in Aboriginal communities. Many of the programs and initiatives to improve rates of Indigenous child sexual assault have only recently been implemented over last year and their success has not been determined.

5.30 The Committee is concerned that the indicators to monitor the progress and implementation of the Interagency Plan have not yet been developed and that the reporting process, through the New South Wales State Plan and the biennial Two Ways Together report on indicators is vague at best.

Issue for consideration 15 – Health and wellbeing: child sexual abuse data

The Committee will review the methodology used to record the incidence of child sexual abuse in Aboriginal communities. The review will consider the existing arrangements used with respect to data collection and examine how it can be refined and improved.

The AHMRC regards all issues arising out of the report of the Aboriginal Child Sexual Assault Task force as needing to be considered together as part of reviewing the adequacy of the response and the specific funding to support it. See Issue 14 Child Sexual Abuse - Funding for Services

Issue 17 Health and Wellbeing Measurement

5.76	Health indicators for Indigenous people are one of the most important indicators of Indigenous wellbeing. While many factors impact on the health of Indigenous communities, it is the measurement of that health status that provides a clear indication of the success of the many programs aimed at addressing the life expectancy gap.
	Issue for consideration 17 – Health and wellbeing: measurement The Committee believes that the measurement of health priorities and the associated programs should be a key element of the New South Wales Government's health strategy for Indigenous communities. The Committee will examine the need for more comprehensive measurement of health outcomes for Indigenous people.

The AHMRC notes that the NSW State Plan emphasises the reduction of hospitalisation for conditions treatable in primary (ambulatory) care as a major indicator. Unless this is accompanied by adequate expansion of primary care services, and the degree of change sought is related in a systematic way to investment in the services needed to manage those illnesses in community-based care, this indicator is dangerous. The issue is further complicated by the fact that the majority of primary care services are not directly funded or managed by NSW Health. The investment in primary care and more general prevention services needs to be made before expecting to see change in hospitalisation, but this raises issues of "cost-shifting" as between the (mainly Commonwealth) costs and the (mainly State) benefits.

The Victorian Government commissioned an analysis of these issues in relation to mental health before the COAG meeting in 2006 from which the National; Action Plan for Mental Health emerged. Their conclusion was that resolving the cost--benefit sharing was essential to effective collaboration. See: Example 1: Victorian Analysis of Issues for Mental Health Programs

Issue 38 Lack of Priorities in NSW State Plan for Justice Issues

9.26 The Committee notes with concern the distinct lack of Aboriginal specific criminal justice priorities in the New South Wales State Plan, particularly given the substantial over-representation of Aboriginal offenders in New South Wales. We believe that this is a significant oversight that adds further disadvantage to Aboriginal offenders.

Issue for consideration 38 – Justice: priorities

The Committee believes that the lack of Aboriginal specific criminal justice priorities in the New South Wales State Plan needs to be addressed.

The AHMRC has no specific comment to make on this issue except to note that the incarceration rates reflect many of the same factors that are driving illness rates also.

Issue 45 Justice - Under-Reporting of Child Sexual Abuse

9.183 The Committee acknowledges the difficult task faced by police in building community trust to address the issue of underreporting, and believes that the use of Aboriginal police officers and ACLOs – particularly females – is key to gaining this trust. We believe that early-intervention programs targeted at male perpetrators of family violence are highly beneficial, and will explore this option further in the Final Report.

Issue for consideration 45 – Justice: underreporting

The ability to address family violence and child sexual abuse issues is impeded by the high level of underreporting of these incidents by Aboriginal communities. The Committee will examine reasons behind under-reporting of domestic violence and sexual abuse. Consideration will also be given to the level of government support for Aboriginal police officers and ACLOs. The Committee will examine the efficacy of early intervention programs targeted at male perpetrators.

See comment on issue 15. Issue 15 Child Sexual Abuse data

Coordinated Service Delivery

Coordinated service delivery

10.4 The Committee heard that services are often delivered in an ad-hoc manner, or in such a fashion that they overlap or create significant gaps in service provision. These concerns included issues relating to the implementation of pilot programs and how they may be replicated more broadly to address the needs of a large number of Indigenous people over a longer period of time. Inquiry participants told the Committee that service delivery at all levels of government and in conjunction with non-government agencies and the private sector required a more coordinated approach.

10.5 These issues are drawn from Chapters 4, 5, 6, 7 and 8: Environmental health and infrastructure; Health and wellbeing; Education; Employment; and Housing.

Issues for further consideration – Coordinated service delivery

- The effective provision of essential services including water, sewerage and waste collection in Aboriginal communities that are not serviced by local government will be considered. – Issue 8, page 90
- The Committee will consider the need for a co-ordinated approach to identify communities' transport requirements and tailor additional services to meet those needs. – Issue 11, page 97
- The Committee intends to examine the issue of improving the relationship between government and non-government services in more detail – Issue 18, page 118
- There are many successful initiatives undertaken by government to improve educational outcomes for small numbers of Indigenous students. The Committee will examine how these programs can meet a larger number of students and improve the outcome for Indigenous people as a whole. – Issue 21, page 144
- The Committee will review appropriate service delivery models to effectively address obstacles to Indigenous employment. – Issue 25, page 177
- The Committee heard examples of businesses overcoming their skills shortages through employment and training schemes targeted at Indigenous workers. The Committee will further consider the strengthening of the relationship between corporations and Indigenous communities – Issue 29, page 194

- Overcrowding is a fundamental problem within the Aboriginal community. The Committee highlights the need for various providers and funding programs to work together strategically to provide affordable, appropriate housing for Indigenous people – Issue 35, page 220
- The Committee believes that housing affordability is a fundamental obstacle to addressing the housing needs of the Indigenous community. The Committee will examine mechanisms to increase the availability of affordable housing – Issue 36, page 224
- There is a significant lack of support services for Aboriginal offenders, whilst in custody, prior to release, after release and in relation to drug and alcohol services. The Committee is concerned about this lack of appropriate service provision for Aboriginal offenders and will examine relevant initiatives – Issue 40, page 248

Issue 8 Water, Sewerage, Waste Disposal

The AHMRC wishes to call attention to the fact that this is one of very few areas where a simple technological solution is available and there can be little doubt of the effectiveness of the

intervention, and whether or not it has taken place. That said, the opportunities for employment creation should not be missed, and sustainability should be considered also.

Issue 11 Transport

4.86	The availability of adequate transport is a high hurdle for many Aboriginal people who need to access services outside their immediate community. The Committee heard of a number of local initiatives where community members provide transport to medical or other appointments where the person does not have a drivers license and has no access to public transport. The needs of communities in relation to transport vary, from a community bus, training for a bus driver, drivers license programs or re-routing existing public transport routes. This will be examined further in the Final Report.
	Issue for consideration 10 – Environment and infrastructure: drivers licenses The Committee will consider the appropriateness of driver training programs aimed at assisting members of the Aboriginal community to obtain drivers' licenses.
	Issue for consideration 11 – Environment and infrastructure: transport The Committee will consider the need for a coordinated approach to identify communities' transport requirements and tailor additional services to meet those needs.

The AHMRC wants to call the Committee's attention to the fact that one of the ways in which ACCHS's have always differed from mainstream health services is in recognising the transport issues and providing a transport service. That said, there are some issues associated with the expectation by mainstream services, for example when discharging Aboriginal people, that the ACCHS will provide transport on demand to meet their discharge convenience, which in rural areas can involve very long journeys and may not be possible at the time that suits a hospital.

Issue 18 Improve Government-Non-Government Relationships

5.80	While the Committee notes that the statistics above relate to Australia wide primary health care funding, we believe that the shortfall is indicative of the depth of need within Indigenous communities. The Committee believes that government services targeted at Indigenous people have a somewhat limited scope and as such, their success is difficult to determine. The Committee recognises the importance of adequately funding community based organisations, which often have, through the nature of their service provision a wider scope through which to identify and need and provide programs to address it.
	Issue for consideration 18 – Government-organisation relationships The Committee intends to examine the issue of improving the relationship between government and non-government services in more detail.

The AHMRC appreciates the Committee's attention to this matter and we have tried to spell out some of the funding issues in ways that may be helpful to considering it further.

Issue 21 Expanding Successful Education Initiatives

6.42	Initiatives outlined in this section are commendable and indicate early signs of progress. However, the Committee is aware that the number of Indigenous students who are benefiting from these programs is small. For Indigenous disadvantage to be overcome the scale of impact needs to be substantial so that a critical mass of students can change the future for the next generation.
	Issue for consideration 21 – Education: expanding success There are many successful initiatives undertaken by government to improve educational outcomes for small numbers of Indigenous students. The Committee will examine how these programs can meet a larger number of students and improve the outcome for Indigenous people as a whole.

The AHMRC endorses this work but has no specific comment.

Issue 25 Barriers to Employment

7.35	The Committee is of the view that barriers to employment are significant and are the responsibility of a range of government departments. Thus, these issues need to be addressed by a co-ordinated and holistic approach to breaking through the barriers.
	Issue for consideration 25 – Employment: service delivery The Committee will review appropriate service delivery models to effectively address obstacles to Indigenous employment.

The AHMRC wishes to make the point that the ACCHS sector has traditionally offered a range of employment from transport driving and office work that can lead on to health worker training and address a number of issues at the same time. That is to say, there are more entry-level opportunities in ACCHSs than there generally are in mainstream health services, and they are supportive ones.

Issue 29 Employment – Corporate Role

7.118 The Committee believes that the initiatives undertaken by organisations such as the ANZ bank, Country Energy, AES, Mission Australia, and the Alexandria Park Community School are indicative of a new way of thinking that promotes opportunities for Indigenous Australians, while at the same time addressing the individual needs of each organisation. Each shows a high level of commitment to developing partnerships between Indigenous Australians and the corporate sector.

7.119 Although the core business of each of the above entities is distinctly different, it is evident that there are common elements running through these initiatives that have made them successful in increasing Indigenous employment opportunities and retention rates. These include:

- support and commitment at all levels of the organisation
- pre-employment training, with support for students while they are still at school
- ongoing mentoring
- current Indigenous employees involved in the recruitment process
- ongoing training
- appropriate and ongoing evaluative mechanisms

Issue for consideration 29 – Employment: corporate role

The Committee heard examples of businesses overcoming their skills shortages through employment and training schemes targeted at Indigenous workers. The Committee will further consider the strengthening of the relationship between corporations and Indigenous communities.

The AHMRC wishes to advise the Committee that in reviewing the "Murray Motion" funding for Aboriginal health from various Commonwealth Agencies, it was noted that a number of Area Health Services and NSW Health itself have been able to tap into STEP/ CLIEP funding alongside the corporate sector, because they have the scale to meet the criteria. These data have been extracted and are shown at Issue 27 CDEP / STEP/ CLIEP. It would be good if the Committee could explore ways in which the ACCHS sector and NSW Health could make more effective use of Commonwealth employment programs to build the Aboriginal Health workforce.

Issue 35 Overcrowding

8.94 The Committee is concerned about the level of crowded living conditions, both statistically and anecdotally within the Aboriginal community. Given the significant ramifications of overcrowding for the health of Aboriginal people, the Committee believes that addressing over crowding needs to be a key priority for the housing sector.

Issue for consideration 35 – Housing: overcrowding

Overcrowding is a fundamental problem within the Aboriginal community. The Committee highlights the need for various providers and funding programs to work together strategically to provide affordable, appropriate housing for Indigenous people.

The AHMRC notes that this issue has been a bone of contention for many years, and has always been compromised by funding, so that it comes down to a choice between accommodating a small number of people adequately, or a larger number of people inadequately. To the extent that it is a design issue, The AHMRC would recommend that the Committee seek the expertise of architects who have worked with Aboriginal communities.

Issue 36 Home Ownership

8.110 The Committee is concerned that more Indigenous people are not able to enter into home ownership and highlights the large gap between the numbers of non-Indigenous and Indigenous Australians who have been able to buy their home.

Issue for consideration 36 – Housing: affordability

The Committee believes that housing affordability is a fundamental obstacle to addressing the housing needs of the Indigenous community. The Committee will examine mechanisms to increase the availability of affordable housing.

As for issue 35 Issue 35 Overcrowding

Issue 40 MERIT and Justice Support

9.90	While not an Aboriginal-specific program, MERIT has a high proportion of Aboriginal participants; and a model is currently being developed that will be specifically tailored to Aboriginal people.[950]
	Committee comment
9.91	The Committee is concerned about the adequacy of rehabilitation programs in prisons, particularly as drug and alcohol abuse are the main predictors that lead to Aboriginal crime. We are of the opinion that diversionary rehabilitation programs such as MERIT can be more effective than custodial rehabilitation programs. An analysis of MERIT will be undertaken in the Final Report.
9.92	We note the evidence that Aboriginal inmates only require a culturally sensitive approach to generic rehabilitation programs, as opposed to Aboriginal specific programs; however we maintain the view that Aboriginal people respond better to the latter.
	Issue for consideration 40 – Justice: support for offenders There is a significant lack of support services for Aboriginal offenders, whilst in custody, prior to release, after release and in relation to drug and alcohol services. The Committee is concerned about this lack of appropriate service provision for Aboriginal offenders and will examine relevant initiatives.

The AHMRC would like to draw the Committee's attention to the fact that the "tailored" model mentioned at 9.90 is being developed by an officer located in the AHMRC. In addition, we would call the Committee's attention to the fact that the AHMRC, Justice Health, the Mental health and Drug & Alcohol Office of NSW Health, and two ACCHS's prepared proposals for "Headspace" funding from the National Youth Mental Health Foundation when it was funded in 2006, seeking no more than $50,000 to document programs already in place to the stage of seeking a full grant. We also prepared another consortium proposal in conjunction with the Alliance of NSW Divisions of General Practice to develop training. The argument underlying this was that in the "Youth" age range from 15-24, about 40% of all episodes of Alcohol and Drug Treatment Services were either for Aboriginal youth, and/or were referrals from legal or corrections services. Neither project was funded, and discussion with the funding body indicated that they saw anything to do with Justice as a 100% State issue. What we offered was the development of a "specialised" youth service that could act as a support for their general ones when they encountered young people they could not handle, and/or expertise that could be made available.

This is a fair example of the way in which "mainstream" initiatives continually fail to address the need of Aboriginal people or offenders, and the way in which submission-based funding always operates against the "too hard" groups that don't fit models designed for the average. It also demonstrates that notions of what "should" be funded by the Commonwealth or the State leads to good programs falling between the cracks. The good news in this particular case was that

OATSIH NSW picked up on the training proposal in a slightly different form, so that Certificate and Diploma courses in Aboriginal Mental Health work could be developed by the Aboriginal Health College to parallel those developed for Mental Health / Substance Use Comorbidity. The following section from the AHC course guide gives an indication of the way in which a suitable range of offerings has been laboriously assembled with various sources of funding, and in some cases delivered, even before the bricks-and-mortar AHC building at The AHMRC Aboriginal Health College, 29th January 2008 was finally agreed.

It is The AHMRC's experience that "mainstream" initiatives typically fund "mainstream" agencies to deal with a particular issue - such as Youth Mental Health in the example given - and then add a dot point labelled "Indigenous" to the brief. Since the agencies generally have no expertise in the area, they then seek input from Aboriginal experts or from the ACCHS sector via reference groups and being "consulted", or they call for submissions to which ACCHS's and others submit their ideas in the hope of receiving funding. While it is only natural for research bodies and consultants and others to take advantage of whatever "issue" is attracting funding at a given time - as the *Close the Gap* issue has been since *The Apology* - there are better and more respectful and sustainable ways of assembling useful knowledge than the current processes of treating the cultural and other knowledge of Aboriginal people as an ore body of intellectual property that can be freely quarried and converted into products that Government wants to buy. The issue of Aboriginal control of Aboriginal health education and research and other intellectual property deserves the Committee's attention, since the current processes are very offensive.

Partnership in Service Delivery

> **Partnership in service delivery**
>
> 10.6 The need for provision of services by government, but in conjunction with the Aboriginal community, was highlighted repeatedly in evidence. The Committee was told that communities need to feel real ownership over both the problem and the kind of service developed to address it.
>
> 10.7 These issues are drawn from Chapters 3, 5, 7 and 8: Service delivery, Environmental health and infrastructure; Health and wellbeing; Employment; and Housing.
>
> ***Issues for further consideration – Partnership in service delivery***
>
> - The Committee will examine the issue of the provision of funding to community-controlled services and services which are delivered in partnership with the Indigenous community. – Issue 4, page 65
> - The effective provision of health services is a key issue in addressing the lifetime expectancy gap. The Committee will examine possible improvements to service delivery and opportunities to work in partnership with Aboriginal communities. – Issue 16, page 116
> - Inquiry participants recognised the important role played by Indigenous elders and their communities in providing support for Indigenous employment and youth programs. The Committee regards the building of trust and respect between Indigenous communities, government, and prospective employers as critical to the provision of Indigenous employment opportunities in the long-term. – Issue 30, page 195
> - The Committee will examine the issue of community participation in the housing design and delivery process. – Issue 34, page 218

Issue 4 Under-valuing of Community Controlled Organisations

> 3.101 The complexity of government arrangements to fund initiatives that are community controlled, or delivered in partnership with community members may adversely impact on services able to be delivered by community controlled organisations. The Committee is concerned that the value of community controlled service providers and services delivered in partnership with communities is not being sufficiently recognised.
>
> **Issue for consideration 4 – Delivery: funding to communities**
>
> The Committee will examine the issue of the provision of funding to community controlled services and services which are delivered in partnership with the Indigenous community.

The AHMRC thanks the Committee for its comments and wishes to strongly endorse the Committee's concern in this matter. It is intensely frustrating to work to assemble a service or call attention to an issue, only to be ignored when it is finally taken up. On the one hand it is good that things are eventually done after years of advocacy. On the other, it is yet another instance of being under-valued.

Issue 16 Health & Wellbeing Services

5.70	It is clear to the Committee that the provision of health services to Indigenous communities in New South Wales is not adequate. The Committee notes the evidence that mainstream services require culturally appropriate ways of delivering their service to Aboriginal people and that additional funding is required to extend the reach of Aboriginal community medical services. The Committee believes that Aboriginal community medical services are a key part of addressing the health of Indigenous communities and looks forward to an evaluation of the Aboriginal health program outcomes once funding has been allocated.
	Issue for consideration 16 – Health and wellbeing: services The effective provision of health services is a key issue in addressing the lifetime expectancy gap. The Committee will examine possible improvements to service delivery and opportunities to work in partnership with Aboriginal communities.

We wish to draw the Inquiry's attention to a number of documents:

- The *NSW Aboriginal Health Partnership Agreement* 2008-2013 between the AH&MRC and the NSW Government, which has been signed by all parties since our previous submission; and the media release from the then Minister for Health noting that this commits the NSW Government to a genuine partnership.

  Appendix : NSW Aboriginal Health Partnership Agreement

As indicated by the answers given by Dr Couzos, and by the funding analyses presented here, it is naturally frustrating for ACCHSs to be dealing with problems with inadequate resources, when "mainstream" services do not have to provide equivalent accountability. This is particularly so when models developed in the ACCHS sector are adopted by the "mainstream" services. Naturally, staff can be attracted away by the higher salaries offered, and so on. There seems to be a perception at both State and Federal levels that Aboriginal Community Controlled Health sector and other Aboriginal-specific service agencies are a kind of "bandaid" until such time as mainstream services can get around to doing the job "properly". The AHMRC's view has always been that the services are complementary , and we note that Article 23 of the UN-DRIP says "as far as possible", not "as far as convenient".

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. **In particular, indigenous peoples have the right** to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, **as far as possible, to administer such programmes through their own institutions.**

Issue 30 Employment – Elders Role

7.118 The Committee believes that the initiatives undertaken by organisations such as the ANZ bank, Country Energy, AES, Mission Australia, and the Alexandria Park Community School are indicative of a new way of thinking that promotes opportunities for Indigenous Australians, while at the same time addressing the individual needs of each organisation. Each shows a high level of commitment to developing partnerships between Indigenous Australians and the corporate sector.

7.119 Although the core business of each of the above entities is distinctly different, it is evident that there are common elements running through these initiatives that have made them successful in increasing Indigenous employment opportunities and retention rates. These include:

- support and commitment at all levels of the organisation
- pre-employment training, with support for students while they are still at school
- ongoing mentoring
- current Indigenous employees involved in the recruitment process
- ongoing training
- appropriate and ongoing evaluative mechanisms

Issue for consideration 30 – Employment: elders role

Inquiry participants recognised the important role played by Indigenous elders and their communities in providing support for Indigenous employment and youth programs. The Committee regards the building of trust and respect between Indigenous communities, government, and prospective employers as critical to the provision of Indigenous employment opportunities in the long-term.

The AHMRC has no specific comment on this matter in relation to Employment, but it is very relevant to Education.

Issue 34 Community Participation in Housing design

Issue for consideration 34 – Housing: participation

The Committee will examine the issue of community participation in the housing design and delivery process.

As for Issue 5 Issue 35 Overcrowding

Funding

Funding

10.8 It is not surprising that the funding of programs and services to address Indigenous disadvantage is a key issue, given the high levels of need within the Aboriginal community.

10.9 These issues are drawn from Chapters 3, 4, 6, 7, 8 and 9: Service delivery; Environmental health and infrastructure; Education; Employment; Housing; and Incarceration and the criminal justice system.

Issues for consideration – Funding

- Although the majority of Aboriginal people in Australia reside in New South Wales, this is not reflected in the level of Federal funding received by New South Wales. This impacts on the State's ability to implement priorities under the Federal-State Overarching Agreement on Aboriginal Affairs 2005 – 2010, the NSW State Plan and the Two Ways Together plan. – Issue 1, page 43
- The Committee will look at the effectiveness and assessment of funding programs that are temporary and intermittent in nature. – Issue 3, page 57
- The Committee will examine the need for ongoing funding for environmental health programs, after funding for the Aboriginal Community Development Program ends in 2009. – Issue 7, page 85
- The Committee will seek evidence of the appropriate levels of funding and services to reduce the incidence of and ameliorate the effects of child sexual abuse, including the implementation of the interagency plan in response to the *Breaking the Silence* report. – Issue 14, page 106
- The need to provide and fund long-term education services with Indigenous specific focus and the necessary funding will be considered – Issue 22, page 148
- The Committee will examine the funding of employment programs to ensure skill development and retention rates – Issue 26, page 184
- An issue for further consideration will be the equitable distribution of funds and co-ordination of programs for social housing in New South Wales, between urban, regional and rural areas, to better address unmet housing needs of Indigenous people – Issue 32, page 207
- The Committee is concerned that, given the demand for housing and consequent overcrowding and health issues, that funding for necessary maintenance of properties is provided. – Issue 37, page 226
- The Committee is concerned that there are insufficient resources available for Circle Sentencing courts and highlights this issue for discussion. – Issue 42, page 254

Issue 1 Funding Issues in general

3.21 Many of these targets and priority areas are reflected in New South Wales policies that are considered throughout this Report. The primary vehicles for driving Indigenous policy in New South Wales are the New South Wales State Plan and the Two Ways Together Plan. These are discussed in the following sections. The majority of Aboriginal people in Australia reside in New South Wales, although these demographics, as set out in Chapter 2, are not reflected in the level of Federal funding received by New South Wales. The need for long term funding commitments, from both the Federal and New South Wales Governments, to implement these priorities is considered in the section on funding later in this chapter.

Issue for consideration 1 – Delivery: Federal funding

Although the majority of Aboriginal people in Australia reside in New South Wales, this is not reflected the level of Federal funding received by New South Wales. This impacts on the State's ability to implement priorities under the Federal-State Overarching Agreement on Aboriginal Affairs 2005 – 2010, the New South Wales State Plan and the Two Ways Together Plan.

So far as funding for health services are concerned, we have addressed that elsewhere here:

Funding and Responsibility for Outcomes in Aboriginal Health

Appendix : Money in the Mainstream, 2004-05

Appendix : Open Government and Commonwealth Aboriginal Health Funding: An Analysis of 'Murray Motion' Reports for 2007

Note: Only 6% of Aboriginal people live in `"discrete communities" in NSW

To think about NSW, you have to combine the "discrete communities" data from the Community Housing and Infrastructure Needs Survey (CHINS) 2001 with Census data from 2001, as below.

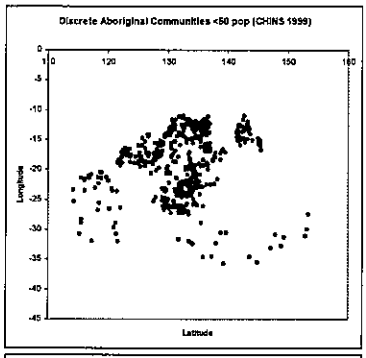
State/Territory	Discrete CHINS 2001	Other	Total Census 2001	Discrete %
New South Wales	7,771	127,529	135,300	6%
Victoria	279	27,621	27,900	1%
Queensland	30,961	95,039	126,000	25%
South Australia	5,226	20,374	25,600	20%
Western Australia	16,558	49,542	66,100	25%
Tasmania	57	17,343	17,400	0%
Northern Territory	47,233	10,367	57,600	82%
Australian Capital Territory	-	3,900	3,900	0%
Australia	108,085	352,015	460,100	23%

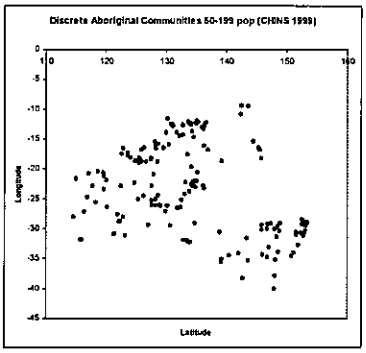
This analysis divides Australia into three State-based groupings. In the south-eastern states of NSW, Victoria, Tasmania and the ACT, more than 90% of Aboriginal and Torres Strait Islander people do not live in "discrete communities" as defined by the CHIN Survey. Even in

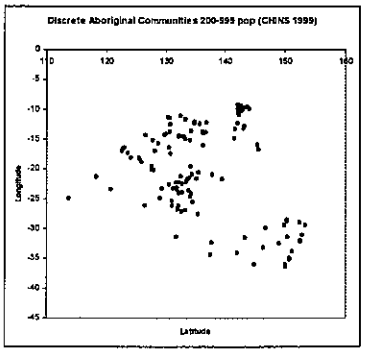
Queensland, South Australia, and Western Australia, at least 75% of Aboriginal and Torres Strait islander people do not live in "discrete communities". It is only in the Northern Territory that the vast majority of Aboriginal and Torres Strait Islander people do live in "discrete communities".

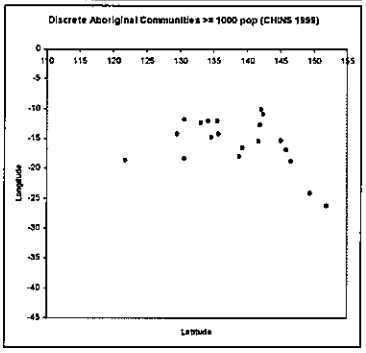
The Archipelagos of "discrete communities"

The following graphs show the latitude and longitude of the "discrete communities" of Aboriginal Australia by size, based on the CHINS data of 1999. The panels show, in order from top left, communities of less than 50 people, 50-199 people, 200-999 people, and 1000 people or more (bottom left). The table adds up the populations in each size category.









Community Size	Population	Number	Avg Pop
Pop 1000+	30,658	20	1,533
Pop 200-999	45,221	129	351
Pop 50-199	19,394	198	98
Pop <50	14,571	944	15
All	109,844	1,291	85

Note that these factors tend to lead to a general bias against NSW in discussions of Aboriginal-specific funding. Such evidence as there is about health differentials does not tend to suggest that there is strong evidence of better health for Aboriginal people in NSW than elsewhere.

This needs to be investigated systematically in relation to the assumptions about "remoteness" that are built into Federal funding, and the assumption that there is much greater usage of Medicare funded services by Aboriginal people in NSW.

The GAP : The War against Potentially Avoidable Mortality

No man is an *Iland*, intire of it selfe; every man is a peece of the *Continent*, a part of the *maine*; if a Clod bee washed away by the *Sea, Europe* is the lesse, as well as if a *Promontorie* were, as well as if a *Mannor* of thy *friends* or of *thine owne* were; any mans *death* diminishes *me*, because I am involved in *Mankinde*; And therefore never send to know for whom the *bell* tolls; It tolls for *thee*."

(John Donne, Meditation XVII, 1624)

To put the funding issues into perspective, in relation to closing mortality gaps, we have drawn on the NSW Chief Health Officer's report data on populations and Potentially Avoidable Mortality.

Although Aboriginal people are poorly identified in NSW data, the fact is that current death rates are so high that there are obvious gaps, even though the ones we can see are almost certainly an underestimate (unless those not identified have the same mortality as non-Aboriginal people).

Potentially Avoidable Mortality is death from a cause that might have been prevented in principle by Primary, Secondary or Tertiary prevention. In data, these can be estimated by classifying the recorded cause of death. It has proved useful in New Zealand for looking at the higher mortality of Māori people:

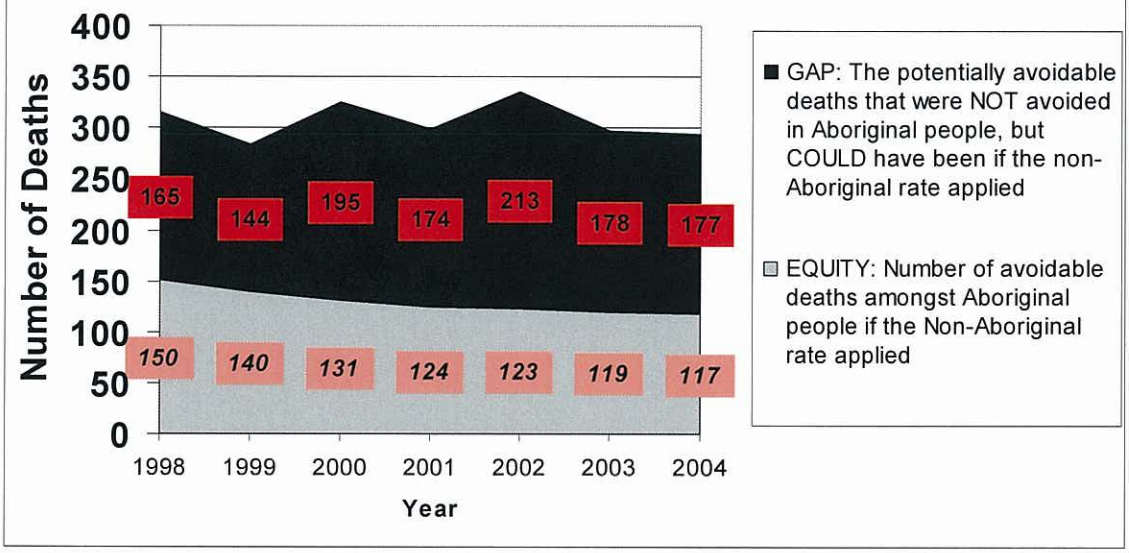
Table 85: Avoidable mortality, ages 0–74, by ethnicity, 1996–97

	Number			Rate			Ratio		Excess	
	Māori	Pacific	Eur	Māori	Pacific	Eur	Māori	Pacific	Māori	Pacific
PAM	855	202	3685	254	179	100	2.5	1.8	520	90
SAM	400	121	1781	125	110	48	2.6	2.3	250	70
TAM	346	102	1534	98	85	44	2.2	1.9	190	50
Total avoidable mortality	1601	424	7000	477	374	192	2.5	1.9	970	210
Unavoidable mortality	543	168	3150	163	148	85	1.9	1.7	260	70
Total all mortality	2144	592	10,150	640	523	278	2.3	1.9	1240	280
Avoidable mortality as % all mortality	75	72	69							

Source of base data: NZHIS (1997 data are provisional)
Notes: number = number of deaths, averaged over 1996 and 1997; rate = age standardised rate per 100,000; ratio = ratio of rate to Eur (= European and other ethnic groups); excess = number of excess deaths in group compared to European/Other group.

The table shows the "gaps" in terms anyone can understand - in 1996-97 there was an "excess" of 1,240 deaths amongst Māori people that would not have occurred if they had been avoided at the same rate as they were for European New Zealanders: that is if Primary (PAM), Secondary (SAM) or Tertiary (TAM) approaches had simply been equitable in their effects.

Number of potentially avoidable deaths amongst Aboriginal people under 75, and the GAP between this and the number if they were prevented as well as for non-Aboriginal people, NSW, 1998-2004.
(Source: NSW Health, Chief Health Officer's Report, 2006)



The NSW Chief Health Officer's report shows the same data for NSW in 2004, and this chart simply uses that publicly available data and represents it in a way that highlights the GAP. Amongst non-Aboriginal people, the rate of potentially avoidable deaths has been declining (that is, more are being actually avoided) over the period 1998-2004 in NSW, which continues a long-term Australian trend. When that rate is applied to Aboriginal people, we get the lower curve. There would still be 117 deaths amongst Aboriginal people if equitable prevention had been achieved, but clearly it had not been. The numbers vary from year to year, and they probably underestimate the GAP, but it is so large, and shows so little sign of change, that "under-identification" is not going to be a problem until it reduces to zero. Then we can worry about whether it is really zero or not. Right now, there were 177 extra deaths in NSW in 2004.

LGA of residence	REF	AREA HEALTH SERVICE / AH&MRC Member / Other AHO	% AHS Aboriginal population	Aboriginal residents	Total population	GAP in Potentially Avoidable Deaths
ALL			NSW (2004)	146,306	6,946,421	177
		SYDNEY SOUTH WEST AHS	100%	17,418	1,413,554	21
		SOUTH EASTERN SYDNEY & ILLAWARRA AHS	100%	16,346	1,239,683	20
		SYDNEY WEST AHS	100%	17,548	1,097,714	21
		NORTHERN SYDNEY & CENTRAL COAST AHS	100%	7,695	1,114,565	9
		HUNTER & NEW ENGLAND AHS	100%	30,828	833,763	37
		NORTH COAST AHS	100%	17,483	474,519	21
		GREATER SOUTHERN AHS	100%	13,064	467,749	16
		GREATER WESTERN AHS	100%	25,924	304,874	31

Dividing these 177 deaths across Area Health Services in proportion to their Aboriginal populations - NSW Health could do this in ways that are more precise, but it is done here simply to illustrate the value of it - it is clear that relatively few deaths have to be prevented with a budget of $11 Billion per annum to close this GAP, and no Area Health Service has an impossible task, or needs to achieve anything it has not already achieved for others.

Using the more detailed data below from NSW Health, we have carried this analysis through to look at every Local Government Area (LGA) in NSW, again in proportion to their Aboriginal populations, and also shown the types of Aboriginal Health Organisations (AHOs - as OATSIH calls them), distinguishing the three types affiliated with the AHMRC, namely Aboriginal Community Controlled Health Services (ACCHS's) who are full members, ACCH Committees who would like to develop to that stage, and ACCH Related services. We have also shown the few OATSIH-funded services that are not affiliated with the AHMRC. Each is listed next to the LGA in which it is located, though many of course serve people from outside that LGA and outside the AHS where it falls. Note that the listing of AHMRC members is more or less contemporary with the data, so not all are current

Distribution of population by Aboriginality by local government area, NSW 2004

Suggested citation:
Public Health Division, Report of the Chief Health Officer.
NSW Health Department, Sydney, 2006. Available at:
http://www.health.nsw.gov.au/public-health/chorep/atsi/atsi_popatsi_lgamap.htm. Accessed (insert date of access).

Note: * indicates figures not provided when based on fewer than 5 cases.
Source: ABS population estimates (HOIST). Centre for Epidemiology and Research, NSW Department of Health.

	ACCHS
Table1	ACCHC
Data follows:	ACCHRS
	OATSIH funded, not AHMRC

The GAP : Sydney South West AHS

LGA of residence	REF	AREA HEALTH SERVICE / AH&MRC Member / Other AHO	% AHS Aboriginal population	Aboriginal residents	Total population	GAP in Potentially Avoidable Deaths
ALL			NSW (2004)	146,306	6,946,421	177
		SYDNEY SOUTH WEST AHS	100%	17,418	1,413,554	21
Ashfield			1%	229	41,379	0.3
Bankstown			9%	1,488	175,007	1.8
Burwood			1%	130	31,666	0.2
Camden			4%	636	52,262	0.8
Campbelltown	038	Tharawal Aboriginal Corporation	25%	4,276	152,342	5.2
Canada Bay			1%	255	66,315	0.3
Canterbury			5%	837	137,831	1.0
Fairfield			8%	1,358	190,185	1.6
Leichhardt			3%	599	56,972	0.7
Liverpool			14%	2,463	171,768	3.0
Marrickville			7%	1,261	76,164	1.5
Strathfield			1%	116	32,688	0.1
Sydney	003	Aboriginal Medical Service Co-Operative Limited	14%	2,484	142,269	3.0
Wingecarribee			3%	591	45,260	0.7
Wollondilly			4%	695	41,446	0.8

There are two AHMRC members in this area. As is generally the case, being "grass roots" organisations based in a community, they are located in LGA's that contain a large percentage of the Aboriginal population of the AHS. However, clearly there are LGA's with significant numbers of Aboriginal people who would have to travel a considerable distance to reach an ACCHS. If this AHS could prevent death as well for the 17,418 Aboriginal people as it does for the 1,418, 664 others there would be about 21 fewer and the GAP would be closed.

The GAP : South Eastern Sydney & Illawarra AHS

LGA of residence	REF	AREA HEALTH SERVICE / AH&MRC Member / Other AHO	% AHS Aboriginal population	Aboriginal residents	Total population	GAP in Potentially Avoidable Deaths
ALL			NSW (2004)	146,306	6,946,421	177
		SOUTH EASTERN SYDNEY & ILLAWARRA AHS	100%	16,346	1,239,683	20
Botany Bay			4%	707	37,887	0.9
Hurstville			3%	449	76,380	0.5
Kiama			1%	235	20,785	0.3
Kogarah			1%	221	54,730	0.3
Randwick			10%	1,710	127,365	2.1
Rockdale			3%	524	96,317	0.6
Shellharbour			9%	1,443	63,919	1.7
Shoalhaven	036	South Coast Medical Service Aboriginal Corporation	22%	3,622	93,812	4.4
	059	Waminda – South Coast Women's Health & Welfare Aboriginal Corp				
	A10	Oolong Aboriginal Corporation Inc. (The)				
Sutherland Shire			9%	1,394	216,534	1.7
Sydney			15%	2,484	142,269	3.0
Waverley			2%	266	63,378	0.3
Wollongong	025	Illawarra Aboriginal Medical Service Aboriginal Corporation	19%	3,171	193,022	3.8
Woollahra			1%	120	53,285	0.1

Again we see that the two ACCHS's are located where the major centres of Aboriginal population are, and note that the SESIAHS share of the Sydney LGA is served by AMS Redfern locally, though the same people would have to deal with two different AHS's. In the Shoalhaven LGA, there are two ACCH-Related services as well as the ACCHS. There are about 20 deaths each year to be prevented in this AHS to close the GAP.

The GAP : Sydney West AHS

LGA of residence	REF	AREA HEALTH SERVICE / AH&MRC Member / Other AHO	% AHS Aboriginal population	Aboriginal residents	Total population	GAP in Potentially Avoidable Deaths
ALL			NSW (2004)	146,306	6,946,421	177
		SYDNEY WEST AHS	100%	17,548	1,097,714	21
Auburn			3%	569	63,966	0.7
Baulkham Hills			3%	461	164,701	0.6
Blacktown	017	Aboriginal Medical Service Western Sydney Co-op Ltd	42%	7,284	281,965	8.8
	A06	Marrin Weejali Aboriginal Corporation	0%			
Blue Mountains	A05	Link-Up (NSW) Aboriginal Corporation	6%	1,041	77,747	1.3
Hawkesbury			7%	1,228	64,363	1.5
Holroyd			5%	855	92,184	1.0
Lithgow			4%	684	20,418	0.8
Parramatta			8%	1,356	152,862	1.6
Penrith			23%	4,070	179,508	4.9

As is generally known, AMS Western Sydney provides services throughout this AHS, and is in fact located at Mt Druitt, roughly midway between the two main population concentrations and accessible by public transport. The Link-Up service is state-wide and is simply located in the Area. There are about 21 deaths each year to be prevented in this AHS to close the GAP.

The GAP : North Sydney & Central Coast AHS

LGA of residence	REF	AREA HEALTH SERVICE / AH&MRC Member / Other AHO	% AHS Aboriginal population	Aboriginal residents	Total population	GAP in Potentially Avoidable Deaths
ALL			NSW (2004)	146,306	6,946,421	177
		NORTHERN SYDNEY & CENTRAL COAST AHS	100%	7,695	1,114,565	9
Gosford			34%	2,593	164,512	3.1
Hornsby			7%	545	157,911	0.7
Hunter's Hill			1%	47	14,063	0.1
Ku-ring-gai			2%	126	108,371	0.2
Lane Cove			1%	83	32,508	0.1
Manly			1%	104	39,350	0.1
Mosman			0%	23	28,214	0.0
North Sydney			1%	111	60,686	0.1
Pittwater			2%	176	57,672	0.2
Ryde			4%	275	100,068	0.3
Warringah			7%	504	139,396	0.6
Willoughby			1%	104	65,491	0.1
Wyong	045	Yerin Aboriginal Health Service Inc. / Eleanor Duncan Centre	39%	3,004	146,323	3.6
	OATSIH	Ngaimpe Aboriginal Corporation (Glen Centre)				

Yerin serves both Gosford and Wyong LGA's. OATSIH also funds a D&A service in Wyong. There are about 9 deaths each year to be prevented in this AHS to close the GAP.

The GAP : Hunter & New England AHS

LGA of residence	REF	AREA HEALTH SERVICE / AH&MRC Member / Other AHO	% AHS Aboriginal population	Aboriginal residents	Total population	GAP in Potentially Avoidable Deaths
ALL			NSW (2004)	146,306	6,946,421	177
		HUNTER & NEW ENGLAND AHS	100%	30,828	833,763	37
Armidale Dumaresq	006	Armidale & District Services Inc	5%	1,464	24,726	1.8
Barraba			0%	80	2,176	0.1
Bingara			0%	37	2,029	0.0
Cessnock			5%	1,468	48,542	1.8
Dungog			1%	205	8,545	0.2
Glen Innes	055	Glen Innes Aboriginal Health Committee	1%	320	5,924	0.4
Gloucester			0%	135	4,950	0.2
Greater Taree	009	Biripi Aboriginal Corporation Medical Centre	6%	1,928	45,811	2.3
Great Lakes	040	Tobwabba Aboriginal Medical Service Inc.	3%	1,046	34,872	1.3
Gunnedah	015	Cumbo-Gunerah Aboriginal Health Service Inc	5%	1,471	12,245	1.8
Guyra			2%	504	4,402	0.6
Inverell	005	Armajun Aboriginal Health Service Incorporated	3%	860	15,664	1.0
	050	Kwiembal Aboriginal Corporation				
Lake Macquarie			13%	4,032	191,349	4.9
Maitland	051	Mindaribba Aboriginal Corp	5%	1,435	60,168	1.7
Manilla			1%	235	3,314	0.3
Merriwa			0%	41	2,331	0.0
Moree Plains	021	Euraba Mungindi Aboriginal Health Service Inc	11%	3,426	16,114	4.1
	033	Pius X Aboriginal Corporation				
	A12	Toomelah Aboriginal Health Service				
	OATSIH	Roy Thorne Substance Misuse Rehabilitation Centre				
Murrurundi			0%	47	2,119	0.1
Muswellbrook	A13	Wanaruah Aboriginal Committee	2%	607	15,180	0.7
Narrabri			4%	1,293	14,097	1.6
Newcastle	007	Awabakal Newcastle Aboriginal Co-Operative Ltd	9%	2,869	145,480	3.5
Nundle			0%	56	1,320	0.1
Parry			2%	592	13,138	0.7
Port Stephens			5%	1,585	63,167	1.9
Quirindi			1%	461	4,901	0.6
Scone			1%	276	9,872	0.3
Severn			0%	105	2,805	0.1
Singleton			2%	539	21,872	0.7
Tamworth	037	Tamworth Aboriginal Medical Service Inc - Tamworth	8%	2,583	37,366	3.1
	042	Walhallow Aboriginal Health Service Incorporated				
Tenterfield			2%	483	6,813	0.6
Uralla			1%	390	6,129	0.5
Walcha			1%	199	3,224	0.2
Yallaroi			0%	56	3,118	0.1

HNEAHS is actually the AHS with the largest number of Aboriginal people, contrary to the general belief that it is Greater Western AHS. This is reflected in the large number of ACCHSs there, although there are some unserved population concentrations. There are about 37 deaths each year to be prevented in this AHS to close the GAP.

The GAP : North Coast AHS

LGA of residence	REF	AREA HEALTH SERVICE / AH&MRC Member / Other AHO	% AHS Aboriginal population	Aboriginal residents	Total population	GAP in Potentially Avoidable Deaths
ALL			NSW (2004)	146,306	6,946,421	177
		NORTH COAST AHS	100%	17,483	474,519	21
Ballina	A07	Namatjira Haven Drug & Alcohol Healing Centre	6%	1,094	40,314	1.3
Bellingen			2%	394	12,865	0.5
Byron			2%	412	31,721	0.5
Clarence Valley-Grafton	011	Bulgarr Ngaru Medical Aboriginal Corporation	13%	2,353	50,050	2.8
Clarence Valley-Casino	018	Dharah Gibinj Aboriginal Medical Service Aboriginal Corp				
Coffs Harbour	022	Galambila Aboriginal Health Service Inc	12%	2,164	67,372	2.6
Hastings	019	Dhoongang Aboriginal Health Service Inc	9%	1,549	70,870	1.9
Kempsey	020	Durri Aboriginal Corporation Medical Service	15%	2,645	28,133	3.2
	OATSIH	Benelongs Haven Limited				
Kyogle			3%	570	9,674	0.7
Lismore			9%	1,647	42,523	2.0
Nambucca	030	Nambucca Valley Aboriginal Health Service Incorporated	7%	1,148	18,545	1.4
Richmond Valley			8%	1,354	21,140	1.6
Tweed	OATSIH	Bugalwena Service - North Coast Area Health Service (Tweed Heads Service)	12%	2,153	81,312	2.6

Again, ACCHSs are located in most LGAs with significant numbers of Aboriginal people, but not all. There are about 21 deaths each year to be prevented in this AHS to close the GAP.

The GAP : Greater Southern AHS

LGA of residence	REF	AREA HEALTH SERVICE / AH&MRC Member / Other AHO	% AHS Aboriginal population	Aboriginal residents	Total population	GAP in Potentially Avoidable Deaths
ALL			NSW (2004)	146,306	6,946,421	177
		GREATER SOUTHERN AHS	100%	13,064	467,749	16
Albury	004	Albury Wodonga Aboriginal Health Service Inc.	7%	944	44,970	1.1
Bega Valley			6%	782	32,493	0.9
Berrigan			1%	75	8,191	0.1
Bland			1%	127	6,563	0.2
Bombala			0%	24	2,510	0.0
Boorowa			0%	36	2,430	0.0
Carrathool			1%	180	3,326	0.2
Conargo			0%	15	1,766	0.0
Coolamon			1%	66	4,116	0.1
Cooma-Monaro			1%	103	9,752	0.1
Cootamundra			2%	316	7,565	0.4
Corowa			0%	64	8,657	0.1
Culcairn			0%	63	3,934	0.1
Deniliquin			2%	249	8,304	0.3
Palerang			1%	114	11,736	0.1
Eurobodalla	026	Katungul Aboriginal Corporation Community & Medical Services	13%	1,645	36,586	2.0
Goulburn-Mulwaree			4%	547	26,987	0.7
Queanbeyan	A09	Ngambra Aboriginal Health Service Inc.	8%	1,007	36,492	1.2
Griffith	024	Griffith Aboriginal Medical Service Incorporated	8%	1,024	25,173	1.2
Gundagai			1%	76	3,721	0.1
Harden			1%	119	3,750	0.1
Hay	047	Barjai Aboriginal Corporation	1%	138	3,523	0.2
Holbrook			0%	20	2,431	0.0
Hume			1%	95	8,271	0.1
Jerilderie			0%	39	1,865	0.0
Junee			2%	251	5,884	0.3
Leeton	056	Leeton & District Aboriginal Corp	3%	409	12,128	0.5
Lockhart			1%	99	3,524	0.1
Murray	016	Cummeragunja Housing & Development Aboriginal Corp	2%	220	6,633	0.3
Murrumbidgee			2%	205	2,727	0.2
Narrandera	057	Narrandera Family Support Group for Alcohol & Drug Dependents Aboriginal Corp	5%	627	6,554	0.8
Snowy River			0%	51	7,570	0.1
Temora			0%	61	6,280	0.1
Tumbarumba			1%	83	3,654	0.1
Tumut	A01	Brungle Aboriginal Health Service	3%	371	11,505	0.4
Upper Lachlan			1%	84	7,459	0.1
Urana			0%	32	1,362	0.0
Wagga Wagga	035	Riverina Medical & Dental Aboriginal Corporation	16%	2,109	57,720	2.6
Wakool			1%	90	4,875	0.1
Yass Valley			2%	235	12,794	0.3
Young			2%	269	11,968	0.3

Note that where small populations are served by an ACCHS, as at Cummeragunja, this often reflects the presence of a "discrete" community, which in NSW typically means a former reserve operated by the Aboriginal Protection Board or Aboriginal Welfare Board in days gone by. There are about 16 deaths each year to be prevented in this AHS to close the GAP.

The GAP : Greater Western AHS

LGA of residence	REF	AREA HEALTH SERVICE / AH&MRC Member / Other AHO	% AHS Aboriginal population	Aboriginal residents	Total population	GAP in Potentially Avoidable Deaths
ALL			NSW (2004)	146,306	6,946,421	177
		GREATER WESTERN AHS	100%	25,924	304,874	31
Balranald	008	Balranald Aboriginal Health Service Incorporated	1%	210	2,723	0.3
Bathurst			5%	1,202	31,836	1.5
Blayney			0%	113	6,667	0.1
Bogan			2%	392	3,023	0.5
Bourke	010	Bourke Aboriginal Health Service Ltd	5%	1,215	3,862	1.5
Brewarrina	012	Brewarrina Aboriginal Health Centre Ltd	5%	1,330	2,106	1.6
	A11	Orana Haven Aboriginal Corporation	0%			
	OATSIH	Weilmoringle Health Outpost C/- Far West Area Health Service				
Broken Hill	A14	Weimija Aboriginal Health Service	5%	1,273	19,998	1.5
	OATSIH	Maari Ma Health Aboriginal Corporation				
Cabonne			1%	251	12,659	0.3
Central Darling	027	Menindee Aboriginal Health Service Inc	4%	940	2,378	1.1
	OATSIH	Nyampa Aboriginal Housing Company	0%			
Cobar	A02	Cobar Aboriginal Health Service	2%	558	5,037	0.7
Coolah			0%	116	3,820	0.1
Coonabarabran			3%	651	6,686	0.8
Coonamble	A03	Coonamble Aboriginal Health Service Inc.	4%	1,158	4,612	1.4
Cowra	060	Weigelli Centre Aboriginal Corp	3%	829	13,185	1.0
Dubbo	039	Thubbo Aboriginal Medical Co-op Ltd	15%	3,986	39,500	4.8
Evans			0%	81	5,534	0.1
Forbes	044	Yoorana-Gunya Family Violence Healing Centre Aboriginal Corp	2%	599	9,927	0.7
Gilgandra	049	Gilgandra Aboriginal Corporation Health Service	2%	550	4,615	0.7
Lachlan	013	Condobolin Aboriginal Health Service Inc.	4%	1,057	7,376	1.3
	028	Murrin Bridge Aboriginal Health Service Inc				
Mudgee			2%	487	18,605	0.6
Narromine	A08	Narromine Aboriginal Health Committee	5%	1,184	7,054	1.4
Oberon			1%	134	5,043	0.2
Orange	031	Orange Aboriginal Health Service Incorporated	6%	1,631	37,849	2.0
Parkes	032	Parkes Aboriginal Health Service Incorporated	4%	940	15,024	1.1
	033	Peak Hill Aboriginal Medical Service Incorporated				
	054	Central West Dental				
Rylstone			0%	75	3,859	0.1
Walgett	041	Walgett Aboriginal Medical Service Co 0perative Limited	9%	2,232	8,144	2.7
Warren			2%	458	3,174	0.6
Weddin			0%	42	3,766	0.1
Wellington	043	Wellington Aboriginal Corp Health Service	5%	1,342	8,798	1.6
Wentworth	014	Coomealla Health Aboriginal Corp	3%	818	7,234	1.0
Unincorporated Far West			0%	70	780	0.1

Next to HNEAHS, the Greater Western AHS has the largest number of Aboriginal people in NSW, dispersed over a large area. OATSIH funds a number of AHOs in the AHS which are not affiliated with the AHMRC, notably the Maari Ma service which has a separate partnership arrangement with GWAHS. Nevertheless, one way and another there are many small services battling against about 31 extra deaths occurring in this AHS each year which need to be prevented to close the GAP.

The GAP : Conclusion

We hope that this demonstration of what it means in concrete terms to Close The GAP in mortality will show the Committee that it can be done, and that a network of AHMRC-Affiliated services and some others is already in place around the state, located in most of the LGAs where there are significant concentrations of Aboriginal people. These services have been built up by Aboriginal people over the 37 years since AMS Redfern opened in 1971, and have battled for recognition and funding for most of that time, under continuous scrutiny and challenge. Nevertheless they exist, and most have survived. The health services funding issue is to support the work that Aboriginal people have done for themselves, and develop the complementary relationships with NSW Health services under the Aboriginal Health Partnership Agreement.

Issue 3 Short Term "Pilot" Funding

Short term funding

3.72 The Committee heard evidence about the Aboriginal community's exasperation with continued pilot programs receiving short term funding. The Committee heard that it is often difficult to measure the success of programs that have only been funded in the short term and is concerned that a lack of clear communication between program operators and government has left both parties unsure of the effectiveness of programs.

Issue for consideration 3 – Delivery: short term funding

The Committee will look at the effectiveness and assessment of funding programs that are temporary and intermittent in nature.

The AHMRC is in total agreement with the waste of time an effort associated with this "pilot" approach. In addition, much time and effort is wasted in "evaluating" them.

Issue 7 Environmental Health Programs

4.27 The Committee notes that the ACDP has, in the short term, been extended until 2009. The Committee has heard evidence of the positive impact of the program in communities where it has been delivered, however the environmental health problems in Aboriginal communities continue to contribute to Indigenous disadvantage. The evidence that has been presented to the Committee leads to the conclusion that there is an absolute necessity for ongoing funding for environmental health programs after funding for the ACDP ends in 2009.

Issue for consideration 7 – Environment and infrastructure: funding

The Committee will examine the need for ongoing funding for environmental health programs after funding for the Aboriginal Community Development Program ends in 2009.

The AHMRC agrees that environmental health programs provide an essential platform for wellbeing and should be funded on an ongoing basis.

Issue 14 Child Sexual Abuse - Funding for Services

5.28	The Committee considers child sexual abuse as a key determinant of adult health and wellbeing but is concerned that funding for programs and services to reduce the incidence and ameliorate the effects of child sexual abuse has been inadequate.

Issue for consideration 14 – Health and wellbeing: child sexual abuse services

The Committee will seek evidence of the appropriate levels of funding and services to reduce the incidence of and ameliorate the effects of child sexual abuse, including the implementation of the interagency plan in response to the *Breaking the Silence* report.

The AHMRC strongly endorses the view that these services need to have specific funding for supporting services, while also calling attention to the fact that the high levels of distress in all communities are overloading all services, leaving many contributing problems untouched.

Issue 22 Education - Long Term Service

6.61	To close the gap between Indigenous and non-Indigenous education levels, the Committee believes that an increase in the level of specifically targeted funding may be required to effectively build Indigenous capacity. The Committee understands that current funding is often short-term or provided through a 'pilot project', limiting the ongoing or long term measures of success. The Committee is interested to see how the New South Wales Government will achieve its claim in the recent evaluation of the SiP program that 'the gap between Aboriginal and non Aboriginal students would be overcome within a decade.'

Issue for consideration 22 – Education: long term services

The need to provide and fund long-term services with Indigenous specific focus and the necessary funding will be considered.

The AHMRC is of the view that even if secondary school gaps are overcome there is still a need for programs focussing on adults who missed out. This is based on the experience of many adults who missed out on the standard educational progress and have later made major achievements in vocational education and continued to other forms of tertiary education. An excessive focus on "standard" education sequences would not be at all appropriate.

Issue 26 STEP Vs Longer Term Funding

7.74	Although STEP increases the time that funding is available to support Indigenous employees, the Committee is concerned that the sustainability of employment services for Indigenous people is limited by the short term nature of the funding. The Committee believes that, if Indigenous employment levels are to increase and remain at that increased level, funding linked to skill development and retention of Indigenous people in the long term need to become preferred policy options.

Issue for consideration 26 – Employment: funding

The Committee will examine the funding of employment programs to ensure skill development and retention rates.

The AHMRC is in total agreement with the Committee's views on this matter.

See also Issue 27 CDEP / STEP/ CLIEP.

Issue 32 Housing - Funding

8.35	It is the view of this Committee that the housing needs of all Indigenous Australians should be addressed. The Committee will further examine provision of housing in urban and regional areas in the Final Report.

Issue for consideration 32 – Housing: funding

An issue for further consideration will be the equitable distribution of funds and coordination of programs for social housing in New South Wales between urban, regional and rural areas, to better address unmet housing needs of Indigenous people.

The AHMRC agrees.

Issue 37 Housing Maintenance and Employment

8.116	The appropriate maintenance of properties, particularly those run by government providers, is an essential part of housing provision. The Committee is concerned about the high number of properties requiring maintenance and highlights the need for programs such as those mentioned above, which provide training and employment opportunities for members of Aboriginal communities as well as critical property maintenance.

Issue for consideration 37 – Housing: maintenance

The Committee is concerned that, given the demand for housing and consequent overcrowding and health issues, that funding for necessary maintenance of properties is provided.

The AHMRC appreciates the Committee's support for the value of combining meeting housing needs with training and employment, as already stated elsewhere here.

Issue 42 Circle Sentencing

9.119 The Committee heard a significant amount of positive evidence regarding Circle Sentencing, including evidence from Circle Sentencing participants during the Committee's site visit to Nowra. We will explore this evidence further in the Final Report where we will analyse the effectiveness of Circle Sentencing and address the issue of compensation.

Issue for consideration 42 – Justice: circle sentencing

The Committee is concerned that there are insufficient resources available for Circle Sentencing courts and highlights this issue for discussion.

See comments at Issue 41 Community Based Sentencing

Employment, Mentoring and Training

Employment, mentoring and training of Indigenous people

10.10 The Committee heard that, across the majority of sectors, there is a strong need for additional Aboriginal employees and in order to increase the numbers and retention of Aboriginal employees, mentoring and training programs.

10.11 These issues are drawn from Chapters 5, 6, 7, and 9: Health; Education; Employment; Incarceration and the criminal justice system.

Issues for further consideration – employment, mentoring and training

- The Committee will review the adequacy of training and scholarships for Indigenous health workers in more detail. – Issue 19, page 121
- Establishing links with family and community and culturally appropriate mentoring programs in order to encourage students in their education and support students in their endeavours at all levels of attainment will be investigated further. – Issue 23, page 156

- The importance of employing Indigenous staff as teachers and role models is apparent, however there is a need to address the attainment levels of current and future students so that this can occur. – Issue 24, page 165
- The Committee notes that the changes to the CDEP scheme, the strengthening of the STEP program and Job Compacts are all relatively new. The Committee will revisit these schemes, when the Job Compacts are finalised and there is data available on their initial impact and progress towards addressing Indigenous employment issues. – Issue 27, page 187
- Given the volume of evidence supporting mentoring programs and their effectiveness in gaining and retaining Indigenous employees, the Committee will consider how mentoring can be incorporated into a variety of programs aimed at addressing Indigenous disadvantage. – Issue 28, page 191
- It is evident from the statistics that current policies and/or initiatives have not been enough to make substantial inroads into Indigenous unemployment. The Committee will examine reasons for this, including the limited time frame, education levels and early disengagement of Indigenous students in the educational process. – Issue 31, page 197

Issue 19 Aboriginal Health Workers

> **"... the health needs of Aboriginal Australians will not be met until there are more Aboriginal people working themselves in health services ..."**
> *Gough Whitlam, National Aboriginal Mental Health Conference, Sydney, 25 November 1993*[1]

The latest analyses of Aboriginal employment in the health workforce[2] are based on 2001 census data, and show that 0.9% identified as Aboriginal people Nationally (Table) and in NSW.

Table 3.09.4: Employment in health-related occupations (health workforce), 2001[(a)]

	Indigenous	All persons	Proportion who were Indigenous
	No.	No.	%
Aboriginal and Torres Strait Islander health workers	844	906	93.2
Medical workers			
Health service managers	72	6,456	1.1
Medical practitioners	87	45,079	0.2
Medical imaging professionals	17	8,279	0.2
Total	***176***	***59,814***	***0.3***
Dental workers			
Dental practitioners	14	7,811	0.2
Dental associate professionals	17	4,475	0.4
Dental assistants	124	13,053	0.9
Total	***155***	***25,339***	***0.6***
Nursing workers			
Nurse managers	29	7,328	0.4
Registered nurses	782	140,781	0.6
Personal care and nursing assistants	795	50,533	1.6
Enrolled nurses	200	19,405	1.0
Other nurses[(b)]	93	21,877	0.4
Total	***1,899***	***239,924***	***0.8***
Pharmacists	12	13,130	0.1
Allied health professionals			
Ambulance officers and paramedics	82	6,689	1.2
Physiotherapists	29	10,119	0.3
Psychologists	23	9,105	0.3
Dieticians	18	1,982	0.9
Other[(c)]	22	9,735	0.2
Total	***174***	***37,630***	***0.5***
Total	**3,260**	**376,743**	**0.9**

(a) Occupation as defined by the Australian Standard Classification of Occupation.
(b) Includes nursing not further defined, educators and researchers, midwives, mental health, developmental disability.
(c) Includes optometrists, speech pathologists, chiropractors and osteopaths, podiatrists.

Note: Small numbers may be rounded in order to protect the confidentiality of individuals; this may affect proportions.

Source: ABS unpublished data (Census of Population and Housing).

1 Taken from transcript held by AHMRC of video from the NAMHC organized by Pat Swan, 1993.
2 Australian Institute of Health and Welfare 2007. *Aboriginal and Torres Strait Islander Health Performance Framework, 2006 report: detailed analyses*. AIHW cat. no. IHW 20. Canberra: AIHW.

The national distribution across professional groups, by numbers, shows:

- 844 Aboriginal Health Workers (93.2%)
- 792 personal care & nursing assistants (1.6%)
- 782 registered nurses (0.6%)
- 200 enrolled nurses (1.0%).
- 87 medical practitioners (0.2%)
- 23 psychologists (0.3%)
- 22 social workers and occupational therapists included in "other allied health" (0.2%)

We have included this summary from another document since it may be of use to the Committee. We believe the key message in it is that paraprofessional scholarships for Aboriginal Health Workers, and other education/ employment issues that we have addressed under other issues, provide a ladder for adults to re–enter education via employment in ACCHS's in a safe and supportive environment; in addition to work to be done in secondary level education. See also the training role of the AHMRC Aboriginal Health College.

Issue 23 Engagement with Communities re Student Education

6.102 The Evidence shows that effective engagement with both the family and community to ensure that students are supported in their endeavours will improve levels of attainment and retention. The impact of students staying at school and increasing their attainment levels holds a key to the future for Aboriginal people and overcoming the current unacceptable level of disadvantage.

6.103 The Committee heard evidence from a variety of witnesses on culturally appropriate ways to effectively engage with the Indigenous community. These will be discussed in the Final Report.

Issue for consideration 23 – Education: mentoring

Establishing links with family and community and culturally appropriate mentoring programs in order to encourage students in their education and support students in their endeavours at all levels of attainment will be investigated further.

The AHMRC agrees and would welcome further more detailed disccusion with the Committee.

Issue 24 Aboriginal Teachers

6.142 An Indigenous staff member can have a significant impact on students. Opportunities for training and employing more Aboriginal teachers and support staff across the education sector needs to be explored. It is also important to imbed cultural awareness training into all teacher training.

Issue for consideration 24 – Education: role models

The importance of employing Indigenous staff as teachers and role models is apparent however there is a need to address the attainment levels of current and future students so that this can occur.

The AHMRC agrees with this.

Issue 27 CDEP / STEP/ CLIEP

7.82 Although there has been some improvement in Indigenous unemployment levels there is still a long way to go. At both the Federal and State Government level, the current employment programs are relatively new and no evaluative material is available for the Committee to assess the appropriateness of the funding or its delivery. There remains a need for employment initiatives to undergo ongoing evaluation and adjustment to maximise their effectiveness.

7.83 The Committee is of the opinion that employment should not and cannot be examined in isolation. It is necessary to consider the impact of other factors on employment at the same time, particularly education.

Issue for consideration 27 – Employment: job compacts

The Committee notes that the changes to the CDEP scheme, the strengthening of the STEP program and Job Compacts are all relatively new. The Committee will revisit these schemes, when the Job Compacts are finalised and there is data available on their initial impact and progress towards addressing Indigenous employment issues.

The AHMRC would like to draw the Committee's attention to the relatively limited use of the Structured Training and Employment Projects (STEP) /Corporate Leaders for Indigenous Employment Project (CLIEP) opportunities by the health industry nationally. Some details are given in the table below, which is a by-product of the work described at :

Appendix : Open Government and Commonwealth Aboriginal Health Funding: An Analysis of 'Murray Motion' Reports for 2007

2007	1
Source	(All)
For	(All)

Sum of Valin07		STATE				
DAO	To	AUS	NSW	QLD	WA	Grand Total
STEP/CLIEP	Australian Red Cross Society	$ 20,848				$ 20,848
	Australian Red Cross Society - Queensland Division			$ 154,987		$ 154,987
	Children of the Dreaming - Centre for Self Healing			$ 76,498		$ 76,498
	Department of Health - NSW		$ 307,579			$ 307,579
	Department of Health - QLD			$ 149,451		$ 149,451
	Greater Western Area Health Service		$ 213,517			$ 213,517
	Health Training Australia Inc				$ 108,319	$ 108,319
	Hunter New England Area Health Service		$ 217,655			$ 217,655
	Medicare Australia	$ 19,000				$ 19,000
	NSW Dept of Ageing Disability & Home Care		$ 88,566			$ 88,566
	Rockhampton Health Service			$ 89,397		$ 89,397
	WA Dept for Child Protection				$ 52,131	$ 52,131
	Walhallow Aboriginal Corporation		$ 87,667			$ 87,667
STEP/CLIEP Total		$ 39,848	$ 914,984	$ 470,334	$ 160,450	$ 1,585,615
Grand Total		$ 39,848	$ 914,984	$ 470,334	$ 160,450	$ 1,585,615

Issue 28 Mentoring

7.104 The Committee heard repeated evidence from a variety of stakeholders that mentoring Indigenous employees improves retention rates. Mentoring programs need to be considered as an integral part of Indigenous programs. To ensure cultural understanding and resilience, mentoring needs to include both the Indigenous and non-Indigenous employees.

Issue for consideration 28– Employment: mentoring

Given the volume of evidence supporting mentoring programs and their effectiveness in gaining and retaining Indigenous employees, the Committee will consider how mentoring can be incorporated into a variety of programs aimed at addressing Indigenous disadvantage.

The AHMRC would like to draw the Committee's attention to the fact that mentoring is an integral part of the vocational education model of the Aboriginal Health College.

Structure and philosophy

Courses must meet current vocational requirements and good practice for the specific area of study, allow for portability of skills and recognition. This is done through use of a quality structure (nationally endorsed qualifications).

Courses also must be culturally safe and secure in the way they are delivered. Fundamental to this is the principle of respect that underlies the decision making processes and behaviour of Aboriginal Health Workers and others employed and working within the Aboriginal health field.

There are major cultural divides in the way in which, Aboriginal communities, bureaucratic systems and mainstream Australian society perceive, define, interpret and apply the principle of respect.

The Aboriginal Health College ensures courses in their structure, content, teaching strategies, assessment and evaluation; affirm the Aboriginal understanding of respect.

Aboriginal Health College courses require an element of self-directed learning, such learning is not directly supervised. Course structures of each program have been planned in such a way as to enhance skills in critical analysis, synthesis, problem solving and self-directed workplace function.

For each module a large proportion of the learning takes place in the workplace, with individual tutorial sessions where necessary to support the modules. These tutorial sessions serve to either introduce concepts and practices for discussion or to consolidate learning. Thus, class work or extended absences from the workplace and community are minimalised through the use of effective workplace Learning and Recognition strategies.

Students study largely within their workplace and in their own community. Course length for each student is determined by existing competence levels, self-direction and the amount of Recognition granted.

Each course is divided into clusters. Within each cluster there may be a number of units. This information is highlighted under each Course outline. Courses allow flexibility ensuring students with competing interests move through each cluster at a pace suitable to both them and their workplace and their family/community commitments.

Issue 31 Employment

7.128 The Committee believes that the actions that the New South Wales Government is undertaking in the development of Job Compacts and STEP need to be carefully monitored for placement numbers and levels as well as retention.

Issue for consideration 31 – Employment: reassessment

It is evident from the statistics that current policies and/or initiatives have not been enough to make substantial inroads into Indigenous unemployment. The Committee will examine reasons for this, including the limited time frame, education levels and early disengagement of Indigenous students in the educational process.

See Issue 27 CDEP / STEP/ CLIEP

Specific Strategies

Specific strategies

10.12 During the course of the Inquiry, a number of strategies and programs were brought to the attention of the Committee as being in need of review. These strategies range from amendments to the *Aboriginal Land Rights Act 1983*, to the provision of education programs specifically targeting literacy and numeracy rates.

10.13 These issues are drawn from Chapters 3, 4, 6, 7, 8 and 9: Service delivery; Environmental health and infrastructure; Education; Employment; Housing; and Incarceration and the criminal justice system.

Issues for further consideration – Specific strategies

- The Committee will investigate further the issue of an independent body for Indigenous representation – Issue 5, page 70
- The Committee will follow with interest the second round of amendments to the *Aboriginal Land Rights Act 1983* (NSW), due to be introduced into Parliament in late 2008. The Committee will examine the need for an appropriate ongoing review mechanism, including the issue of the separation of regulatory and assistance functions of the New South Wales Aboriginal Land Rights Council – Issue 6, page 78
- The provision of accessible Internet to Aboriginal communities will be considered.– Issue 9, page 91
- The Committee will consider the appropriateness of driver training programs aimed at assisting members of the Aboriginal community to gain drivers licenses – Issue 10, page 97
- To help support and strengthen families in Aboriginal communities, the Committee will consider opportunities to bolster existing men's and women's groups, and appropriate programs to assist parents, in particular young parents. – Issue 13, page 103

- The Committee notes that there has been some improvement in the literacy and numeracy levels of Aboriginal students in New South Wales, however we remain concerned that these levels require significant improvement in order for Indigenous students to meet the national benchmarks. The Committee will examine the efficacy of strategies to address literacy and numeracy rates of Indigenous children and the adequacy of funding. – Issue 20, page 140
- The Committee considers that the regulatory requirements for community housing providers should be reviewed, in order to facilitate the provision of community housing to the Aboriginal community. – Issue 33, page 214
- The Committee will consider the accessibility of community based sentencing options to Aboriginal offenders – Issue 41, page 252
- Evidence suggests that juvenile diversions are less likely to be granted to Aboriginal young offenders than to non-Aboriginal young offenders. The Committee will consider the availability and use of diversions for young Aboriginal offenders in the Final Report – Issue 43, page 261
- Evidence suggests that some Aboriginal offenders with a mental health disorder are being incarcerated due to a lack of adequate mental health services. The Committee is concerned about the wellbeing of these offenders – Issue 44, page 264

Issue 5 Representative Body

> **Issue for consideration 5 – Delivery: representation**
>
> The Committee will investigate further the issue of independent body for Indigenous representation.

The AHMRC endorses the views of the Aboriginal Social Justice Commissioner.

2008

Towards a new National Indigenous Representative Body

A Community Guide

Without genuine engagement with Indigenous Australians, governments will struggle in their efforts to make lasting progress to improve the conditions of our people and in our communities.

There is currently no transparent, rigorous process or mechanism at a national level to engage with Indigenous communities, where policies and priorities can be developed and which can hold governments accountable for their performance.

We need a new National Indigenous Representative Body if we are to achieve long-term, positive change. The new Australian Government recognised this in its Apology speech on 13 February this year.

The Government strengthened this commitment when, along with the Federal Opposition, it signed a Statement of Intent in March 2008. This commits the Government to work in partnership with Indigenous people, and their representative organisations, to 'close the gap' on health inequality and life expectancy by 2030.

It is now time to give substance to these commitments so that Indigenous Australians can participate in the decisions made by government. This is why discussion about a new National Indigenous Representative Body is so important.

From 2006 I have been carrying out research to identify the key issues we need to consider in establishing such a national representative body.

The research was published in an Issues Paper that looks at the lessons we can learn from past Australian experiences, what representative bodies are currently in place in Australia and overseas models of representation for indigenous peoples.

It also raises some key issues we need to consider to ensure that a new National Indigenous Representative Body is effective and sustainable. The Issues Paper is over 100 pages, so I provide this community guide as a summary.

My hope is that we can develop a body that truly represents the interests of all sections of the diverse Aboriginal and Torres Strait Islander community, no matter what their age, sex, background or where they live.

And I hope that such a body will be able to inspire and support our people, while also holding governments accountable for their efforts, so that we can ultimately enjoy the same life chances as all other Australians.

I urge all Aboriginal and Torres Strait Islander peoples to work together to make sure we have a body that we can all be proud of; and a body that will represent us.

Tom Calma
Aboriginal and Torres Strait Islander Social Justice Commissioner

TOM CALMA is the Aboriginal and Torres Strait Islander Social Justice Commissioner.

Tom, an Aboriginal elder from the Kungarakan tribal group and a member of the Iwaidja tribal group of the Northern Territory, commenced his five-year term in July 2004.

As Commissioner he advocates for the recognition of the rights of Indigenous Australians and seeks to promote respect and understanding of these rights among the broader Australian community.

Tom has been involved in Indigenous affairs at a local, community, state, national and international level and has worked in the public sector for over 35 years.

Aboriginal and Torres Strait Islander Social Justice Commissioner

Human Rights and Equal Opportunity Commission
www.humanrights.gov.au

Issue 6 Land Rights Act (NSW)

3.163	The Committee notes the significant reviews the Land Council system has undergone since the commencement of the *Land Rights Act* in 1983. The Committee understands the concerns surrounding the regulatory requirements resulting from the *Aboriginal Land Rights Act 2006* (NSW), however, given the endemic level of mismanagement and corruption throughout the land council system up until the 2001 amendments, the Committee cannot condone the relaxation of these restrictions at this early stage.
	Issue for consideration 6 – Delivery: *Aboriginal Land Rights Act 1983*
	The Committee will follow with interest the second round of amendments to the *Aboriginal Land Rights Act 1983* (NSW), due to be introduced into Parliament in late 2008. The Committee will examine the need for an appropriate ongoing review mechanism, including the issue of the separation of regulatory and assistance functions of the New South Wales Aboriginal Land Council.

The AHMRC objects strenuously to the term "endemic" in the Committee comment, which is not justified. Part of the "indigenous disadvantage" that this Inquiry is supposed to be considering is racist slurs of this kind. Do we have to point out that the vast majority of ICAC files refer to non-Aboriginal organisations and the Committee saw no need to refer to "endemic level of mismanagement and corruption" when referring to them?

Issue 9 Internet access

4.60	The lack of Internet access in Aboriginal communities is a concern. Access to the Internet impacts on education and employment outcomes and general community wellbeing. The provision of accessible Internet to Aboriginal communities is an issue that will be considered in the Final Report.
	Issue for consideration 9 – Environment and infrastructure: Internet
	The provision of accessible Internet to Aboriginal communities will be considered.

The AHMRC endorses this, and would add to it that support for communications infrastructure that allows health services to co-operate and work together would be a high priority also.

Issue 10 Driver Training

This was addressed previously Issue 11

Issue 13 Men's and Women's and Young Parents' Groups

5.17	The Committee heard much evidence about the impact of family breakdown on individual and community wellbeing. Men's and women's groups play an important role in supporting families, and in particular young mothers and fathers. Programs such as *Hey Dad!* and the Men's Shed in Bidwill and the Babana Aboriginal Men's Cultural Group in Redfern also offer important support to men. Opportunities for more widespread men's and family programs will be examined in the Final Report.

Issue for consideration 13 – Health and wellbeing: family

To help support and strengthen families in Aboriginal communities, the Committee will consider opportunities to bolster existing men's and women's groups, and appropriate programs to assist parents, in particular young parents.

The AHMRC strongly endorses this, and believes that groups of this kind provide venue for health literacy and similar work that can improve health in fairly direct ways if the groups are supported.

Issue 20 Literacy & Numeracy & Funding

6.26	Attainment levels of Indigenous students remain well below the national average. A marked increase in the rate of any improvement in Aboriginal student attainment levels will be necessary to meet the defined targets.

Issue for consideration 20 – Education: literacy and numeracy

The Committee notes that there has been some improvement in the literacy and numeracy levels of Aboriginal students in New South Wales, however we remain concerned that these levels require significant improvement in order for Indigenous students to meet the national benchmarks. The Committee will examine the efficacy of strategies to address literacy and numeracy rates of Indigenous children and the adequacy of funding.

The AHMRC supports the initiative and emphasises the importance of Aboriginal Community Controlled organisations in providing models that give young people a visible demonstration of the value of these skills in working to improve the wellbeing of their communities.

Issue 33 Community Housing Providers

> Issue for consideration 33 – Housing: regulations
>
> The Committee considers that the regulatory requirements for community housing providers should be reviewed, in order to facilitate the provision of community housing to the Aboriginal community.

The AHMRC supports the view that creative investment in housing has the potential to increase job skills, employment, and many things other than simply the repair of houses. The AHMRC wished to draw attention to the importance of making use of investments of this kind to achieve several goals at the same time. It calls attention to comments by FAHCSIA in Senate Estimates committees that it is adopting a new approach and not simply contracting out work via tender.

Issue 41 Community Based Sentencing

> 9.111 The benefits of community based sentencing are clear to the Committee. We note with concern the difficulties in implementing and accessing community based sentencing options, and the need for viable alternatives. These will be considered in the Final Report.
>
> Issue for consideration 41 – Justice: community-based sentencing
>
> The Committee will consider the accessibility of community based sentencing options to Aboriginal offenders.

The AHMRC calls attention to the recent BOCSAR review of Circle Sentencing and its cautionary note that in and of itself, unless general disadvantage is attended to, it is unlikely to deal with the problems.

Issue 43 Diversion for Young Offenders

9.150 The Committee is concerned about the over-representation of young Aboriginal people in the criminal justice system. Diversions are important tools for keeping young Aboriginal offenders out of the system. However, evidence has shown that Aboriginal young offenders are less likely to be granted a diversion than non-Aboriginal young offenders. In its Final Report the committee will examine why this is so and consider opportunities to increase the availability and use of diversions for young Aboriginal offenders.

Issue for consideration 43 – Justice: diversions

Evidence suggests that juvenile diversions are less likely to be granted to Aboriginal young offenders than to non-Aboriginal young offenders. The Committee will consider the availability and use of diversions for young Aboriginal offenders in the Final Report.

The AHMRC shares the Committee's concern. The issues here have generally been discussed in relation to the MERIT program and services for youth.

See Issue 40 MERIT and Justice Support

Issue 44 Offenders with Mental Health Problems

9.167 The Committee notes the evidence regarding the incarceration of Aboriginal offenders with a mental health disorder due to a lack of mental health services. We are particularly concerned about the impact of incarceration on the mental health of those offenders.

Issue for consideration 44 – Justice: mental health

Evidence suggests that some Aboriginal offenders with a mental health disorder are being incarcerated due to a lack of adequate mental health services. The Committee is concerned about the wellbeing of these offenders.

The AHMRC shares this concern but would emphasise that it is a lack of appropriate mental health services that is the main problem and would note that Justice Health has undertaken many good collaborative initiatives in this area so that it arguably provides a better service than is available to Aboriginal people outside the Justice system.

The issues encountered when working with the active support of Justice Health to improve services are addressed elsewhere: See Issue 40 MERIT and Justice Support

ISSUES YET TO BE CONSIDERED

Committee comment

10.14 The Committee is committed to addressing each of these issues in the Final Report. The second and final stage of the Inquiry will commence with the tabling of this report and will revolve around the issues summarised in this chapter.

10.15 During the second half of the Inquiry, we will also inquire into and report on the following terms of reference;

1 (a) policies and programs being implemented both within Australia (States/Territories/Federal0 and internationally aimed at closing the gap between the lifetime expectancy between Aboriginal people and non-Aboriginal people (currently estimated at 17 years), with the assessment of policies and programs including but not limited to: New Zealand, Canada, North America, South America, and also considering available reports and information from key NGO and community organisations,

(c) previous Social Issues committee reports containing reference to Aboriginal people – and assess the progress of government in implementing adopted report recommendations,

(d) the Federal Government intervention in the Northern Territory and advise on potential programs/initiatives that may or may not have relevance in terms of their application in New South Wales,

(e) opportunities for strengthening cultural resilience within Aboriginal communities in New South Wales with a focus on language, cultural identity, economic development and self determination

(f) the experiences of the outcomes of the COAG Murdi Paaki trial but also take into account the other COAG trials occurring across Australia and their outcomes/lessons learned.

10.16 The Committee will consult on these issues over the next five months and will present its Final Report to the Legislative Council 30 November 2008. The Committee anticipates that this report will focus on the areas outlined above to present informed, specific recommendations to the Minister for Aboriginal Affairs, through the Parliament.

10.17 The Government's response to the recommendations in the Final Report is expected six months from the date of tabling. It will tell us how the Government intends to implement our recommendations. The Government response is published on the Committee's website www.parliament.nsw.gov.au/socialissues.

The General Issue of Programs from Elsewhere

The AHMRC is not in a position to provide a comprehensive discussion of such programs, but we would urge the Committee to be guided by work that has been assembled by the National Health Equity Summit and by NACCHO. We take it that the Committee's

reference to "reports and information from key NGOs and community organisations" can be taken to include that.

There are many difficulties in generalising the results of programs from one place to another even within Australia, in view of the diversity in the situations in which Aboriginal people live.

We have dealt with that by a general paper on the issues of considering cost effectiveness data, using as an illustration the Nurse-Family Partnership, Inc NFP© program that has already been selected by the Commonwealth as "evidence based" and "cost effective".

See: Appendix : "Cost-effectiveness" is not necessarily portable

The Northern Territory Intervention

We would draw the Committee's attention to the ABC Darwin radio interview with Mr Mal Brough on the anniversary of the Northern Territory intervention. Mr Brough described how it was planned. It seems he wrote down some dot points on a piece of paper one Tuesday morning, and the Prime Minister said "Go for it" that afternoon. After some sleepless days, the "bureaucrats", who according to Mr Brough had a look in their eyes that showed they ""really believed in what they were doing", turned the dot points into a Cabinet submission on Thursday. Thus $587 million was allocated to be spent on 55,000 people in a single year. Why is this example of endemic mismanagement of Aboriginal affairs by the previous administration even being considered as worth studying?

The view of it from the Editorial page of *The Lancet* is a fair summary of the quality of an initiative planned in this manner by "bureaucrats" whose "belief" in what they were doing seems not to have survived a change of government in the more important cases.

Editorial

Aboriginal health: a decade-old election promise

The printed journal includes an image merely for illustration

Last week, the Australian Medical Association (AMA) released *Key Health Issues for the 2007 Federal Election*—a document that highlights areas of the health system which are currently failing some or all of the population. At the top of the AMA's list of 18 issues is Indigenous health. When John Howard's Government came to power over 11 years ago they promised to improve the health and social wellbeing of Aboriginal people. To date there is no evidence that this pledge has been met.

Indigenous Australians have a greater burden of ill health than the rest of the Australian population, experience lower levels of access to health services, are more likely to experience disability and reduced quality of life due to ill health, and die at younger ages.

This dire situation now looks set to worsen. On Aug 17, the Australian Senate passed the Northern Territory National Emergency Response Bill 2007. This Bill, which was rushed through parliament, is Howard's reply to *Little Children Are Sacred: Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse*. The legislation allows the government to take control of 73 Aboriginal communities in the Northern Territory, boost police and army presence, enforce bans on alcohol and pornography, abolish the permit system—which restricts access to Aboriginal land by non-Indigenous people—and limit welfare payments.

But few of the aggressive measures in the Bill address child abuse; most are only likely to exacerbate the problem. The proposed interventions also do not tally with the report recommendations and contradict the approach called for by the authors, who emphasised the "critical importance" of consulting with Aboriginal people when designing initiatives for Aboriginal communities.

Indigenous health is a national emergency that requires investment in health services and the social determinants of health—education, housing, economic development—which underlie the appalling inequalities that Aboriginal people face. The Howard administration's latest approach to Indigenous health will not fulfil its decade-old election promise. John Howard's legitimacy to govern seems fatally compromised based on this critical health failure. ■ *The Lancet*

For the **AMA report** see http://www.ama.com.au/web.nsf/doc/WEEN-76RAVH/$file/060907_-_AMA_Key_Health_Issues_-_Document.pdf

For a **summary of the Northern Territory National Emergency Response Bill 2007** see http://parlinfoweb.aph.gov.au/piweb//Repository/Legis/ems/Linked/07080702.pdf

For the ***Little Children Are Sacred* report** see http://www.nt.gov.au/dcm/inquirysaac/pdf/bipacsa_final_report.pdf

Compulsory Community Wellbeing in Cape York and the NTER

SUMMARY: If we implemented the Cape York model in NSW, it would require $1.5 billion per year, just for services for Aboriginal people, or 50% more than the total Mental Health budget, and half would come from the NSW Government.

The essence of Compulsory Community Treatment in the mental health context is that it rests on a decision that the person meets criteria for involuntary treatment, which has many checks and balances and appeal and review processes, plus a separate decision about the environment in which that treatment can be effectively provided, following the principle that this should be the one that least restricts the person's liberty.

Where the Mental Health Review Tribunal so decides, this can be via an authorised agency in the community, typically a Community Mental Health Centre, rather than hospital. However, if the person does not abide by the conditions of the Order, then they may be required to receive the treatment in hospital. There is no other "sanction", in other words, than an evidence-based decision that treatment could not be effectively provided to this particular person in the community.

In the case of the Cape York model, the only "sanction", at the end of the day, is that a person may be placed under income management, so far as that income is provided by some welfare payment from the Common wealth Government. They must have been notified as having committed one of a number of defined "offences", some of which might have other sanctions attached to them, and if so, that is a separate process. However, after having been notified, a community-based committee of authorised people plays a role similar to that of the Mental Health Review Tribunal in NSW (except that the person cannot have a legal representative) and may draw up a treatment plan. If the person agrees to that, fine. If they don't agree, or if they agree but then fail to do what they have agreed to do, or if they are renotified for some new offence, then the process can lead to them being placed under income management. Clearly, this has no impact on anyone who has enough non-welfare income to ignore the sanction, and no "treatment" implications for anyone who doesn't mind having their welfare income managed. It isn't a very coercive system, and at the end of the day it boils down to setting up conditions on the receipt of welfare income, and nothing else.

What is most relevant here is the fact that the Cape York trial places decision-making in the hands of a community-based committee, and the communities concerned entered into it voluntarily, via elected local government bodies in the case of those that are Aboriginal Shire Councils, and via community committees in the case of those that were sub-areas of a Shire Council. Through aligned legislation in Queensland and the Commonwealth, the decisions have legal force, and the Federal powers are used to implement the community committee's decisions. The Queensland legislation lapses after 3.5 years, so that's why it is called a "trial". It is to be independently evaluated in due course.

In the case of the Northern Territory intervention, it is very different, with all decisions resting with the Federal Minister. Lastly, the Federal legislation allows these income management powers to be made available to States and Territories, for Aboriginal or non-Aboriginal people, under arrangements to be determined.

So, in effect, Australia is exploring a process where the right to receive welfare income remains the same, but the conditions under which it is received may be manipulated in ways that are intended to give people a more or less gentle nudge in the direction of more "responsible" use of the money. There is nothing new about this. It was used as part of the processes to improvise immunisation rates ten years ago. A key concern in planning was how to achieve the high levels of immunisation needed to achieve so-called "herd immunity", where the number of unimmunised cases is so low that even if an infection occurs, it can't easily spread. Apart from a very small number of conscientious objectors to immunisation, the main problem was that, as usual, those who are poor and whose lives are exposed to what Marcia Langton calls "everyday lived crisis" were not getting kids immunised, and eventually the Federal Minister attached the Family Allowance to proof of immunisation or proof of conscientious objection. And of course, it wasn't that people objected, rather that there were many things for them to deal with, and they tended to let it slip. Note that the income wasn't just "managed", however. And note also that immunisation is a small number of brief events that don't really take much time or effort. It does not require a very radical or sustained change in behaviour. And lastly, note that obtaining immunisation is very easy, since the relevant services are available,

Thus, in the Cape York trial, $100 million worth of services are being added, since there would be little point having Community Care Plans if there were no services where the people could actually comply with them. That is, if a person is supposed to get treatment for substance use or a gambling problem or whatever, then it has to be available, else the trial comes down to income management and nothing else, since they would fail to comply with the care plan simply because they couldn't. This funding amounts to $10,000 per person per year, for the 3000 people in the communities. If you apply that to 150,000 Aboriginal people in NSW, that's $1.5 billion a year, and the Cape York trial is a 50:50 partnership between Queensland and the Commonwealth.

Probably, the NSW Government would want fairly strong evidence before it would agree to spend an additional $750 million per annum on Aboriginal people, and the Commonwealth might too. Of course, the Cape York communities are "discrete" communities, and only 6% of people in NSW live in "discrete" communities, but even 6% of $750 million is $45 million pa, which needs some thought. And why should others be denied the extra services?

To look at these issues objectively as they might occur outside a community with charismatic leadership, we need to examine the history, not just of Cape York in

particular, but of the problems the trial is supposed to be addressing. For example, much the same problems were discussed by the anthropologists David McKnight after more than 30 years of working with the community on Mornington Island.

The Canadian anthropologist David McKnight (1935-2006) received his BA in English Literature and Philosophy at Bishop's University in Quebec in 1957. He studied Anthropology at University College London, receiving a BA in 1963 and a master's degree in 1965. His PhD from London University in 1977 was based in the marriage class systems of the peoples of Mornington Island. He was on the faculty of the Department of Anthropology at Edinburgh University from 1968 until 1971 and the Department of Social Anthropology at the London School of Economics from 1971 until his retirement in 1997. [3]

McKnight's research on Mornington Island produced a PhD after 11 years (1977) and a small illustrated non-technical book[4] after 29 years (1995). He retired from the London School of Economics in 1997. In retirement he produced four[5,6,7,8] books of a planned series of six, of which the best known is *From Hunting to Drinking: The Devastating Effects of Alcohol on an Australian Aboriginal Community* (2002).

It has had mixed reviews. On the one hand, his obituaries in 2006 are glowing with praise for his empathy and understanding. One will serve for the whole:

"The anthropologist David McKnight, a leading ethnographer of Australian Aborigines, published four exceptional volumes between 1999 and 2005 that disclosed the drama, intelligence and humanity of their culture. He also detailed, systematically and with immense insight, the pain, violence and inhumanity of processes that have led to the loss of their distinctive ways of life …

In field research that spanned nearly 40 years, McKnight embodied the fundamental truth that you cannot do good anthropology if you do not have empathy for the people themselves. He listened to them, became their close friend, and thus was able to speak of them in very human terms. …

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3 Overing J, Lanoue G, Creider C. David *McKnight: Empathetic ethnographer of the Australian Aborigines.* URL: http://news.independent.co.uk/people/obituaries/article1190562.ece

4 McKnight D. *Lardil:: Keepers of the Dreamtime.* San Francisco: Chronical Books, 1995.

5 McKnight D. *People, Countries, and the Rainbow Serpent: Systems of Classification among the Lardil of Mornington Island (Oxford Studies in Anthropological Linguistics, No 12).* Oxford University press, 1999.

6 McKnight D. *From Hunting to Drinking: The Devastating Effects of Alcohol on an Australian Aboriginal Community* . London and New York, Routledge, 2002.

7 McKnight D. *Of Marriage, Violence And Sorcery: The Quest For Power In Northern Queensland.* Ashgate Publishing, 2005.

8 McKnight D. *From Hunting to Drinking: The Devastating Effects of Alcohol on an Australian Aboriginal Community* . London and New York, Routledge, 2002.

It was McKnight's strength that he waited until the latter part of his life to write his major books, long after he had understood Aborigines in any conventional anthropological sense - when he had become wise enough to understand from his own life experiences how they felt. He was one of our best ethnographers because he knew the details, theirs and his, that allowed him to feel their world. He was a man whose country was the heart. ... Eventually he became a prized elder and close kinsman. In appreciation of his great interest in their lives, they gave him the totemic name "Boora-rung-ee" - "the man who asks why" - and, sadly, in later years, he became recognised as the sole remaining "Keeper" ("speaker") of Demiin, their language of dreamtime ritual.

With his powerful work *From Hunting to Drinking*, he leapt into the midst of post-colonial debate. This book dwells on the disintegration of Aborigines of Mornington Island, where Lardil people dwell, and their descent into heavy alcohol abuse and appalling personal violence.

Alcoholism set in among these peoples from the mid-1970s, when the "Shire", an Australian form of local government, was imposed upon them and stripped them of control over their own lives. State benefits replaced the practices of hunting and gathering. Drinking and gambling became the main social activities, for men and women alike.

McKnight's writing on the situation carries sophisticated messages on the violence of neo-liberal "best-of- intentions" solutions. He is at his very best when juxtaposing the political values of Western political philosophy with those of Aborigines. The depersonalised institutionalised power of Western democracies, along with its types of domination that we take for granted, are anathema to the Aborigine. It is out of despair that they drink, but the despairing gaze of the Aborigine teaches us. We have been taught to "colonise" ourselves, as well as others. The true horror of this story of subjugation and its effect is that it is a global story. It was with deep sorrow, but great determination, that McKnight wrote his book.[9]

It is unclear what "*the despairing gaze of the Aborigine*" is supposed to teach, and likewise what it means to "*colonise*" oneself, but clearly his anthropological colleagues were impressed. There seems to be little doubt that McKnight was culturally appropriate:

"To be trusted by the Elders, community and the students one would need to have gradually formed long-lasting relationships that the Elders expect. Only then can a person learn to hunt and fish in the traditional Gununa style and be adopted into a family. When Bobby Thompson talks about his adopted brother the anthropologist Professor David McKnight he has said, "He became one of us. He used to walk out to the Windward side with just a bag of food to visit families. We taught him how

[9] Overing J, Lanoue G, Creider C. David *McKnight: Empathetic ethnographer of the Australian Aborigines.* URL: http://news.independent.co.uk/people/obituaries/article1190562.ece

to fish, find turtle eggs, how to catch and cook a goanna and how to find fresh water. He gradually learned correct community protocol" (conversation 26th May, 2002).

Big Jake continued: "We want teachers like old McKnight, people who'll come around to visit the families to sit and have a cup of tea with us. We want to get to know those teachers" (Conversation 15th May, 2002)."[10]

On the other hand, the reviews of McKnight's account in *From Hunting to Drinking* were critical of his analysis of the problems he had observed developing over more than 30 years:

"Not only are there serious flaws in McKnight's rather one-eyed approach and strategy, he all too often and readily tosses off remarks and opinions in lieu of analysing situations and contexts. … Given McKnight's long association with the islanders, he might well have reflected on what wrought the changes between the first generation of drinkers, who had 'an ethos of being able to hold [their] liquor' (p. 196), and the current generation, where the exact opposite seems to apply. Lastly, his statements to the effect that 'Mornington Island now consists of a community of individuals who are bereft of a social identity except in negative terms' (p. 6), 'one can say unequivocally that community life has been destroyed' (p. 115), and that the islanders 'no longer have a shared meaningful political discourse and ipso facto a sense of a community' (p. 213) scream out for a careful and detailed consideration of what 'community' (and the rest) is, and is not.

I do not question that McKnight is truly alarmed by, and dearly wishes to see something done about, what he perceives happening on Mornington Island. I do question his approach to many of the rocky issues, and the soundness of the corrective course he charts." [11]

"McKnight presents the abolition of the Shire structure as an important step to Indigenous empowerment and responsibility. He also recommends restrictions to access to alcohol (although his presentation of the 1838 banning of alcohol to Indigenous peoples is both perfunctory and critical). He proposes that funds available for alcohol, specifically unemployment benefits and CDEP payments (or 'sit down' and 'stand up' money), be curtailed, noting the historical correlation between the introduction of such payments and access to alcohol. (He calculates that the population of 900 on Mornington Island spend approximately $4 million each year on beer and only the barest minimum on food.)

[10] Dimon-Tilbrooke H. Bridging the Gununamanda Community and School: A Successful Learning Environment. Elders as the Rightful teachers in an Aboriginal Community: The Elders Regaining their Tribal Authority. Paper presented at the second Australian Indigenous Education Conference, Townsville, Queensland, 2-4 July 2002. URL: http://www.faess.jcu.edu.au/downloads/Dimon .

McKnight recognises the external and internal hindrances to implementing these policies and expresses frustration with the perceived inability or unwillingness of the Mornington Islanders to recognise and address alcohol abuse and with their inability to conclude that they must rid themselves of the Shire and regain control of their lives. His recommendations, however, are site specific responses to a global pattern ... The Shire government is an example of the general failure of governments to acknowledge and accommodate Indigenous culture. McKnight believes removal of the Shire will encourage self-reliance among the Mornington Islanders, but he does not address how this change would challenge the relationship between non-Indigenous and Indigenous peoples or empower Indigenous peoples within this relationship."[12]

The question that arises out of McKnight's work is the value of waiting for more than 30 years to document a "...distinctive way of life ..." that was being progressively damaged, and of being a participant observer from a distance. However, he was not the first anthropologist to feel compelled, at this period, to write about the effects of alcohol on communities they had worked with for many years. The anthropologist Peter Sutton's work is quite well known:

I should declare my biases at the outset. I completed the first draft of this paper in September 2000, just after returning from a particularly harrowing visit to a remote Aboriginal community with which I have had close personal and professional associations since the mid-1970s. ... What took me there this time was a double funeral for people I had known half a lifetime.

The cemetery there now reminds me of the Australian war graves at Villers-Bretonneaux in France ... White crosses, many of them fresh, stretch away seemingly for hundreds of metres. In my time with this community, eight people known to me have died at their own hands ... From the same community in the same period, 13 people known to me have been victims of homicide ... In almost all cases, assailants and victims were also relatives whose families had been linked to one another for generations. ... As far as I know, only one homicide and one suicide occurred in the same community between 1960 and 1985. A wet canteen was opened there, for the first time, in 1985. Most of the homicides and suicides I refer to here took place between 1986 and 2001.

It has been a devastating time, in more ways than just these. ... A significant number of other individuals known to me from the same place have died prematurely in other ways. Many of these premature deaths, and most of the homicides, have been alcohol-related, although alcohol alone cannot carry anything like a full explanation for the dramatic deterioration in the people's quality of life ... Prior to the 1950s, most were resident in the same region but in a relatively decentralised

[11] Sackett, L. Review of David McKnight. from Hunting to Drinking: The Devastating Effects of Alcohol on an Australian Aboriginal Community. *The Australian Journal of Anthropology 2004*; 15, 240.

way. For the majority, their lands have remained accessible and were long ago reserved for their use, albeit increasingly under mission supervision until the 1970s. … Certain classical traditions such as language use and ceremonial life remain comparatively strong, regionally speaking. The impact of constant high levels of conflict and crime on the members of such a small population of kin, now concentrated mainly in one village of suburban layout, is not easy to imagine for those who live in different circumstances.

On my return to the city, I felt unable to give comfort to the view that a non-Indigenous person should leave public statements on these questions to Indigenous people alone, although I am conscious that there are those who maintain this view with passion. The tragic circumstances I refer to are not alone the business of those who suffer them. Australians generally, I argue, carry a duty of care towards all citizens equally, and especially to the vulnerable.[13]

Sutton's stated reason for not having previously commented on these matters over the better part of 30 years is one that McKnight might have shared:

Like many others, for years I refrained from much public engagement with Indigenous policy issues because of the rising Indigenous leadership and its capacity to carry the burden. Now, given the critical situation so many people are in, an `all hands on deck' approach seems necessary.

At about the same time, and before McKnight's book appeared, Noel Pearson was delivering the inaugural Dr Charles Perkins AO Memorial Ovation at Sydney University[14]. He took as his topic: "On the human right to misery, mass incarceration and early death", and dealt with the same issues as Sutton and McKnight.

In my critique of prevalent Aboriginal policies over the past 30 years, I of course do not discredit or disavow the great achievements that have been made in the area of Aboriginal rights and recognition in this period. There have been great many achievements, not the least in the fight against formal discrimination - a fight towards which Charles Perkins made a decisive contribution. So let me not be misunderstood: the struggle for these rights was heroic and correct and their achievements were great advances for Aboriginal people and for the nation.

The question that we have to confront is this: why has a social breakdown accompanied this advancement in the formal rights of our people, not the least the restoration of our homelands to our people? Aboriginal families and communities now often live on their homelands, in very much

[12] Spruyt D. Who's Dysfunctional? *Australian review of Public Affairs – Digest*, 7 June 2004. URL: http://www.australianreview.net/digest/2004/06/spruyt.html

[13] Sutton P. The politics of suffering: Indigenous policy in Australia since the 1970s. *Anthropological Forum 2001*; 11:125-173.

[14] URL: http://www.koori.usyd.edu.au/news/oration.shtml

flasher housing and infrastructure than decades ago - but with a much diminished quality of life, such that commentators familiar with these remote communities increasingly call them 'outback ghettoes'. Indeed this social breakdown afflicts with equal vehemence those Aboriginal peoples who have never been dispossessed of their lands and who retain their classical traditions, cultures and languages.

Let me pose the question in the broader context of the past 30 years and ask why during the period of indigenous policy enlightenment and recognition and despite billions of dollars and much improved housing and infrastructure and government services, there has been a corresponding social deterioration. What is the explanation for this paradoxical result? …

Why are my people disintegrating, and why are we unable to do anything about it?
I will go straight to the core of the matter and talk about addiction and substance abuse. [15]

The Cape York Institute for Policy and Leadership[16] was created in 2004 to develop Pearson's explanations into programs. Following the passage of the *Family Responsibilities Act 2008 (Qld)* in February 2008, the Cape York Welfare Reform Trial commenced operation on 1 July 2008 and will run for three and a half years until 1 January 2012 at a cost of approximately $100 million, or about $10,000 per person per year for the 3,000 people in the four Aboriginal communities involved[17]. The program will have to generate evidence of its cost-effectiveness as it proceeds[18], since no prior trial had been done.

Welfare Reform Trial, Indigenous Communities

Hon. AM BLIGH (South Brisbane—ALP) (Premier) (9.41 am): Today my government will embark on a groundbreaking reform of service provision and welfare payments in remote Aboriginal communities. Four Queensland communities—Aurukun, Coen, Hope Vale and Mossman Gorge—have agreed to be part of a new welfare reform trial. … Should they abuse or neglect their children, fail to send them to school or be found guilty of a crime by a magistrate, from

15 Pearson N. On the human right to misery, mass incarceration and early death. Dr Charles Perkins Memorial Oration, University of Sydney, 25th October 2001. URL: http://www.koori.usyd.edu.au/news/pearson.pdfc

16 URL: http://www.cyi.org.au/

17 "According to the explanatory notes, almost 3,000 residents live in the four welfare reform communities … Funding for this four-year trial is listed at $48 million from the Commonwealth in addition to the one-off funding of $3.5 million to support the establishment of the commission and a further $48 million in funding from this state government in health, education, policing, justice and child safety resources in Cape York communities. … . This expenditure equates to about $30,000 per person." Parliament of Queensland. Record Of Proceedings (Hansard), Tuesday, 11 March 2008, p 661-662.. URL: Hansard Home Page http://www.parliament.qld.gov.au/hansard/

18 "It will be interesting to see at the end of this exercise, for which I understand the state government is contributing some $48 million and the Commonwealth government is contributing some $48 million, the cost-benefit and the real outcomes for those 3,000 people in those communities." Parliament of Queensland. Record Of Proceedings (Hansard), Tuesday, 11 March 2008, p 649. URL: Hansard Home Page http://www.parliament.qld.gov.au/hansard/

1 July they could be subjected to intervention by and a ruling from this new commission. The commissioner and local commissioners, who will be nominated by their community leaders, will then interview the person and consider a range of options. **This may be a warning, it may be a compulsory money management course, it may be alcohol treatment and, as a last resort, some people may have some or all of their welfare payments managed on their behalf for anywhere up to 12 months.**

I want to put on the record my thanks to the community leaders and the Cape York Institute for their leadership on this issue. …

Leadership was also shown by the mayors at the round table of Indigenous mayors held in Cairns on 15 February. The mayors and I have agreed to major changes in the management of alcohol in Indigenous communities. This includes reviewing and tightening alcohol management plans in every community. I expect that some communities will take the tough choice to become dry, which Woorabinda through its council and community justice group has already done. We will support them with an extra $65 million in state funds and an additional $36.4 million being provided by the federal government. Some $100 million in total will deliver new detox and rehabilitation services and provide diversionary and support services. Additional police officers will also be available in these communities if necessary.

Importantly, no Indigenous council will hold a general liquor licence after 31 December this year. We will introduce legislation that will once and for all sever the link between council income and alcohol profits from canteens. Affected councils will be compensated for the loss of their revenue in their general council grants. The mayors agreed to return to their communities from this round table to discuss the practicalities of going dry. Teams of senior government officers will meet with councils and community justice groups in April to discuss individual restrictions.

As with the welfare reform trial, the hard work is just beginning. But by developing a strong partnership across the federal, state and local levels, we can make a real difference to the lives of Queenslanders in remote Indigenous communities. I thank the mayors for their leadership. They are demonstrating that they are capable of taking the lead in an area as complex and difficult as some of these agreement signed last year as the framework for managing these changes. Alcohol abuse is blight on many Indigenous communities. We are going to work with these communities to bring about a significant shift in the way that we manage alcohol supplies and the way that we support and treat people who are binge drinking or affected by alcohol in other ways.[19]

[19] Parliament of Queensland. Record Of Proceedings (Hansard), Tuesday, 26 February 2008. URL: Hansard Home Page http://www.parliament.qld.gov.au/hansard/

The form of compulsory community treatment administered by the Queensland Family Responsibilities Commission is backed (only) by the sanction of welfare income management in the Cape York ("Queensland Commission") provisions within the *Social Security (Administration) Act 1999 (Cth)*[20]. However, other provisions within that Act allow the same sanctions to be invoked more generally[21], as the relevant Queensland Minister explained in March 2008.

Hon. LH NELSON-CARR (Mundingburra—ALP) (Minister for Communities, Minister for Disability Services, Minister for Aboriginal and Torres Strait Islander Partnerships, Minister for Multicultural Affairs, Seniors and Youth)

... The legislative measures that link child welfare payments to school attendance and child welfare generally are set to be applied to the whole of Australia in 2009-10. Accordingly, in the near future any Australian who neglects or abuses their children may find their welfare payments for those children quarantined or managed.[22]

This proposal clearly has bipartisan support in Queensland:

Mr SPRINGBORG (Southern Downs—NPA) (Leader of the Opposition) (2.30 pm):
The former Commonwealth government put the problems of Aboriginal communities on the front page. Thanks to the initiatives of the Howard-Vaile government, the problems facing our remote Aboriginal communities were more publicised and more recognised by the community. The Cape York Welfare Reform Project released its design report entitled *From hand out to hand up* in May 2007. The report was funded by the former Commonwealth government under initiatives of the former Commonwealth government to improve the standard of living, education, health and employment in Aboriginal communities.
...
We should not stop at Indigenous communities. ... **I would dare say that numerically these problems would exist dozens of times more or hundreds of times more in non-Indigenous communities than in Indigenous communities.** ... In my own electorate, as in the electorate of any other honourable member in this place, there are any number of students who have a problem with absenteeism because their parents do not want to deal with their responsibility of being a parent. Frankly, there is any number of students in the non-Indigenous community who are going to school without a full belly. They are going to school without even having had breakfast. They are going to school in year 2 without knowing how to tie their own shoelaces. They are going to school after being subject to an extremely abusive situation at home. They do not have a decent

20 URL: http://www.austlii.edu.au/au/legis/cth/consol_act/ssa1999338/s123uf.html
21 See the outline at URL: http://www.austlii.edu.au/au/legis/cth/consol_act/ssa1999338/s123ta.html

bed to sleep in. They are not properly supervised and they do not have a roof over their head. So why should their parents or guardians be quarantined from this process in the long term?

...

Everyone says, 'This is an horrific social problem. Let's do something about it,' and they want to quarantine it to Indigenous communities. Frankly, if people want to be taken seriously, they need to give a little bit back. **They need to be prepared to say, 'Look, if this proves successful in these Indigenous communities, then it should be going into the non-Indigenous communities.'**

...

At the end of the day, if we are prepared to be judgemental, to help and to say that this is the system we want in Indigenous communities to ensure that their children are going to have all of the opportunities for the future, longer adult life expectancy and all of those sorts of things, we should equally seek to do the same sorts of things in non-Indigenous communities. The only difference with non-Indigenous communities is that the problems are more dispersed and so are not as obvious.[22]

David McKnight's work from 1966 through to the publication of *From Hunting to Drinking* in 2002 and his death in 2006 is as good an example as could be found of an "outsider" (he was a Canadian who spent most of his working life at the London School of Economics and retired to Italy to write his books) becoming "culturally competent" in relation to one particular Aboriginal community. Despite that, or because of it, he focused on the social and cultural wellbeing of the community, and he locates the causes of the problem of drinking in an imposed government structure – the creation of the Shire by the Bjelke-Petersen government in 1976 – and the way this externally imposed form of governance interacted in damaging ways with the culture of the people.

At the same time, Noel Pearson's work in relation to his own communities in North Queensland is that of an "insider", who, however, used models and ideas from both local and global culture to analyse the same problem as it affected those communities. Pearson's analysis and conclusions are very different from McKnight's:

Maybe we should confront the possibility that the policy analysis and recommendations that have informed the past 30 years of deterioration may have been wrong. Our refusal to confront this possibility is a testament to the degree to which we will insist on our ideological indulgences ahead of diminishing social suffering.

[22] Parliament of Queensland. Record Of Proceedings (Hansard), Tuesday, 11 March 2008. URL: Hansard Home Page http://www.parliament.qld.gov.au/hansard/

Let me now set out my own explanation of this strangeness in our national Aboriginal policies. It is an explanation that I have been articulating and thinking about over recent years and they focus on our economic condition - namely, our circumstance of overwhelming dependency on passive welfare. I am in fact greatly indebted to the late Charles Perkins for my ruminations about our economic situation: he understood and articulated the problems for our people caused by our lack of a real economic base, very many years earlier. Passive welfare was a scourge which he urged our people to move beyond - and he was completely forthright with our people in relation to this, He was, patently, correct. I have also been reflecting on the insights of the late Mervyn Gibson from my hometown who first spoke to me about how grog had insinuated itself into our Aboriginal culture, and I have been assisted in my understanding by the analyses of substance abuse epidemics by the late Swedish Professor, Nils Bejerot[23].

Why are my people disintegrating, and why are we unable to do anything about it? I will go straight to the core of the matter and talk about addiction and substance abuse.

Our worst mistake is that we have not understood the nature of substance abuse. I maintain a fundamental objection to the prevailing analysis of substance abuse amongst our people. The prevailing analysis is that substance abuse and addiction is a symptom of underlying social and personal problems. According to the symptom theory we must help people deal with the reasons that have seen them become addicted to various substances. According to this theory we must address the "underlying issues" if we are to abolish substance abuse. The severe substance abuse in Aboriginal communities is said to have been caused by immense ingrained trauma, trans-generational grief, racism, dispossession, unemployment, poverty and so on.

But the symptom theory of substance abuse is wrong. Addiction is a condition in its own right, not a symptom. Substance abuse is a psychosocially contagious epidemic and not a simple indicator or function of the level of social and personal problems in a community. Five factors are needed for an outbreak of substance abuse: (i) the substance being available (ii) spare time (iii) money (iv) the example of others in the immediate environment and (v) a permissive social ideology.[23] If these

[23] Reference not in original, but Pearson has expanded this in an article "agendas of Addiction" in The Australian 1 March 2008: "The analysis by the Swedish psychiatrist Nils Bejerot, which I have used and adapted to understand the recent history of indigenous Cape York, is actually a refutation of simple cause-and-effect thinking of the type "so and so became an addict because", or "this community descended into drunken chaos because". Bejerot attacked the symptom theory of addiction - that addictions are a symptom of other more fundamental personal or socioeconomic problems - and separated five essential factors (which could be described as "the socially sanctioned opportunity to experiment and to later indulge") from all of the other factors that are involved in addiction. Bejerot's point was that all of these other factors should be understood as susceptibility or risk factors. Therefore mental illness may make someone susceptible to drug experimentation and use, but it is not a causal factor. Similarly, poverty may increase susceptibility, but there is no automatic causal relationship with addiction. Many poverty-stricken communities are free of addiction epidemics, as are many people with mental illness. Bejerot's analysis was that the presence of five factors on their own constitutes a risk that an individual will become an addict, or that a community will be affected by an epidemic of addiction: (1) Availability of the addictive substance , (2) Money to acquire the substance , (3) Time to use the substance, (4) Example of use of the substance in the immediate environment , (5) A permissive ideology in relation to the use of the substance." See also: URL: http://en.wikipedia.org/wiki/Nils_Bejerot

five factors are present, substance abuse can spread rapidly among very successful people as well as marginalised people.

Of course substance abuse originally got a foothold in our communities because many people were bruised by history and likely to break social norms. The grog and drug epidemics could break out because personal background and underlying factors made people susceptible to trying addictive substances. But when a young person (or an older non-addict) is recruited to the grog and drug coteries today the decisive factor is the existence of these epidemics themselves, not his or her personal background. And for those who did begin using an addictive substance as an escape from a shattered life and from our history, treating those original causes will do little (if indeed you can do anything about those original causes). The addiction is in itself a much stronger force than any variation in the circumstances of the addict.

...

Put it this way: today people **begin** abusing grog and drugs in our communities because other people do. And if "underlying issues" make somebody start drinking or using drugs, the most important "underlying issue" today is the chaos caused by the grog and drug epidemics. And if trying addictive substances is a symptom of bad or chaotic circumstances, an established addiction is not; changing the circumstances will not cure addiction, and hence not stop abusive behaviour.

This analysis is of course a simplification; our history and our exclusion from mainstream society have not become irrelevant factors. But these generalisations are more valid than the symptom theory.[15]

Clearly, a model of addiction that comes from Sweden might be considered "culturally inappropriate" for Cape York. On the other hand, so is alcohol. The 1987 paper by Gibson and Pearson[24] expresses the relationship as follows:

Anthropologists and other white people who have set themselves up as "experts" on Aboriginal society, such as missionaries and government officials, have contributed to the creation and perpetuation of the myths that now *shackle* Aboriginal society. ...

This paper is concerned with the question of whether the social phenomenon of alcohol among Aborigines is the expression of *true culture and identity*, or whether it is a *distortion* and an *exploitation* of that culture and identity. This paper argues that Aboriginal society is caught in the *stranglehold* of distorted and mythic traditions.

…

The ideas that form The Myth are those that have been internalised from the white interpretation of black people. Anthropologists, through their advice to policy-makers and in their contribution to the public perception of Aborigines, have contributed to the construction of The Myth, which has been used to explain some of the most *ridiculous* things.

It is time to *stop* portraying gambling in Aboriginal society as some kind of traditional re-distribution of wealth. It is time to *stop* interpreting alcoholism as some kind of helpless result of cultural clash. Rather we should be seeing it for what it is. That is: the deliberate distortion of tradition for the sake of fulfilling an individual physical desire for alcohol. It is time to stop portraying the contemporary Hope Vale alcoholic as a passive victim of colonization. Rather we must consider how he has actively created his own problems.

…

If Anthropology is to serve any purpose for Aboriginal people, surely it must be to help recognize these problems. Anthropology has contributed to the construction and the maintenance of the myths under which the Aborigines *labour,* surely now it must engage in their destruction.[24]

This perception of the conflict between "*true culture and identity"* and the culture of alcohol is not limited to Cape York. McKnight and Sutton identify the same problem - alcohol - but they really don't have much in the way of solutions to offer. McKnight blames "the Shire" even though Aboriginal people on the Shire Council are as much (or as little) in charge of the bureaucrats as any Council is, and then blames the cultural practices for decision-making, though he comes close to Pearson in saying that the decision-making is compromised by alcohol.

Sutton's paper is about violence, and in parts he argues that regulated violence was a traditional part of Aboriginal culture. He argues then that (a) loss of the cultural regulation combined with (b) alcohol led to the *Villers-Bretonneux* graveyard he described. This led to an argument as to whether any sort of violence was ever "traditional". McKnight's last completed book before he died was an analysis of how duels and "square-ups" were regulated by *Lardil* people on Mornington Island, including "blockers" whose job was to prevent the duellists hurting one another too much, and he explains that the skill to do this

[24] Gibson M. Anthropology and tradition: a contemporary aboriginal viewpoint. Peoples of the North, ANZAAS, Townsville, 1987. The version at URL: http://www.capeyorkpartnerships.com/team/noelpearson/papers/np-mg-anthropology-tradition-1987.pdf contains the note: "This paper was written by Noel Pearson for Mervyn Gibson who presented it to the ANZAAS Conference in Townsville in 1987. The paper is based on insights and ideas which Mervyn

… cont'd

came from the whole complex process of moving through degrees of initiation and acquiring the skills and status needed to be a peacemaker.

The relevant point is that the most senior Elder on the island, and the Mayor, regarded alcohol and violence as " rubbish whiteman things":

> "I'm a little bit scared that in fifty or sixty years we'll only have urban Aboriginal people left with no knowledge of the Law. They will be drunks. The only way they can be a leader, a Lawman, is to give up the rubbish whiteman things, you know grog, tobacco, drugs and violence."
> (Personal Communication, *Kulthangar,* 22 September 2000).[25]

In relation to the term "urban Aboriginal" it is enough to note that Australia's first transcultural psychiatrist, Dr John Cawte, wrote: "*Stereotypes rush in where social distance provides a vacuum*", and that Professor Marcia Langton has set up two stereotypes to defend the Cape York model and the NT intervention (in the context of the change of Government, when possibly both were at risk):

> It seems almost axiomatic to most Australians that Aborigines should be marginalised: poor, sick, and forever on the verge of extinction. At the heart of this idea is a belief in the inevitability of our incapability –the acceptance of our 'descent into hell'. This is part of the cultural and political wrong - headedness that dominates thinking about the role of Aboriginal property rights and economic behaviour in the transition from settler colonialism to modernity.
>
> In this mindset, the potential of an economically empowered, free - thinking, free - speaking Aborigine has been set to one side because it is more interesting to play with the warm, cuddly cultural Aborigine – the one who is so demoralised that the only available role is as a passive player.

There is obviously the possibility of being economically empowered and free-thinking and free-speaking and warm and cuddly and cultural at the same time, though it is true that it would be hard to combine the first three with being demoralised and passive. In the context, this is clearly Marcia Langton as Chair of the Cape York Institute, and so far as the four Cape York Communities are concerned, the relevant legislation has been passed and $100 million in funding for the services in support of the 3.5 year trial has been promised, as discussed later in this report.

had discussed with Noel. Many of the basic themes in Noel's publication "Our Right to Take Responsibility" can be found in this paper."

Nevertheless, she states the basic challenge that is being debated now:

"Jean Baudrillard generated international controversy when he described in his essay 'War Porn' the way images from Abu Graib prison in Iraq and other 'consensual and televisual' violence were used in the aftermath to September 11, 2001.

...

This made me think about the everyday suffering of Aboriginal children and women, the men who assault and abuse them, and the use of this suffering as a kind of visual and intellectual pornography in Australian media and public debates. The very public debate about child abuse is like Baudrillard's 'war porn'. It has parodied the horrible suffering of Aboriginal people. The crisis in Aboriginal society is now a public spectacle, played out in a vast 'reality show' through the media, parliaments, public service and the Aboriginal world. This obscene and pornographic spectacle shifts attention away from everyday lived crisis that many Aboriginal people endure – or do not, dying as they do at excessive rates.

...

The bodies that have piled up over the last thirty years have become irrelevant, except where they serve the purposes of the 'culture war'. But in the meantime, the bodies of real people continue to pile up, human lives broken on the wheel of suffering. **How much longer will this abuse of Aboriginal people be tolerated?"**[26]

Professor Langton's first alternative implies that most Australians are willing to stand back and let Aboriginal Australia flourish or die, physically, culturally, and in every other way, rather than run the risk of doing something that someone might say was "culturally inappropriate".

Her other alternative is that continuing and extending Mr Brough's NT intervention is the only alternative to a "hands-off" non-policy.

Neither of those alternatives sits very well with the NSW "Two Ways Together" approach to these things.

The "Cape York" model would cost $1.5 billion in NSW. Crudely, one can do the same thing with the notional $587 Million for the NT Intervention over 12 months for about 55,000 people and arrive at a similar figure per person-year of intervention

So the actual issue to consider is:

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[25] Bond H. 'We're the mob you should be listening to' : Aboriginal Elders talk about community-school relationships on Mornington island. PhD Thesis, School of Education, James Cook University. March 2004. URL: http://eprints.jcu.edu.au/971/02/02whole.pdf

- Is the evidence coming out of the Cape York intervention **or;**
- the evidence coming out of the NT intervention;
- likely to be so powerful as to convince
- the Commonwealth Government to offer NSW $750 million per annum **and;**
- the NSW Government to match it with $750 million per annum?

If the answer is "no", then the analysis dissolves into questions that are more complicated, rather than less complicated. For example, leaving aside the NT intervention simply because its funding isn't as well--defined as the Cape York one, there is bound to be some good result of spending all that money on the trial. The question would then be how to roll out the model elsewhere.

As always, the issue is transferring the results to environments so unlike the unique ones in Cape York. Effectiveness is not necessarily portable across cultures and settings. Unless the evaluation were to be done in an extraordinarily complex way, the effectiveness of the individual components of this piece of social engineering would be hard to establish, let alone their dependence on features unique to the Cape York environment, as against those likely to be common to other settings. It is not just "income management", because that is just the sanction to be invoked if the referral to a remedial care package is rejected. The outcomes of the intervention depend on the outcomes of the care packages. The services providing the treatment have to be evaluated too. And of course, the more culturally appropriate they are to Cape York, the less so they will be elsewhere.

However that might be dealt with, rolling out the NSW version of the Cape York model would have to be costed for the NSW situation, and agreed between NSW and the Commonwealth, which is not usually a simple thing.

All things considered, since the Cape York trial ends at the end of 2011, and there is an evaluation to be done, and there is a federal Election in 2010 and a NSW Election in 2011, implementation of such a model seems unlikely to be of much interest.

[26] Langton M. *Trapped in the Aboriginal reality show*. Griffith Review, Edition 19: Re-imagining Australia, 2007.

But, if it isn't, then, in Marcia Langton's either / or formulation, the only other model on offer is a straw one, namely that "most" Australians would be happy to leave things as they are, in which case the answer to her question " How much longer will this abuse of Aboriginal people be tolerated?" would be "indefinitely". That does not seem to be consistent with the evidence presented to, and the views of the Committee.

That leaves us, in NSW, in a position where the activities in the NT and in Queensland are irrelevant except (at best) quarries for bits and pieces of ideas that might be incorporated into a NSW-designed model that suits NSW. Which is not to say that the Commonwealth shouldn't fund half of it, of course, and the notional figure of $10,000 per person year is a useful starting point, since that's what Cape York is getting,

What suits NSW is what Aboriginal people have been saying for a long, long time, namely that holistic health care is needed, and that it has to include social as well as individual care, and simple things like respecting and valuing people.

It may be necessary to explain that there is nothing very mysterious about the concept of "holistic" health care in case the Committee looks for a definition in the 32 page discussion paper on *Aboriginal Holistic Health: A Critical Review* from CRCAH in 2007[27]:

> "In my review, I could not find a single or definitive written source to guide my understanding of, and engagement with, Aboriginal holistic health (referred to as 'the concept') or to enable me to transfer it to the myriad of people in the health system. ... I discuss the findings through twelve engagement points and by drawing on ten themes from the literature."

There is a similar paper from the VicHealth Koori Health Research and Community Development Unit[28]. These seem to suggest that Aboriginal people don't know what they're talking about. Since the Terms of Reference for the Committee's Inquiry are comprehensive and seem to appreciate the social determinants of health, as does the Interim Report, it is clear that the NSW Parliament has engaged with the concept.

Nevertheless, we have drawn a picture of the analysis in the 2005 paper that looks at the terms used in policy documents and related things, and how often various themes occur. This is shown below, turned into a chart.

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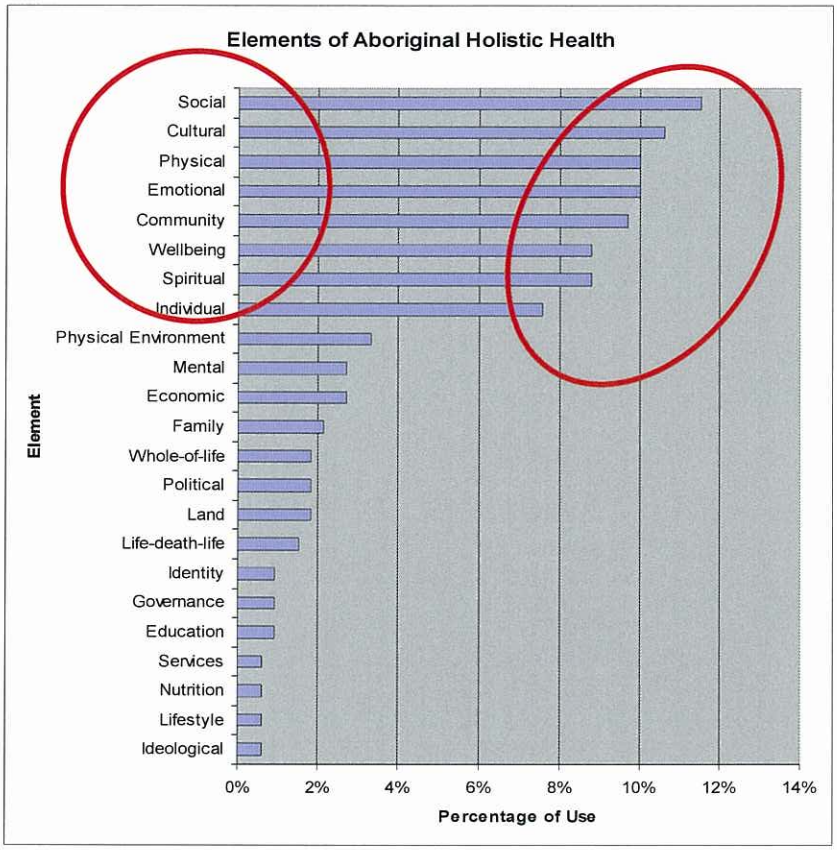
27 Lock M. *Aboriginal Holistic Health: A Critical Review.* Cooperative Research Centre for Aboriginal Health Discussion Paper Series: No. 2. © CRCAH 2007

Clearly, despite what these papers seem to think, there are a number of core concepts systematically involved in "Aboriginal holistic health care" , namely health as:

- Social
- Cultural
- Physical
- Emotional
- Community
- Wellbeing
- Spiritual
- Individual
- And other things, sometimes



There are other ideas associated with it, but by no means as frequently. At the end of the day, it means whatever it takes in a context where there are so many gaps in so many services. In the mainstream, it means a "Whole of All Governments" Action Plan combined with working "Two ways Together" with Aboriginal Community Controlled Organisations to do all the things that need to be done to "Close the Gaps".

And, as of 13th November 2007, it means honouring the 25 years of negotiation that went into the principles in the United Nations Declaration on the Rights of Indigenous Peoples, as stated in the NSW Aboriginal Health Partnership Agreement.

[28] Lutschini M. Engaging with holism in Australian Aboriginal health policy – a Review. *Australia and New Zealand Health Policy 2005*, 2:15 doi:10.1186/1743-8462-2-15

Appendix : NSW Aboriginal Health Partnership Agreement

http://www.ahmrc.org.au/Downloads/Partnership%20Agreement%202008-2013.pdf

NSW ABORIGINAL HEALTH PARTNERSHIP AGREEMENT 2008 - 2013

Aboriginal Health & Medical Research Council of New South Wales

NSW HEALTH

PART I: PREAMBLE

Guiding Principles

- The Aboriginal Health and Medical Research Council of NSW (AH&MRC) and the NSW Government, through its health portfolio, are equal members of the NSW Aboriginal Health Partnership (Partnership) established in 1995.
- The Partnership adheres to the principles espoused in the *National Aboriginal Health Strategy* 1989 and continued in the *National Strategic Framework for Aboriginal and Torres Strait Islander Health – a Framework for Action by Governments*. In particular, the parties commit themselves to the practical application of the principles of Aboriginal peoples' self-determination, a partnership approach and the importance of inter-sectoral collaboration.
- The Partnership is also informed by the *Overarching Agreement on Aboriginal Affairs* between the Commonwealth of Australia and the State of New South Wales; the *NSW State Plan*, the *NSW State Health Plan* and the *NSW Aboriginal Affairs Plan Two Ways Together*.
- The Partnership acknowledges the principles in the UN Declaration on the Rights of Indigenous Peoples and the national targets for closing the gap in life expectancy, child mortality and other aspects of health inequity.
- While acknowledging that the NSW Government will consult and engage with a wide range of community organisation representatives and stakeholders, the aim of the Partnership is to ensure that the expertise and experience of the Aboriginal Community Controlled Health sector is brought to health care processes. This expertise comprises knowledge of Aboriginal culture and health care, and clinical service provision of the AH&MRC's constituent services.
- The NSW Aboriginal Health Partnership will enhance and support Aboriginal Community Controlled Health Services and NSW Health in health service provision to the Aboriginal people of New South Wales.
- The NSW Aboriginal Health Partnership Committee will provide leadership and ongoing advice on general health policy, strategic planning, service issues and equity in allocation of resources wherever appropriate.

Aboriginal Health & Medical Research Council of New South Wales

NSW HEALTH

PART II: STATE LEVEL

The Parties to the Agreement

At the State level, the NSW Aboriginal Health Partnership is between the AH&MRC, representing the Aboriginal Community Controlled Health sector of New South Wales, the Minister for Health, representing the NSW Government, and the Director-General, NSW Department of Health.

Role of the NSW Aboriginal Health Partnership at State level

At State level, the NSW Aboriginal Health Partnership seeks to improve health outcomes for Aboriginal people through:

- Developing agreed positions relating to Aboriginal health policy, strategic planning, services and equity in allocation of resources.
- Ensuring that Aboriginal health retains a high priority in the health system overall; that it is integrated as a core element in all NSW Health policies and their implementation; and that effort is sustained.
- Promoting a partnership approach at all levels within the health system.
- Keeping Aboriginal health stakeholders and community informed about the outcomes of the NSW Aboriginal Health Partnership.

Composition of the NSW Aboriginal Health Partnership Committee

The primary mechanism for giving expression to the NSW Aboriginal Health Partnership at State level is the NSW Aboriginal Health Partnership Committee. Members of the Committee are those participants specifically nominated in this Agreement. Other participants may be co-opted to attend meetings as agreed. Current NSW Aboriginal Health Partnership Committee members are:

NSW Health Department: The Deputy Director-General, Population Health; Director, Centre for Aboriginal Health; and two other members, nominated by the Director-General.

Aboriginal Health & Medical Research Council of NSW: Chairperson; Deputy Chairperson; Chief Executive Officer; and one other member nominated by the AH&MRC Chairperson.

Alternate representatives, appropriately nominated by the respective parties, shall apply in the event of inability to attend.

Aboriginal Health & Medical Research Council of New South Wales

NSW HEALTH

Duration of the Agreement

This Agreement will come into effect from the date of signing by all parties and shall continue in force for a period of five years unless the parties agree to terminate the agreement or execute a further agreement in substitution.

Both parties agree to begin working towards signing a new Agreement at the start of the fifth year.

Status of Attachments

The attachments to this Agreement are to be read as provisions of this Agreement. [Attachment 1]

PART III: AREA LEVEL

The parties to this Partnership Agreement will support the development of Partnership agreements between Aboriginal Community Controlled Health Services and/or their Consortia, recognizing their expertise and experience in Aboriginal health, and Area Health Services to give effect to the Partnership at the Area level, acknowledging that Areas will consult and engage with a wide range of Aboriginal community organisation representatives and stakeholders. .

Aboriginal Health & Medical Research Council of New South Wales

NSW HEALTH

SIGNATORIES TO THIS AGREEMENT

Signed for and on behalf of the NSW Government by the Honourable Reba Meagher MP, Minister for Health:

Signature: Reba Meagher

Date: 30 April, 2008

In the presence of: D Gosencol

Signed for and on behalf of the NSW Department of Health by Professor Debora Picone AM, Director-General:

Signature: Debora Picone

Date: 30 April 2008

In the presence of: D Gosencol

Signed for and on behalf of the Aboriginal Health and Medical Research Council of New South Wales by the Chairperson, Ms Christine Corby:

Signature: C Corby

Date: 30 April 2008

In the presence of: D Gosencol

Signed for and on behalf of the Aboriginal Health and Medical Research Council of New South Wales by the Chief Executive Officer, Ms Sandra Bailey:

Signature: S Bailey

Date: 30 April 2008

In the presence of: D Gosencol

Aboriginal Health & Medical Research Council of New South Wales

NSW HEALTH

ATTACHMENT 1

STATE LEVEL NSW ABORIGINAL HEALTH PARTNERSHIP

Processes

- Meetings will occur at least three times a year.
- Meetings will be co-chaired as determined by the parties.
- The agenda will be set by the Chief Executive Officer of the AH&MRC together with the Director of the Centre for Aboriginal Health.
- Secretarial support for the NSW Aboriginal Health Partnership meetings will be the responsibility of the Centre for Aboriginal Health, NSW Department of Health.
- Standards for minutes of the NSW Aboriginal Health Partnership meeting will be as follows:
    - Agenda will be circulated fourteen (14) days prior to the meeting.
    - Draft minutes of meetings to be distributed to members within fourteen (14) days of the meetings.
    - Comments to be returned within seven (7) days of draft minute distribution.
    - Co-chairs are to meet and resolve any issues prior to final minutes being distributed.
    - Final copy of minutes to be distributed to all members of the NSW Aboriginal Health Partnership Committee within twenty-eight (28) days of the meeting.
- The NSW Aboriginal Health Partnership Committee will maintain a calendar of meetings.

Aboriginal Health & Medical Research Council of New South Wales

NSW HEALTH

http://www.health.nsw.gov.au/news/2008/20080430_00.html

NSW HEALTH

MINISTER FOR HEALTH
Reba Meagher

media release

30 April 2008

Minister signs new Aboriginal Health Partnership Agreement

NSW Minister for Health Reba Meagher today reaffirmed the Iemma Government's commitment to a genuine partnership with the Aboriginal community to tackle health issues when she signed the new Aboriginal Health Partnership Agreement.

Delivering the keynote address to the Aboriginal health research conference *Strong Foundations...Strong Future*, Ms Meagher said the partnership agreement laid the foundation for collaboration between NSW Health and Aboriginal organisations over the next five years.

"The Aboriginal Health Partnership Agreement provides a strong framework for NSW Health, the Aboriginal Health and Medical Research Council of NSW and Aboriginal Controlled Community Health Services to work together to deliver real improvements in health for Aboriginal communities," Ms Meagher said.

"Aboriginal Australians die 17 years earlier than non-Aboriginal Australians and Aboriginal infant mortality is three times that of non-Aboriginal Australians.

"This gap in health status is unacceptable.

"The Iemma Government is working to close the gap, and partnerships with Aboriginal health organisations and communities provide the best opportunity for us to make real progress."

Ms Meagher told the conference that the Aboriginal Health Partnership Agreement is informed by the *Overarching Agreement on Aboriginal Affairs* between the Federal and State governments as well as the NSW State Plan, the NSW State Health Plan and the NSW Aboriginal Affairs Plan *Two Ways Together*.

"But the development of plans and targets is not an end in itself," Ms Meagher said.

"The Iemma Government is investing an additional $30 million over four years toward improving health outcomes for Aboriginal communities so that we can close the gap in health status and life expectancy.

"Each year, the Iemma Government invests more than $60 million in Aboriginal-specific health services."

Ms Meagher also announced a new five-year funding agreement for the Sax Institute, which is hosting the *Strong Foundations...Strong Future* conference.

"The Sax Institute is a non-government, not-for-profit organisation which is widely recognised as a leader in bringing together health researchers and policy makers to work toward better health outcomes for the community," Ms Meagher said.

"One of the key objectives of the Sax Institute is to encourage health research in areas that will have direct practical application within our health system and, therefore, on people's health.

"The Iemma Government's $1.8 million a year investment in the Sax Institute ensures this vital research continues."

For a range of health information, go online to www.health.nsw.gov.au

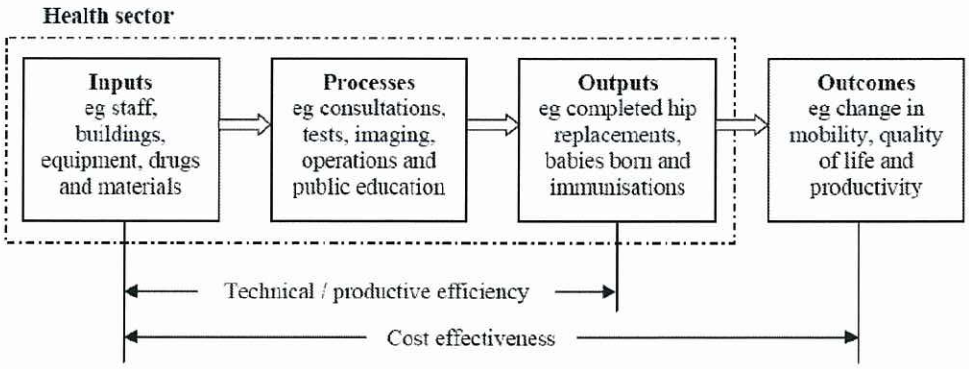
Appendix : Money in the Mainstream, 2004-05

Background

At their meeting on 14th January 2008, Commonwealth and State/ Territory Treasurers and Health Ministers met under the auspices of the Council of Australian Governments (COAG), and decided that evaluating the cost-effectiveness of programs for Aboriginal and Torres Strait Islander people was a major priority. To that end, they decided that: "*all jurisdictions will cooperate in the development of a national framework for reporting expenditure on Indigenous services*"[29].

"The national framework will comprise expenditure by all jurisdictions, at both Commonwealth and State/Territory levels and will seek to include both Indigenous- specific and mainstream spending on services for Indigenous Australians in areas such as: education; justice; health; housing; community services; employment; and other significant expenditure. In so doing, the focus will be in relation to on-the-ground services. … A report in accordance with the national framework will be provided to COAG annually, and an initial 'stock take' report will be provided for the first COAG meeting in 2009."

Figure 1 **Relationship between inputs, outputs and outcomes**



Source: Productivity Commission (2005, p. 370).

Those responsible for managing public money always face more demands than there is money to meet, and the relative "cost effectiveness" of different programs seems like a reasonable basis for deciding between two programs for (say) delivering primary health care. However, even in that relatively simple case, where the choice is between two

[29] Council of Australian Governments. *Communiqué: Ministerial Council Meeting, Brisbane, Monday 14 January 2008*. URL: www.coag.gov.au/meetings/other/health_ministers_communique_140108.pdf accessed 16 June 2008.

different ways of delivering the same service, there is much more to evaluating the cost-effectiveness of programs than just knowing the costs of the inputs (Fig 1)[30].

Money Problems in the Mainstream

It is generally more difficult to assess the outcomes of programs than it is to assess their costs. However, in Aboriginal health, even the costs are poorly documented, and the data are never current.

For example, the most recent (2008) analysis of expenditures on Aboriginal and Torres Strait Islander health by the Australian Institute of Health and Welfare (AIHW) is for the 2004-05 financial year[31], and a significant portion of the expenditure data is based on estimates of unknown quality.

Even in the case of hospital services, expenditure is estimated from casemix costs with a substantial (upward) adjustment for the estimated under-identification of Aboriginal and Torres Strait Islander patients in some jurisdictions.

In the case of non-admitted patient services:

> "Estimates of the Aboriginal and Torres Strait Islander proportion of total non-admitted patient expenditure were derived from data provided by the state and territory authorities in the light of all of the information available to them".

In the case of community health services:

> "Except for some Indigenous-specific programs, most community health services lacked patient-level detail in their records. The estimates presented here were based on information from the jurisdictions and the best indicators of Aboriginal and Torres Strait Islander use. Where there were no such indicators, the Aboriginal and Torres Strait Islander share was based on the proportion of the populations that the programs were intended to serve."

[30] Productivity Commission 2005, Australia's Health Workforce, Research Report, Canberra. (from in Gabbitas O, Jeffs C. Assessing productivity in the delivery of health services in Australia: Some experimental estimates. Paper presented to the Australian Bureau of Statistics-Productivity Commission Productivity Perspectives 2007 Conference. Canberra 17 December 2007.

[31] Australian Institute of Health and Welfare. *Expenditures on health for Aboriginal and Torres Strait Islander peoples 2004–05.* Health and welfare expenditure series no. 32. Cat. no. HWE 40. Canberra: AIHW, 2008.

In the case of Medicare and Pharmaceutical Benefits Scheme data, the estimation process is too complex to summarise briefly, but it depends on a mixture of incomplete activity and survey data, and assumptions about how this may represent the whole.

Is it a level playing field? What are the "outcomes" of Medicare?

Everyone would agree that in an ideal world we would require evidence that programs are cost-effective before we invest in them. However, where programs have already been implemented for the general Australian population without demanding such evidence, we are on doubtful ethical grounds if we require a higher standard of evidence before equitable access to them is provided for Aboriginal people.

In general, the outcomes of the primary health care services funded by the Commonwealth under Medicare, or funded by States and Territories in community health, Emergency Departments, and outpatient clinics are not routinely monitored and evaluated for effectiveness. Many of the treatments provided may have been assessed for efficacy in clinical trials in particular places at particular times with selected volunteers, but few will have been studied for effectiveness in the unselected populations to whom they are applied in routine practice. This does not prevent advocacy for more services being successful. Indeed, even a small number of adverse events that can be attributed to a shortage of such services will generally attract a great deal of media attention and a rapid response from Health Ministers and Treasurers.

Programs like Medicare that deliver services to the general population (and which fail to do so equitably to Aboriginal people) are not going to be withdrawn while we await evidence of their cost effectiveness. No cost effectiveness data are demanded before funding is provided to reduce public waiting lists for elective surgery; or to give psychologists access to Medicare billing. In those cases we either take the value of the services as established, or we regard evidence of socioeconomic variation in access to healthcare services as the basis for an argument on grounds of equity: on the grounds of the “fair go” that we like to believe is an Australian characteristic. Why then is so much more demanded of Aboriginal programs, where the inequities in funding, access and outcomes are so glaringly apparent?

Is it a level playing field? No: Not in primary/ community care

The data problems described in the AIHW expenditure report, particularly the lack of client-level community health data in most States and Territories, will cost time and money to address. But even when we know the costs, we will not know the outcomes, unless a much larger investment is made in routine client-level monitoring, and/or applied health services research to identify

effective programs, and the quality assurance associated with program fidelity monitoring to ensure that programs remain effective when applied in routine practice. Only then, with both costs and outcomes well-determined, will we have "cost-effectiveness" evidence that is useful.

Selective Demands for Cost-Effectiveness can be "Institutional Racism"

Against that background, an apparently rational and objective demand for data that do not exist, and which are unlikely to become available any time soon, becomes an unconscious form of institutionalised racism[32] : "…cultural and individual factors coming together in institutional environments which work for the benefit of the ethnic majority rather than the minority"[33].

Is there a "good enough" method for knowing costs of Aboriginal health programs?

This paper is an attempt to derive a "good enough" method for monitoring investments in Aboriginal health, starting with the funding that is designated specifically for that purpose, since the main data problems identified by the AIHW are those arising in 'mainstream' health service data collections, because they do not capture and report client-level healthcare transactions at all (as with the majority of non-hospital care funded by States and Territories), or because they capture the transactions but not the relevant demographic data or illness data (as with most MBS/ PBS transactions). Thus, for either or both reasons they cannot actually prove that Aboriginal people are receiving services by producing the records that show (a) that the person identified as Aboriginal, and (b) received such-and-such episodes of care, at such-and-such a consumption of clinical resources, and such-and-such a cost.

Would the Australian Tax Office accept estimates of "under-identified" deductions?

Instead, the gaps are filled, even in hospital care, by inflating the observed data by an estimate of the degree of "under-identification" observed in hospital surveys; and in non-hospital care the gaps in data are filled by accepting estimates made by unspecified means. To put it bluntly, the Australian Taxation Office would have problems with a private business that claimed to be incurring $2.3 billion in deductible expenditure based on evidence of this kind. The figure of $2.3 billion is used here because it is the AIHW estimate of health expenditure on Aboriginal and Torres Strait islander people in 2004-05. This is a per capita level about 17% higher than that for other Australians, in a context of illness levels several times higher, and a 17-year gap in life

[32] Henry BR, Houston S, Mooney GH. Institutional racism in Australian healthcare: a plea for decency. *Medical Journal of Australia 2004*; 180:517-520.

expectancy. However, it is also a great deal higher than it would be if only the provable costs were counted.

Who is responsible, and in what proportions?

When there appears to be a comparable (per capita) expenditure of money, combined with glaring gap in health outcomes, it is only reasonable for Australian Treasurers to wonder if programs are "cost effective". However, it is also reasonable to focus attention on services in proportion to the amount of money they consume. These proportions can be estimated from the AIHW health expenditure report for 2004-05.

The 2004-05 AIHW Aboriginal Health Expenditure in a Nutshell

Table 2.8: Funding per person for health services to Indigenous and non-Indigenous people, 2004-05

	ABORIGINAL %	ABORIGINAL $/ person	OTHER %	OTHER $/ person
State and Territory governments	48%	$2,243	21%	$823
Plus funds from Commonwealth	18%	$857	11%	$427
Direct spending	66%	$3,100	31%	$1,250
Commonwealth Government	45%	$2,113	48%	$1,940
Less funds to States/ Territories	18%	$857	11%	$427
Less funds to Non-government	1%	$24	5%	$180
Direct spending	26%	$1,232	33%	$1,333
Non-government	8%	$362	31%	$1,256
Plus funds from Commonwealth	1%	$24	5%	$180
Direct spending	8%	$386	36%	$1,436
TOTAL FUNDING	100%	$4,719	100%	$4,019
TOTAL SPENDING	100%	$4,719	100%	$4,019

SOURCE: AIHW, 2004-05 data

Table 2.11: Expenditures by state and territory governments[a], total and per person, 2004-05

	ABORIGINAL %	ABORIGINAL $/ person	OTHER %	OTHER $/ person
State/ Territory Direct spending	66%	$3,100	31%	$1,250
Direct spending (as reported in dissection below)	65%	$3,092	35%	$1,458
Public hospital services	45%	$2,121	25%	$1,046
Admitted patient services	34%	$1,611	20%	$802
Non-admitted patient services	11%	$510	6%	$244
Community health	11%	$510	6%	$244
Public health	3%	$139	1%	$46
Other (Patient Transport, Dental, Research, Admin n.e.c.)	7%	$312	3%	$122
Commonwealth Direct spending	26%	$1,232	33%	$1,333
Direct spending (as reported in dissection below)	25%	$1,199	32%	$1,288
Hospitals	1%	$26	1%	$22
High-level residential care	1%	$63	5%	$221
Medical services	6%	$286	14%	$567
Through Medicare	5%	$221	12%	$483
Other	1%	$65	2%	$84
Medications	3%	$148	8%	$302
Benefits paid pharmaceuticals[b]	3%	$144	7%	$297
Other	0%	$4	0%	$5
Community health	9%	$443	0%	$7
Through ACCHOs	9%	$426	0%	$1
Other	0%	$17	0%	$5
Public health	1%	$43	1%	$23
Other (Patient Transport, Dental, Aids & Appliances, Research, Admin n.e.c.)	4%	$192	4%	$147
Non-Government Direct spending	8%	$386	36%	$1,436

This figure can be read if you have an electronic copy and blow it up to 200% or more, but for others it is a reference point for the left (finding) and right (expenditure) sections presented below:

33 Race, RW. Analysing ethnic education policy-making in England and Wales. URL: http://www.shef.ac.uk/socstudies/Shop/race_article.pdf .

The 2004-05 AIHW Aboriginal Health Funding Analysis (48% State, 45% Commonwealth)

	ABORIGINAL		OTHER	
	%	$/ person	%	$/ person
State and Territory governments	48%	*$2,243*	21%	*$823*
Plus funds from Commonwealth	18%	*$857*	11%	*$427*
Direct spending	66%	*$3,100*	31%	*$1,250*
Commonwealth Government	45%	*$2,113*	48%	*$1,940*
Less funds to States/ Territories	18%	*$857*	11%	*$427*
Less funds to Non-government	1%	*$24*	5%	*$180*
Direct spending	26%	*$1,232*	33%	*$1,333*
Non-government	8%	*$362*	31%	*$1,256*
Plus funds from Commonwealth	1%	*$24*	5%	*$180*
Direct spending	8%	*$386*	36%	*$1,436*
TOTAL FUNDING	100%	*$4,718*	100%	*$4,019*
TOTAL SPENDING	100%	*$4,718*	100%	*$4,019*

SOURCE: AIHW, 2004-05 data

Reading from the top and ignoring the OTHER data, which you can compare yourself, this shows::

- States fund 48% of the Aboriginal Health dollar ($2,243 per person)
- Under the AHCA, they get another 18% ($857) from the Commonwealth
- They spend 66% of the Aboriginal health dollar ($3,100 per person)

- Commonwealth Funds 45%, but only directly spends 26%
- Private Insurance and out of pocket is only 8% vs 36% (No money for insurance. Note that the Commonwealth rebate adds 1% versus 5% .)

The rest should be clear now.

State/ Territory Expenditure Dissection (66% of the Aboriginal health dollar)

Table 2.11: Expenditures by state and territory governments[a], total and per person, 2004–05

	ABORIGINAL		OTHER	
	%	$/ person	%	$/ person
State/ Territory Direct spending	66%	*$3,100*	31%	*$1,250*
Direct spending (as reported in dissection below)	65%	*$3,082*	35%	*$1,458*
Public hospital services	45%	*$2,121*	25%	*$1,046*
Admitted patient services	34%	*$1,611*	20%	*$802*
Non-admitted patient services	11%	*$510*	6%	*$244*
Community health	11%	*$510*	6%	*$244*
Public health	3%	*$139*	1%	*$46*
Other (Patient Transport, Dental, Research, Admin n.e.c.)	7%	*$312*	3%	*$122*

This shows the Funding coming into the State (both State AND Commonwealth funds) to be spent. Because the AIHW Tables showing the dissection of the expenditure don't quite agree, I've put in a separate line. As you see, there's not too much difference between the funds ($3,100 per person) versus the spending (which adds up to $3,082 per person). It doesn't mean someone's pocketing the difference (or I hope not, anyway) and probably there's something in the pages and pages of the AIHW report that would explain it.

- Note that these percentages refer to the Total Aboriginal health expenditure, not just the percentages of the Total State expenditure.
- 34% goes on hospital patients in hospital beds (inpatients)
- 11% goes to hospital patients NOT in beds (outpatient clinics, Emergency Depts)
- 11% goes to community health
- 3% goes to "public health"
- 7% goes on other stuff

Commonwealth Expenditure Dissection (26% of the Aboriginal health dollar)

	ABORIGINAL		OTHER	
	%	$/ person	%	$/ person
Commonwealth Direct spending	**26%**	*$1,232*	**33%**	*$1,333*
Direct spending (as reported in dissection below)	**25%**	*$1,199*	**32%**	*$1,288*
Hospitals	**1%**	*$26*	**1%**	*$22*
High-level residential care	**1%**	*$61*	**5%**	*$221*
Medical services	**6%**	*$286*	**14%**	*$567*
Through Medicare	5%	*$221*	12%	*$483*
Other	1%	*$65*	2%	*$84*
Medications	**3%**	*$148*	**8%**	*$302*
Benefits paid pharmaceuticals[(a)]	3%	*$144*	7%	*$297*
Other	0%	*$4*	0%	*$5*
Community health	**9%**	*$443*	**0%**	*$7*
Through ACCHOs	9%	*$426*	0%	*$1*
Other	0%	*$17*	0%	*$5*
Public health	**1%**	*$43*	**1%**	*$23*
Other (Patient Transport, Dental, Aids & Appliances, Research, Admin n.e.c.)	**4%**	*$192*	**4%**	*$147*
Non-Government Direct spending	**8%**	*$386*	**36%**	*$1,436*

This shows the Funding spent directly by the Commonwealth. Because the AIHW Tables showing the dissection of the expenditure don't quite agree, I've put in a separate line. As you see, there's not too much difference between the funds ($1, 232 per person) versus the spending (which adds up to $1,199 per person). I've put the private down the bottom, since (see funding) a lot of it is the private health insurance rebate..

- Note that these percentages refer to the Total Aboriginal health spend
- 1% goes on hospital patients in hospital beds (inpatients)
- 1% goes to high level residential care (closing the gap would INCREASE this to 5%)
- 6% goes to Medical services (Mainly Medicare)
- 3% goes to Medications (PBS)
- 9% goes to what they call ACCHO's ($443 per person mainly OATSIH money)
- 1% goes to "public health"
- 4% goes on other stuff

Private Expenditure (8% of the Aboriginal health dollar)

Non-Government Direct spending	**8%**	*$386*	**36%**	*$1,436*

- 8% basically private Insurance, with 1% from the rebate. Note the difference.

State–by–State Government Expenditure

Table 2.11: Expenditures by state and territory governments[(a)], total and per person, 2004–05

	ABORIGINAL		OTHER	
	%	$/ person	%	$/ person
State/ Territory Direct spending	**66%**	*$3,100*	**31%**	*$1,250*
Direct spending (as reported in dissection below)	**67%**	***$3,148***	**34%**	***$1,361***
NSW	*16.2%*	***$2,618***	*12.1%*	***$1,456***
VIC	*3.5%*	***$2,701***	*8.3%*	***$1,327***
QLD	*15.0%*	***$2,546***	*5.3%*	***$1,108***
WA	*11.7%*	***$3,844***	*3.3%*	***$1,369***
SA	*4.8%*	***$4,011***	*3.0%*	***$1,567***
TAS	*0.7%*	***$891***	*0.8%*	***$1,285***
ACT	*0.6%*	***$3,209***	*0.8%*	***$1,897***
NT	*14.2%*	***$5,461***	*0.3%*	***$1,629***

NSW spends $530 per person less than the Australian Average on Aboriginal people

NSW spends $85 per person more than the Australian average on other people

Discussion of the 2004-05 AIHW Aboriginal Health Expenditure

If questions are to be asked about the cost effectiveness of Aboriginal health programs by State/Territory Treasurers and Health Ministers, 67% of those questions could be discussed with one another about the services they manage.

The Commonwealth Treasurer and Health Minister might spend roughly the same amount of attention on the cost effectiveness of the 18% of total per capita funding they provide to their State/ Territory Colleagues, and to the cost-effectiveness of the Commonwealth's own MBS/PBS and AHO funding programs (18% combined, 9% each).

There are some obvious questions about differences from the Australian average of $3,148 per person in:

- NT ($5,461), SA ($4,011) and WA ($3,844)

versus

- VIC ($2,701), NSW ($2,618), QLD ($2,546)

It is strange in

- Tasmania, where the Department of Human Services advised that no adjustment for under-identification should be used for admitted hospital patients, and came in as extremely low, at $891 per capita. This raises queries about "adjustments".
- ACT, which was excused from the per capita reporting because "the expenditure numbers for the ACT include substantial expenditures for NSW residents", but I worked it out anyway and it is average ($3,209)

For non-Aboriginal people, the per capita expenditure ranged from 20% above (NT) and 19% below (QLD) the Australian per capita average.

For Aboriginal people the per capita expenditure varies much more widely, from +73% (NT) to -72% (Tasmania).

It is unprofitable to speculate why, because so much of the data is estimated and adjusted. However, , so far as we know, there is no obvious difference in health which would explain such wide variation in expenditure per capita. Thus, even if we can't assess the cost-effectiveness of this 67% of Aboriginal health expenditure, we can say that money doesn't seem to be spent in a way that matches illness, either between Aboriginal: non-Aboriginal people, or across States. This is generally referred to as allocative inefficiency: not allocating money in proportion to need.

Appendix : Open Government and Commonwealth Aboriginal Health Funding: An Analysis of 'Murray Motion' Reports for 2007

Summary

The Commonwealth Government reports under the 'Murray Motion' (*Senate Procedural Order of Continuing Effect No. 9 – Departmental and Agency Contracts*) provide current public data every 6 months on active grants valued at over $100,000. This study explored their value in monitoring expenditure specifically targeted at Aboriginal health and wellbeing. Their value varies across agencies, but those from the departments and agencies most directly relevant to health and family services are good. Though limited in detail, the reports were adequate for identifying the State/Territory receiving the funds, the broad health service sector of the recipient, and an estimate of funds attributable to the reporting year. They were less useful for coding the purpose of the funding, since many were multi-purpose grants.

The total estimated in this way from the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in the 2007 calendar year report was $207.3 million. This increased to $236.7 million when identifiable Aboriginal-specific grants from other agencies in the Department of Health and Ageing were added.

In 2007, 96% of the $401 per capita in funding from OATSIH could be assigned to a State/Territory, the rest being best regarded as national. The per capita rate was much higher in the NT ($643), Victoria ($595), SA ($515), the ACT ($511), and WA ($484) than in Queensland ($335), NSW ($223) or Tasmania ($206).

53% of overall OATSIH funding was supplied to Aboriginal Community Controlled Health Services (ACCHS's) affiliated with the National Aboriginal Community Controlled Health Organisation (NACCHO). This was higher for NACCHO affiliates in the ACT (92%), Victoria (82%), South Australia (75%), Tasmania (75%), NSW (73%) and Western Australia (65%), than in the Northern Territory (34%) and Queensland (33%) or in Australia-wide funding (17%). Apart from ACCHS's, the main recipients were other Aboriginal NGO's (21%, mainly in the NT and Queensland) and State/Territory Governments and agencies (12%).

Despite the limitations imposed by the data, the 'Murray Motion' reports provide a useful current surveillance mechanism for monitoring Commonwealth Government funding that is specifically targeted at Aboriginal health. This is only about 9% of the most recent (2004-05) overall estimates of Aboriginal health funding by the Australian Institute of Health and Welfare, but it is

based on public information and data, rather than estimates of unknown quality that are used to fill gaps in service documentation by States, Territories, and the Commonwealth.

Method

The methods used to assemble the data are described in sufficient detail for the process to be emulated by others.

Source of data:

'Murray Motion' reports for calendar year 2007 were downloaded from the following agencies:

- Department of Health and Ageing[34] (DOHA): There were two PDF files (Part 1 of 143 pages and Part 2 of 126 pages), here referred to as DOHA1 and DOHA2 respectively, covering 4,212 contracts and grants.
- National Health & Medical Research Council[35] and Cancer Australia[36]. These DoHA agencies had separate listings. The NHMRC helpfully provided a spreadsheet with 1545 entries (labelled NMHRC). Cancer Australia has a 1-page PDF with no relevant entries (see definition below)
- Department of Housing, Families, Community services and Indigenous Affairs[37] (FAHCSIA). There were two PDF files, one for funding agreements (199 pages, labelled FAHCSIA-FUN here), and one for commercial contracts (28 pages, labelled FAHCSIA-COM here).
- Department of Education, Employment and Workplace Relations[38] (DEEWR). There were three PDF files, one for the former Department of Education Science and Training (38 pages, labelled DEST here), one for the former Department of Employment and Workplace relations (labelled DEWR here), and one for the period of DEEWR's existence in 2007 (unlabelled since it contained no relevant entries).
- Australian Research Council[39] (ARC): The ARC provided a 17-page PDF listing, but the stated purpose of funding was limited to either "Linkage projects" or "Discovery projects" for the most part, and seemed to cover consolidated grants to the grant administering body, typically a university. Thus it contained no useful detail on the content of the research. This will no doubt be addressed by the planned ARC grants database.

[34] URL: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-contracts-index.htm
[35] URL: http://www.nhmrc.gov.au/about/contracts/murray_motion.htm
[36] URL: http://www.canceraustralia.gov.au/about-us/funding/contract-declaration.aspx
[37] URL: http://www.facsia.gov.au/internet/facsinternet.nsf/aboutfacs/contract_listing.htm
[38] URL: http://www.deewr.gov.au/deewr/Publications/GovernmentAgencyContracts.htm
[39] URL: http://www.arc.gov.au/about_arc/tenders.htm

Identification of funding related to Aboriginal health:

Although each file listing contained the mandatory information, the level of detail differed and search strategies had to be somewhat different for each file.

DOHA files: Grants were listed for each Division/ Agency/ Office; so that those from OATSIH were clearly identifiable. All of these were taken as relevant to Aboriginal health. To identify the "other health" grants that might be specifically relevant to Aboriginal health, the DoHA files were searched successively for key words commencing "Abori-", "Indig-", and "Torres". The Acronyms used for the divisions of DoHA were not explained on the file, but the following interpretation is based on the DoHA organisational chart and is probably correct: AACD = Ageing & Aged Care Division, ACD = Acute Care Division, ACSQHC = Australian Commission on Safety and Quality in Health Care, BG = Business Group, MBD = Medical Benefits Division, MHWD = Mental Health & Workforce Division, and NICNAS = National Industrial Chemicals Notification and Assessment Scheme in DOHA1; and OATSIH = Office of Aboriginal and Torres Strait Islander Health, OGTR = Office of the Gene Technology Regulator, OHP = Office of Health Protection, PACD = Primary and Ambulatory Care Division, PBD = Pharmaceutical Benefits Division, PHD = Population Health Division, PSD = Portfolio Strategies Division, RPGD = Regulatory Policy & Governance Division, and TGA = Therapeutic Goods Administration in DOHA2.

NHMRC file: the file was searched for words commencing "Abori" and "Indig" and "Torres". The NHMRC also produces a file from its research database[40] that identifies many more Aboriginal health research projects than were found by the previous method. However, the file included little of 2007, and accepted a relevant label in any of five keywords, so that it included 100% of the value of research studies whose relevance to Aboriginal health was non-specific. This grossly inflates the reported NHMRC investment in "Aboriginal health" research. For consistency, only the Murray Motion list was used, and searched as for the DoHA list.

FAHCSIA Files: Since FAHCSIA inherited the majority of ATSIC's former functions, the issue in these files was to identify "health" rather than "Aboriginal" entries. The main source of entries were the specific Family Violence programs, Fixing Houses for Better Health program, and Indigenous Children's programs. Otherwise, the words "health" and "medical" were searched, and a few other entries were found during the process of cutting and pasting entries.

DEEWR/DEWR/DEST files. The DEST file was searched for all the previous keywords, but in general it was impossible to identify Aboriginal programs as being specific to health and wellbeing,

[40] URL: http://www.nhmrc.gov.au/funding/dataset/issues/aboriginal.php

or to identify health and wellbeing programs as specific to Aboriginal people. In the case of DEWR files, there were many employment programs for Aboriginal people, but only those with health-related employers or that involved health-related training were included.

Distribution of identifiable Funding across Sources, 2007

Valin07 DAO	Source DEST	DEWR	DOHA1	DOHA2	FAHCSIA-COM	FAHCSIA-FUN	NHMRC	Grand Total
							$ 8,446,428	$ 8,446,428
AACD			$ 195,194					$ 195,194
AACD			$ 8,290,742					$ 8,290,742
ACD			$ 119,122					$ 119,122
ACSQHC			$ 91,978					$ 91,978
FHBH					$ 2,609,237	$ 4,058,169		$ 6,667,406
FVP						$ 13,634,217		$ 13,634,217
ICP						$ 3,512,838		$ 3,512,838
ISDG	$ 655,918							$ 655,918
LSIC					$ 46,639			$ 46,639
MBD			$ 747,398					$ 747,398
MHWD			$ 3,519,125					$ 3,519,125
NAHS					$ 784,598			$ 784,598
OATSIH				$ 207,289,252				$ 207,289,252
OHP				$ 934,520				$ 934,520
PACD				$ 5,190,770				$ 5,190,770
PHD				$ 51,808				$ 51,808
PHD				$ 10,224,904				$ 10,224,904
STEP/CLIEP		$ 1,585,615						$ 1,585,615
UCP						$ 115,324		$ 115,324
(blank)					$ 63,331	$ 2,231,014		$ 2,294,345
Grand Total	$ 655,918	$ 1,585,615	$ 12,963,558	$ 223,691,255	$ 3,503,804	$ 23,551,563	$ 8,446,428	$ 274,398,141

Identification of Type of Organisation receiving funding:

This was a time-consuming process that entailed looking up each organisation's name in a series of sources.

(1) Those appearing in a previously assembled list of Aboriginal Community Controlled Health Services (ACCHS) and health related services affiliated with the National Aboriginal Community Controlled Health Organisation (NACCHO) via state/territory affiliates were coded ACCH.

(2) State and Federal Government Departments and agencies were coded GOV.

(3) Local Government entities were coded LGA, except

(4) the Aboriginal Local Government entities in the NT and Queensland, which were coded ALGA.

(5) Universities and Colleges were coded EDU.

(6) 'mainstream' non-government organisations other than those above were coded NGO, and this included professional associations and organisations, except for

(7) Divisions of General practice, which were coded DGP.

(8) Most other organisations were coded as Aboriginal non-government organisations (ANGO).

This was automatic if they appeared in the Public Register of Aboriginal and Torres Strait Islander Corporations[41]. In other cases, the name was searched in the Australian Business Name

[41] URL: http://www.orac.gov.au

lookup[42], and where relevant in the Australian Securities & Investments Commission lookup[43]. Generally the type of organisation and taxation status in the ABN entry was sufficient to distinguish charitable NGO's from commercial ones.

Those which were also funded by OATSIH as Aboriginal health Organisations; and /or which has "Aboriginal" or similar in their title; and/or were associated with a known Aboriginal organisation already identified, were classed as ANGO.

In other cases it was necessary to conduct a Google search to identify documents that could help resolve the issue. In general, the aim was to be inclusive for the ANGO group, and require clear evidence for classification as COM or NGO.

Identification of jurisdiction receiving funding:

This was generally resolved by the processes used to identify organisation type, since the databases consulted contained the State/Territory. There were one or two cases (in central Australia) where an organisation in one jurisdiction was funded to supply services also to others, in which case the funded organisation's location was taken. In more general cases the coding was AUS, meaning Australia-wide or not state-specific. In the case of NMHRC-funded projects, however, even if they were of general application in principle, the location of the funded institution was used.

Expenditure and dates:

The calendar year 'Murray Motion' reports include in scope all grants that were "active" in the calendar year, even if they extend over multiple years, even of they extend only for a short time into the year in question. There is no indication of how much of a particular grant might be expended in a particular year. This was addressed by using the reported start date and end date of the grant to establish its overall duration, and taking one year's worth of the total funding as the 2007 amount (or the proportion of a year if the dates fell within the period). In addition, a coded table was set up that identified the calendar years and financial years in which each grant was "active", because in fact many grants are on a 12-month calendar year basis and may be renewed, so that there seemed to be some risk of double-counting. In fact it made little difference whether analyses were run on the data for the 2007 calendar year or the 2007-08 financial year, and though both are show discussion centres on the 2007 data..

[42] URL: http://abr.business.gov.au

Example: ACT entries

2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007	2007-2008	2008-2009	2009-2010	2010-2011	Source	Page	DAO	STATE	DOM	To	Value	For
-	-	-	-	-	-	-	1	1	-	-	-	DOHA2	029	OATSIH	ACT	ACCH	Winnunga Nimmityjah Aborigina	$3,724,035	To provide comprehensive primar
-	-	-	-	-	-	-	1	1	-	-	-	DOHA2	031	OATSIH	ACT	COM	Careers Unlimited Pty Ltd	$119,535	To provide Secretariat and suppo
-	-	-	-	-	-	-	1	1	1	-	-	DOHA2	117	PHD	ACT	ANGO	Aboriginal Corporation for Sport	$279,400	Sport and Recreation programs t
-	-	-	-	-	-	1	1	1	1	-	-	DOHA2	107	PHD	ACT	NGO	Australian Injecting and Illicit Dr	$345,142	To provide young Indigenous dru
-	-	-	-	-	-	-	1	1	1	1	-	DOHA1	132	MHWD	ACT	EDU	Australian National University	$311,622	Aboriginal and Torres Strait Islan
-	-	-	-	-	-	-	1	1	1	-	-	FAHCSI	103	ICP	ACT	NGO	Marymead Child and Family Ce	$142,035	Indigenous Children Programme

Populations:

For per capita calculations the preliminary estimates of the 2006 census populations of Aboriginal and Torres Strait islander people in each jurisdiction have been used.[44]

Results

In fact it made little difference whether the 2007 calendar year reports were used to estimate funds available in the 2007 calendar year or the 2007-08 financial year.

- $207 million - OATSIH Funding in the 2007 reports, for 2007
- $200 million - OATSIH Funding in the 2007 reports, for 2007-08
- $274 million - All Identifiable Commonwealth Funding in the 2007 reports, for 2007
- $263 million - All Identifiable Commonwealth Funding in the 2007 reports, for 2007-08

Outcome 8 – Financial Resources Summary

	(A) Budget Estimate 2006-07 $'000	(B) Actual 2006-07 $'000	Variation (Column B minus Column A) $'000	Budget Estimate 2007-08 $'000
Administered Expenses				
Program 8.1: Aboriginal and Torres Strait Islander Health				
Appropriation Bill 1/3/5	383,689	371,498	(12,191)	447,232
Total Administered Expenses	**383,689**	**371,498**	**(12,191)**	**447,232**
Departmental Appropriations				
Output Group 1 - Policy Advice	18,891	20,092	1,201	20,648
Output Group 2 - Program Management	33,292	35,410	2,118	36,390
Total price of departmental outputs *(Total revenue from Government & other sources)*	52,183	55,502	3,319	57,038
Total revenue from Government (appropriations) contributing to price of departmental outputs	50,651	54,254	3,603	55,566
Total revenue from other sources	1,532	1,248	(284)	1,472
Total price of departmental outputs *(Total revenue from Government & other sources)*	**52,183**	**55,502**	**3,319**	**57,038**
Total estimated resourcing for Outcome 8 *(Total price of outputs & administered expenses)*	**435,872**	**427,000**	**(8,872)**	**504,270**
Average Staffing Level (Number)				
Department	**417**	**415**	**(2)**	**439**

By way of comparison, DOHA reported "Administered Expenses" of $371 Million for 2006-07; as against the identified Grant funds from All DOHA files ($237 million or 64%). The identified Grant funding from OATSIH was $207 million (56% of Administered Expenses).

[43] URL: http://www.asic.gov.au/asic/asic.nsf

Results in a Nutshell: OATSIH only, 2007

2007	1
Source	(All)
DAO	OATSIH
Years	(All)
To	(All)
For	(All)

Valin07	DOM									
STATE	ACCH	DGP	EDU	LGA	NGO	ANGO	GOV	COM	ALGA	Grand Total
ACT	$ 1,877,322							$ 166,122		$ 2,043,444
NSW	$ 24,040,395	$ 1,408,444	$ 248,228		$ 290,251	$ 4,585,935	$ 2,443,467	$ 105,453		$ 33,122,173
NT	$ 14,447,279	$ 201,888	$ 2,815,180		$ 371,237	$ 14,080,995	$ 6,424,691	$ 2,413,223	$ 2,048,501	$ 42,802,994
QLD	$ 16,046,645	$ 1,421,379	$ 813,809	$ 63,184	$ 3,833,168	$ 16,903,991	$ 9,370,907	$ 156,923	$ 416,385	$ 49,026,391
SA	$ 10,072,092		$ 496,632	$ 191,518		$ 539,290	$ 1,699,366	$ 378,719		$ 13,377,638
TAS	$ 2,611,632				$ 73,674	$ 748,077		$ 50,373		$ 3,483,756
VIC	$ 15,068,216		$ 2,087,536			$ 737,455	$ 447,486			$ 18,340,692
WA	$ 24,518,771	$ 1,280,267	$ 833,805		$ 1,380,650	$ 6,306,278	$ 2,999,413	$ 422,202		$ 37,741,386
AUS	$ 1,286,323		$ 42,384		$ 148,634		$ 2,117,348	$ 3,756,089		$ 7,350,778
Grand Total	**$ 109,968,674**	**$ 4,311,978**	**$ 7,337,574**	**$ 254,702**	**$ 6,097,613**	**$ 43,902,021**	**$ 25,502,699**	**$ 7,449,105**	**$ 2,464,886**	**$ 207,289,252**

Valin07	DOM									
STATE	ACCH	DGP	EDU	LGA	NGO	ANGO	GOV	COM	ALGA	Grand Total
ACT	92%	0%	0%	0%	0%	0%	0%	8%	0%	$ 2,043,444
NSW	73%	4%	1%	0%	1%	14%	7%	0%	0%	$ 33,122,173
NT	34%	0%	7%	0%	1%	33%	15%	6%	5%	$ 42,802,994
QLD	33%	3%	2%	0%	8%	34%	19%	0%	1%	$ 49,026,391
SA	75%	0%	4%	1%	0%	4%	13%	3%	0%	$ 13,377,638
TAS	75%	0%	0%	0%	2%	21%	0%	1%	0%	$ 3,483,756
VIC	82%	0%	11%	0%	0%	4%	2%	0%	0%	$ 18,340,692
WA	65%	3%	2%	0%	4%	17%	8%	1%	0%	$ 37,741,386
AUS	17%	0%	1%	0%	2%	0%	29%	51%	0%	$ 7,350,778
Grand Total	**53%**	**2%**	**4%**	**0%**	**3%**	**21%**	**12%**	**4%**	**1%**	**$ 207,289,252**

53% of funds went to ACCHS's overall, but with large variations across jurisdictions.

- ACT (92%), VIC (82%), SA (75%), TAS (75%), NSW (73%) and WA (65%)
- NT (34%) and QLD (33%)
- AUS (17%)

Apart from ACCHS's, the main recipients were other Aboriginal NGO's (21%, mainly in the NT and Queensland) and State/Territory Governments and agencies (12%).

Results in a Nutshell: OATSIH only, 2007-08

2007-2008	1
Source	(All)
DAO	OATSIH
Years	(All)
To	(All)
For	(All)

Valin0708	DOM									
STATE	ACCH	DGP	EDU	LGA	NGO	ANGO	GOV	COM	ALGA	Grand Total
ACT	$ 1,882,465							$ 166,577		$ 2,049,042
NSW	$ 24,106,259	$ 1,412,303	$ 248,909		$ 291,046	$ 4,598,499	$ 2,450,161	$ 105,742		$ 33,212,919
NT	$ 14,486,860	$ 202,441	$ 2,822,893		$ 372,254	$ 14,119,573	$ 6,337,507	$ 1,680,182	$ 2,054,113	$ 42,075,824
QLD	$ 16,090,608	$ 1,425,274	$ 816,038	$ 63,357	$ 3,843,669	$ 16,950,304	$ 3,696,006	$ 157,353	$ 417,525	$ 43,460,134
SA	$ 10,099,687		$ 497,993	$ 192,043		$ 540,768	$ 1,704,042	$ 379,757		$ 13,414,289
TAS	$ 2,618,788				$ 73,675	$ 750,126		$ 50,511		$ 3,493,301
VIC	$ 15,109,498		$ 2,093,255			$ 739,475	$ 448,712			$ 18,390,941
WA	$ 24,585,946	$ 1,283,775	$ 836,089		$ 1,384,432	$ 6,222,764	$ 3,007,631	$ 198,646		$ 37,519,282
AUS	$ 1,289,847		$ 42,500		$ 149,041		$ 1,587,055	$ 3,766,380		$ 6,834,822
Grand Total	**$ 110,269,958**	**$ 4,323,792**	**$ 7,357,677**	**$ 255,400**	**$ 6,114,319**	**$ 43,921,509**	**$ 19,231,113**	**$ 6,505,148**	**$ 2,471,639**	**$ 200,450,554**

Valin0708	DOM									
STATE	ACCH	DGP	EDU	LGA	NGO	ANGO	GOV	COM	ALGA	Grand Total
ACT	92%	0%	0%	0%	0%	0%	0%	8%	0%	$ 2,049,042
NSW	73%	4%	1%	0%	1%	14%	7%	0%	0%	$ 33,212,919
NT	34%	0%	7%	0%	1%	34%	15%	4%	5%	$ 42,075,824
QLD	37%	3%	2%	0%	9%	39%	9%	0%	1%	$ 43,460,134
SA	75%	0%	4%	1%	0%	4%	13%	3%	0%	$ 13,414,289
TAS	75%	0%	0%	0%	2%	21%	0%	1%	0%	$ 3,493,301
VIC	82%	0%	11%	0%	0%	4%	2%	0%	0%	$ 18,390,941
WA	66%	3%	2%	0%	4%	17%	8%	1%	0%	$ 37,519,282
AUS	19%	0%	1%	0%	2%	0%	23%	55%	0%	$ 6,834,822
Grand Total	**55%**	**2%**	**4%**	**0%**	**3%**	**22%**	**10%**	**3%**	**1%**	**$ 200,450,554**

Results in a Nutshell: All Identifiable Commonwealth, 2007

2007	1
Source	(All)
DAO	(All)
Years	(All)
To	(All)
For	(All)

Valin07	DOM									
STATE	ACCH	DGP	EDU	LGA	NGO	ANGO	GOV	COM	ALGA	Grand Total
ACT	$ 1,877,322		$ 41,171		$ 144,762	$ 99,927		$ 166,122		$ 2,329,303
NSW	$ 26,985,710	$ 1,544,086	$ 2,839,516		$ 840,269	$ 6,668,488	$ 6,911,135	$ 3,072,104		$ 48,861,308
NT	$ 16,513,170	$ 201,866	$ 4,984,491		$ 675,087	$ 19,180,303	$ 8,667,538	$ 2,413,223	$ 3,467,220	$ 56,102,921
QLD	$ 17,895,135	$ 1,421,379	$ 2,815,945	$ 63,164	$ 4,525,523	$ 21,543,580	$ 13,488,871	$ 225,516	$ 749,507	$ 62,728,643
SA	$ 10,889,261		$ 1,349,406	$ 191,518	$ 267,206	$ 3,274,558	$ 2,767,481	$ 378,719		$ 19,118,150
TAS	$ 2,795,509				$ 119,605	$ 827,849		$ 50,373		$ 3,793,336
VIC	$ 15,869,475		$ 3,992,828		$ 79,213	$ 1,497,929	$ 674,977	$ 248,908		$ 22,363,331
WA	$ 26,460,020	$ 1,300,733	$ 2,996,092	$ 101,156	$ 1,565,422	$ 7,908,871	$ 5,370,374	$ 856,119		$ 46,556,786
AUS	$ 1,286,323		$ 42,364		$ 1,060,753	$ 1,587,706	$ 2,417,875	$ 6,149,322		$ 12,544,364
Grand Total	$ 120,571,924	$ 4,468,087	$ 19,061,834	$ 355,858	$ 9,277,840	$ 62,587,213	$ 40,298,251	$ 13,560,407	$ 4,216,727	$ 274,398,141

Valin07	DOM									
STATE	ACCH	DGP	EDU	LGA	NGO	ANGO	GOV	COM	ALGA	Grand Total
ACT	81%	0%	2%	0%	6%	4%	0%	7%	0%	$ 2,329,303
NSW	55%	3%	6%	0%	2%	14%	14%	6%	0%	$ 48,861,308
NT	29%	0%	9%	0%	1%	34%	15%	4%	6%	$ 56,102,921
QLD	29%	2%	4%	0%	7%	34%	22%	0%	1%	$ 62,728,643
SA	57%	0%	7%	1%	1%	17%	14%	2%	0%	$ 19,118,150
TAS	74%	0%	0%	0%	3%	22%	0%	1%	0%	$ 3,793,336
VIC	71%	0%	18%	0%	0%	7%	3%	1%	0%	$ 22,363,331
WA	57%	3%	6%	0%	3%	17%	12%	2%	0%	$ 46,556,786
AUS	10%	0%	0%	0%	8%	13%	19%	49%	0%	$ 12,544,364
Grand Total	44%	2%	7%	0%	3%	23%	15%	5%	2%	$ 274,398,141

44%of funds went to ACCHS's overall, but with large variations across jurisdictions.

- ACT (81%), VIC (71%), SA (57%), TAS (74%), NSW (55%) and WA (57%)
- NT (29%) and QLD (29%)
- AUS (10%)

Results in a Nutshell: All Identifiable Commonwealth, 2007-08

2007-2008	1
Source	(All)
DAO	(All)
Years	(All)
To	(All)
For	(All)

Valin0708	DOM									
STATE	ACCH	DGP	EDU	LGA	NGO	ANGO	GOV	COM	ALGA	Grand Total
ACT	$ 1,882,465		$ 41,284		$ 145,159	$ 100,200		$ 166,577		$ 2,335,685
NSW	$ 26,740,077	$ 1,548,316	$ 2,847,295		$ 806,024	$ 6,515,801	$ 6,930,070	$ 3,060,520		$ 48,468,103
NT	$ 16,556,411	$ 202,441	$ 4,998,148		$ 676,937	$ 18,717,036	$ 8,184,644	$ 1,680,182	$ 3,437,936	$ 54,455,735
QLD	$ 17,756,850	$ 1,425,274	$ 2,823,661	$ 63,357	$ 4,537,922	$ 20,898,375	$ 7,825,251	$ 226,134	$ 751,560	$ 56,308,385
SA	$ 10,786,046		$ 1,353,103	$ 192,043	$ 177,687	$ 2,929,719	$ 2,775,063	$ 379,757		$ 18,595,419
TAS	$ 2,723,675				$ 119,932	$ 791,777		$ 50,511		$ 3,685,896
VIC	$ 15,752,314		$ 3,663,640		$ 79,430	$ 1,251,288	$ 676,826	$ 249,590		$ 21,673,090
WA	$ 26,413,114	$ 1,304,297	$ 3,004,300		$ 1,569,711	$ 7,495,744	$ 5,385,087	$ 633,752		$ 45,806,006
AUS	$ 1,289,847		$ 42,500		$ 898,207	$ 1,592,058	$ 1,778,103	$ 6,166,170		$ 11,766,884
Grand Total	$ 119,904,800	$ 4,480,328	$ 18,773,931	$ 255,400	$ 9,011,009	$ 60,291,999	$ 33,555,045	$ 12,633,193	$ 4,189,496	$ 263,095,202

Valin0708	DOM									
STATE	ACCH	DGP	EDU	LGA	NGO	ANGO	GOV	COM	ALGA	Grand Total
ACT	81%	0%	2%	0%	6%	4%	0%	7%	0%	$ 2,335,685
NSW	55%	3%	6%	0%	2%	13%	14%	6%	0%	$ 48,468,103
NT	30%	0%	9%	0%	1%	34%	15%	3%	6%	$ 54,455,735
QLD	32%	3%	5%	0%	8%	37%	14%	0%	1%	$ 56,308,385
SA	58%	0%	7%	1%	1%	16%	15%	2%	0%	$ 18,595,419
TAS	74%	0%	0%	0%	3%	21%	0%	1%	0%	$ 3,685,896
VIC	73%	0%	17%	0%	0%	6%	3%	1%	0%	$ 21,673,090
WA	58%	3%	7%	0%	3%	16%	12%	1%	0%	$ 45,806,006
AUS	11%	0%	0%	0%	8%	14%	15%	52%	0%	$ 11,766,884
Grand Total	46%	2%	7%	0%	3%	23%	13%	5%	2%	$ 263,095,202

Relativities by State, OATSIH 2007

$ per capita	STATE	Relativity
$ 511	ACT	2.29
$ 223	NSW	1.00
$ 643	NT	2.88
$ 335	QLD	1.50
$ 515	SA	2.30
$ 206	TAS	0.92
$ 595	VIC	2.66
$ 484	WA	2.17
$ 14	other	
$ 401	AUS	1.73

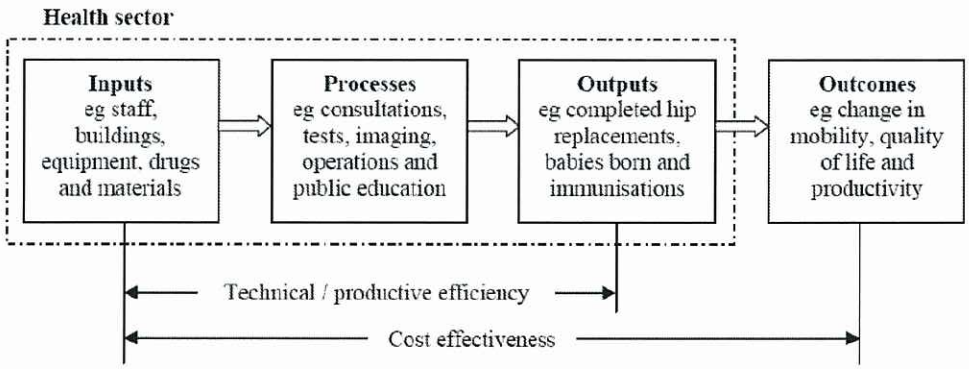
In 2007, 96% of the $401 per capita in funding from OATSIH could be assigned to a State/Territory, the rest being best regarded as national. The per capita rate was much higher in the NT ($643), Victoria ($595), SA ($515), the ACT ($511), and WA ($484) than in Queensland ($335), NSW ($223) or Tasmania ($206).

Appendix : "Cost-effectiveness" is not necessarily portable

At their meeting on 14th January 2008, Commonwealth and State/ Territory Treasurers and Health Ministers met under the auspices of the Council of Australian Governments (COAG), and decided that evaluating the cost-effectiveness of programs for Aboriginal and Torres Strait Islander people was a major priority. To that end, they decided that: "*all jurisdictions will cooperate in the development of a national framework for reporting expenditure on Indigenous services*"[45].

"The national framework will comprise expenditure by all jurisdictions, at both Commonwealth and State/Territory levels and will seek to include both Indigenous- specific and mainstream spending on services for Indigenous Australians in areas such as: education; justice; health; housing; community services; employment; and other significant expenditure. In so doing, the focus will be in relation to on-the-ground services. ... A report in accordance with the national framework will be provided to COAG annually, and an initial 'stock take' report will be provided for the first COAG meeting in 2009."

Figure 1 **Relationship between inputs, outputs and outcomes**



Source: Productivity Commission (2005, p. 370).

Those responsible for managing public money always face more demands than there is money to meet, and the relative "cost effectiveness" of different programs seems like a reasonable basis for deciding between two programs for (say) delivering primary health care. However, even in that relatively simple case, where the choice is between two different ways of delivering the same service but the service is complex, there is much more to evaluating the cost-effectiveness of programs than just knowing the costs of the inputs (Fig 1)[46].

[45] Council of Australian Governments. *Communiqué: Ministerial Council Meeting, Brisbane, Monday 14 January 2008*. URL: www.coag.gov.au/meetings/other/health_ministers_communique_140108.pdf accessed 16 June 2008.

[46] Productivity Commission 2005, Australia's Health Workforce, Research Report, Canberra. (from in Gabbitas O, Jeffs C. Assessing productivity in the delivery of health services in Australia: Some experimental estimates. Paper presented to the Australian Bureau of Statistics-Productivity Commission Productivity Perspectives 2007 Conference. Canberra 17 December 2007.

Outcomes, Causality and Effectiveness

At a minimum, one needs also to know the outcomes, and that the outcomes are actually caused by the program/s, rather than by something else[47]. Thus, in the case of complex population programs like the Australian National Youth Suicide Prevention Strategy, there are many factors other than the investment in the strategy that need to be excluded before the observed reduction in youth suicide can be credited to the intervention[48]. The same applies to claims that general suicide rate reductions can be attributed to greatly increased prescribing of antidepressants, which at least in the UK did not survive rigorous evaluation[49].

Who Pays and Who Benefits?

There are even more basic problems that apply to the evaluation of "cost-effectiveness" of real-world programs, because they take place in an environment of competing interests. It might seem that dollars spent at a particular time have the same value (for example, 2007 Australian dollars), but this can depend on whose dollars they are and who is making the decisions. Moreover, outcomes and other benefits tend to be of different kinds, to be received by different groups who may not be the ones investing the dollars, and to arrive at different times. Where the gap between cost and benefit is long, estimating the present value of a future saving is dominated by the inflation rate assumed for the discount applied to future savings[50]. Each of these issues warrants some discussion, because "cost-effectiveness" seems like an objective decision-making process, but except in obvious cases of actual harm or lack of benefit, it does not protect against the value judgements that exist in all decisions about investing public money for public benefit.

Cost Shifting

In Australia's federal system these issues often arise as a debate about "cost-shifting" between levels of Government[51], but the same issues arise between public and private sectors, between individuals and society as a whole, between generations, and of course

[47] Gilmour S, Degenhardt L, Hall W, Day C. Using intervention time series analyses to assess the effects of imperfectly identifiable natural events: a general method and example. BMC *Medical Research Methodology 2006*; 6:16, 2006.
[48] Morrell S. Page AN. Taylor RJ. The decline in Australian young male suicide. *Social Science & Medicine 2007*; 64(3):747-754
[49] Gunnell D. Ashby D. Antidepressants and suicide: what is the balance of benefit and harm? BMJ. 329(7456):34-8, 2004 Jul 3.
[50] A more objective approach is to estimate current costs as a result of past failures to prevent and treat effectively. For more information see Collins DJ, Lapsley HM. Estimating the economic cost of drug abuse in Australia. (National campaign against drug abuse monograph series, No 15. Canberra: Australian Government Publishing Service, 1991.
[51] Buckmaster L, Pratt A. Not on my account! Cost-shifting in the Australian health system. Canberra: Parliamentary Library Research Note, 200506, No 6, 2 September 2005.

between advocates of one field of human activity versus another. Two examples will illustrate the issues better than a general discussion.

Example 1: Victorian Analysis of Issues for Mental Health Programs

In July 2006 COAG agreed to increase Australian mental health funding by about 25% ($1 billion per annum) via the National Action Plan for Mental Health 2006-2011[52]. Prior to the COAG meeting, the Victorian Government invested $1.2 million in a report[53] to advise it what needed to be done. It concluded:

"Ongoing increases in funding are required, beyond the already significant increases announced by Victoria and the Commonwealth. The case for further investment is strong, but the path forward carries some obstacles. This is in part because the benefits will not necessarily flow to the level of Government that provides the funding, and also because Australia's federal system carries strong disincentives for one level of Government to increase spending in an area that is arguably the domain of another level of Government. This can result in underinvestment in areas where responsibilities are blurred or there is some ambiguity about funding responsibility."

The recommended solution for this particular problem was:

"…collaboration between the State and Commonwealth Governments in several key areas. These include:

- Agreement on the mental health outcomes to be measured and monitored;
- Agreement to share data – to the maximum extent allowable – to enable those outcomes to be measured at the local and State levels;
- Agreement on the sharing of fiscal benefits from improved outcomes;
- Agreement to jointly support new governance arrangements at the local level;
- Agreement to jointly fund some initiatives; and
- Willingness to review funding arrangements where it is clear that they lead to sub-optimal resource allocation – this may include the greater use of existing cost-sharing mechanisms such as those used to fund programs in health, disability support, housing and homelessness, to focus on the mentally ill."

[52] Council of Australian Governments. National Action Plan for Mental Health 2006-2011. [URL: http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.pdf]

[53] Department of Premier and Cabinet, Victoria. *Improving Mental Health Outcomes in Victoria: The Next Wave of Reform.* April 2006. [Electronic publication. URL: http://www.dpc.vic.gov.au] The most relevant section here is Chapter 7.

Example 2: Dissection of Issues for the Nurse-Family Partnership evidence

In the USA in 2003, the PNC Financial Services Group, Inc asked the RAND Corporation[54] to prepare a thorough, objective review and synthesis of current research on interventions of various forms in early childhood to improve outcomes for participating children and their families. In particular, the review was to consider:

- "the potential consequences of not investing additional resources in the lives of children—particularly disadvantaged children— prior to school entry
- the range of early intervention programs, focusing on those that have been rigorously evaluated
- the demonstrated benefits of interventions with high-quality evaluations and the features associated with successful programs
- the returns to society associated with investing early in the lives of disadvantaged children."

One of the programs reviewed is Nurse-Family Partnership (NFP) which the Commonwealth Government has already decided is worth investing in. The RAND review is only a little less enthusiastic about NFP than is implied by the links on the NFP website[55]; or the OATSIH website[56]. The summary table below comes from the publication, but has been annotated.

Table 4.4 in RAND review (NFP section only, Annotated)
Benefit-Cost Results of Selected Early Childhood Intervention Programs — Follow-Up During Secondary School Years

Program	Type	Age at Last Follow-Up	Number Followed @ 15	Costs per Child	Distribution of Benefits per Child: Participants	Distribution of Benefits per Child: Savings to Government	Distribution of Benefits per Child: Rest of Society	Total Benefits to Society per Child	Net Benefits to Society per Child	Benefit-Cost Ratio
NFP—higher-risk sample(a)	Home Visiting/ Parent Education	15	97	**$ 7,271**	$ 1,277	$ 32,447	$ 7,695	**$ 41,419**	$ 34,148	**5.70**
NFP—lower-risk sample (b)		15	145	**$ 7,271**	$ 2,051	$ 5,095	$ 2,005	**$ 9,151**	$ 1,880	**1.26**
NFP—pooled (a and b)		*15*	*242*	***$ 7,271***	$ 1,741	$ 16,058	$ 4,286	**$ 22,085**	$ 14,814	**3.04**
NFP—All studies (c)		15	97	**$ 9,118**	$ 2,674	$ 9,548	$ 14,075	**$ 26,298**	$ 17,180	**2.88**
Notes										
(a)	Women who, at the time of enrolment in the Elmira NY study in 1978-80, were unmarried and had low socioeconomic status (SES).									
(b)	Two-parent families or higher-SES families in the Elmira NY study, data not separately published.									
(c)	This is from a separete analysis using benefit data at different ages of follow-up, as available from the studies in Elmira NY (enrolment 1978-80), Memphis TN (enrolment 1990-91), and Denver CO studies (enrolment 1994-95), and cost data from the Denver CO study.									

[54] Karoly LA. Kilburn MR, Cannon JS. *Early Childhood Interventions - Proven Results, Future Promise.* RAND Corporation, 2005. [Electronic free copy at URL: http://www.rand.org/pubs/monographs/MG341/]

[55] See URL: http://www.nursefamilypartnership.org .

[56] "The [Early Childhood] Section [of OATSIH] has a direct role in developing and implementing the Australian Nurse-Family Partnership Program funded under the 2007/08 measure 'Health@Home Plus'. It provides $37.4 million over four years to provide structured, sustained nurse-led home visits to women pregnant with an Aboriginal and/or Torres Strait Islander child up to the age of two years. Child and family support will be provided to high need children aged 2-8 years.

The Nurse-Family Partnership (NFP) model has been developed over the last 30 years by Professor David Olds, Director of the Prevention Research Center for Family and Child Health, University of Colorado, United States of America. Longitudinal studies have found that the positive effects of the NFP include improved outcomes in a range of antenatal, early childhood and maternal life course indicators. The NFP model will be adapted to suit the Australian context including geographical diversity, Aboriginal and Torres Strait Islander culture and society and the Australian health care system, particularly the primary health care system."
http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-contact-div-fhw

The original Table 4.4 in the RAND report was confusing in one respect. It had only the first two data rows and the last one, and the last was labelled "NFP- Full sample". The reader naturally tended to assume that the "Full sample" was the overall result of combining the "higher risk" and "lower risk" groups above, which creates a puzzle: Why would the "Full sample" cost per child be $9,118 when the cost per child in each sub-sample part is given as $7,172? In fact the last row comes from a separate cost-effectiveness study, as explained in the notes added to the table here and by re-labelling the result "NFP- All studies".

For comparison, the results for the "Higher risk" and "Lower risk" sub-samples have been pooled with the aid of sample size information not in the original RAND table, and the results are shown as "NFP- Pooled".

Different Benefits to Recipients, Governments, Society

These analyses demonstrate two key points. One is that that there are benefits to (at least) three broad groups: to the participants themselves, to the governments who are generally providing the funding, and to society as a whole (which provides the funding to governments). These are all "monetarized" (that is, converted into dollars) but clearly the three different classes of benefit might be viewed differently by the three groups involved.

Different Benefits for Different Participants

The second point is that the benefit may be different for the same program for different populations exposed to it. As the RAND report puts it:

"... there is some evidence in Table 4.4 that effectively targeting program services generates more-favorable economic outcomes. The benefit-cost analysis of the NFP program conducted by Karoly et al. (1998)[57] estimated results separately for both a higher-risk sample of mothers and children served and a lower-risk sample. Because the categories of benefits estimated for those two subsamples were the same, a comparison of the benefit-cost results can be made without concern for differences in methodology. As seen in Table 4.4, the net benefits per child were about 18 times as great for the higher-risk sample ($34,148 versus $1,880), and the benefit-cost ratios were 5.70 and 1.26 for the higher-risk and lower-risk samples, respectively. These differences in results are due solely to the differential effect of the early childhood program on the higher-risk versus the lower-risk populations."

[57] This reference is to an earlier RAND corporation report from the same group: Karoly LA, Greenwood PW, Everingham SS, Hoube J, Kilburn MR, Rydell CP, Sanders M, Chiesa J. Investing in Our Children What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions. Rand Corporation Monograph Report MR-898, 1998. This can be downloaded by chapters at URL: http://www.rand.org/pubs/monograph_reports/MR898/ . Chapter 3 contains an excellent discussion of costs and benefits. Appendix A contains the details of the calculations for NFP (then known as the Elmira Prenatal/Early Infancy Project (PEIP).

Cost-Effectiveness is not necessarily portable

This is a simple way of illustrating the fact that "cost-effectiveness" is not an absolute characteristic of a program, but rather an observation that depends on many things: a particular way of implementing a program, in a particular environment, at a particular time, for a particular group of people. The results may or may not be reproducible when any of these things are varied. This is highly relevant in the light of the fact that OATSIH has stated: "*The NFP model will be adapted to suit the Australian context including geographical diversity, Aboriginal and Torres Strait Islander culture and society and the Australian health care system, particularly the primary health care system*" [56] Such an adaptation needs independent evidence of cost-effectiveness.

The pooled results in the third row of Table 4.4 are consistent with those of the "all studies" result in the last row. The difference in costs per child arise from the fact that the first three rows use the costs of the Elmira NY intervention in 1978-, while the last row uses the cost of the Denver CO intervention in 1994-1997, both converted to 2003 US dollars. The benefits in the first three rows are based only on the Elmira NY data, while those in the last row draw on the three NFP studies. At first glance, this seems to show that the "cost benefit" analysis is stable across different geographic samples (in the US) but in fact the contribution from the Memphis TN and Denver CO studies is very small. To see why, we need to consider another topic.

Different Benefits Depending on the Benefits that are Valued

The last row in Table 4.4 is actually from an independent analysis of "cost effectiveness", by the Washington Institute of Public Policy[58], whose brief is: "... to carry out practical, non-partisan research—at legislative direction—on issues of importance to Washington State".

In this case, the Washington legislature stated the benefits that they valued, namely the ability of programs to: "(1) Reduce crime; (2) Lower substance abuse; (3) Improve educational outcomes such as test scores and graduation rates; (4) Decrease teen pregnancy; (5) Reduce teen suicide attempts; (6) Lower child abuse or neglect; and (7) Reduce domestic violence."

[58] URL: http://www.wsipp.wa.gov/ The site contains a wide range of analyses across many policy areas, namely: Child Welfare, Costs and Benefits, Criminal Justice (Adults, Juveniles, Sex Offenders), Education (Higher Education, K-12), Employment/Welfare, Government, Health Care, Mental Health, Prevention , Research-Based Programs, State Economy. Its reports and their technical appendixes are models of good documentation.

The table below is a small section of their summary report[59].

Table 1
Summary of Benefits and Costs (2003 Dollars)

Estimates as of September 17, 2004	Measured Benefits and Costs Per Youth			
	Benefits (1)	Costs (2)	Benefits per Dollar of Cost (3)	Benefits Minus Costs (4)
Pre-Kindergarten Education Programs				
Early Childhood Education for Low Income 3- and 4-Year-Olds*	$17,202	$7,301	$2.36	$9,901
HIPPY (Home Instruction Program for Preschool Youngsters)	$3,313	$1,837	$1.80	$1,476
Parents as Teachers	$4,300	$3,500	$1.23	$800
Parent-Child Home Program	$0	$3,890	$0.00	-$3,890
Even Start	$0	$4,863	$0.00	-$4,863
Early Head Start	$4,768	$20,972	$0.23	-$16,203
Child Welfare / Home Visitation Programs				
Nurse Family Partnership for Low Income Women	$26,298	$9,118	$2.88	$17,180
Home Visiting Programs for At-risk Mothers and Children*	$10,969	$4,892	$2.24	$6,077
Parent-Child Interaction Therapy	$4,724	$1,296	$3.64	$3,427
Healthy Families America	$2,052	$3,314	$0.62	-$1,263
Systems of Care/Wraparound Programs*	$0	$1,914	$0.00	-$1,914
Family Preservation Services (excluding Washington)*	$0	$2,531	$0.00	-$2,531
Comprehensive Child Development Program	-$9	$37,388	$0.00	-$37,397
The Infant Health and Development Program	$0	$49,021	$0.00	-$49,021

In the Technical Appendix, the "monetized" benefit of each program is shown against each of these headings, as also is (in detail) the way in which outcomes stated in non-monetary terms (for example, differences in cognitive tests or school results; differences in arrests of juveniles) have been converted into money

For example, a program that shows an effect on cognitive tests at age 8 can be linked to an effect on high school graduation rates, which in turn can be linked to an increase in lifetime earnings. By laborious and ingenious means, reductions in arrest rates to age 15 can be used to impute savings in lifetime crime rates and the distribution of direct and indirect costs to victims and the offender-processing costs to the corrections systems. In effect, a great deal of technically impressive work has been done to add value to the information that is contained in the program evaluation reports themselves.

For example, the "crime" data for NFP is limited to the followup at age 15 in the Elmira NY study, which simply reports the average number of arrests to age 15 in those who were and were not exposed to the program. The actual offences are not reported, but the cost-benefit study draws on external data sets to (in effect) allocate the probability of a US-average

[59] Aos S, Lieb R, Mayfield J, Miller M, Pennucci A. *Benefits and costs of prevention and early intervention programs for youth.* Olympia, WA: Washington Institute for Public Policy, September 2004. (Document No. 04-07-3901). The Summary Report, Technical Report (Appendix A) and References (Appendix B) can be downloaded from URL: http://www.wsipp.wa.gov/pub.asp?docid=04-07-3901

lifetime criminal career (and its costs) to a child, given that they were exposed to arrest by age 15. This then has crime-processing costs and victim costs.

The resulting table for the NFP data is shown below, from the Technical Appendix, p 105.

Nurse Family Partnership for Low Income Women
— Summary of Estimated Benefits and Costs —

	Primary Program Recipient				Secondary Program Recipient (or child abuse and neglect for primary program recipient)			
	Benefits and Costs From Different Perspectives				Benefits and Costs From Different Perspectives			
	Program Participants	Non-Program Participants As:		Total	Program Participants	Non Program		Total
Benefits By Area		Taxpayers	Non-Taxpayers			Taxpayers	Non-Taxpayers	
Crime	$0	$6,861	$7,616	$14,476	$0	$1,055	$906	$1,961
High School Graduation	$0	$0	$0	$0	$1,127	$282	$352	$1,762
Test Scores	$0	$0	$0	$0	$2,101	$525	$656	$3,282
Education (years)	$0	$0	$0	$0	$0	$0	$0	$0
K-12 Special Education	$0	$0	$0	$0	$0	$0	$0	$0
K-12 Grade Repetition	$0	$0	$0	$0	$0	$42	$0	$42
Public Assistance	$0	$0	$0	$0	$0	$0	$0	$0
Child Care	$0	$0	$0	$0	$0	$0	$0	$0
Child Abuse and Neglect	$0	$0	$0	$0	$0	$800	$4,886	$5,686
Teen Births (under age 18)	$0	$0	$0	$0	$0	$0	$0	$0
Tobacco (prob of initiation)	$0	$0	$0	$0	$0	$0	$0	$0
Alcohol (prob of initiation)	$0	$0	$0	$0	$0	$0	$0	$0
Illicit Drugs (prob of initiation)	$0	$0	$0	$0	$0	$0	$0	$0
Tobacco (regular use)	$0	$0	$0	$0	$0	$0	$0	$0
Alcohol (disordered use)	$0	$0	$0	$0	$379	$152	$10	$541
Illicit Drugs (disordered use)	$0	$0	$0	$0	$195	$113	$1	$309
Total Benefits (this sheet)*	$0	$6,861	$7,616	$14,476				
Total Benefits (second sheet)*	$2,674	$2,688	$6,459	$11,822	$2,674	$2,688	$6,459	$11,822
Total Benefits (both sheets)*	$2,674	$9,548	$14,075	$26,298				
Program Costs	$0	-$9,118	$0	-$9,118				
Net Benefit (NPV)	$2,674	$430	$14,075	$17,180				
Total Benefit-to-Cost Ratio				$2.88				
* Note: total benefits may not equal the sum of the individual items because only one of the three human capital variables (high school graduation, test scores, education years) is counted.								
Addendum: Non-participant benefits divided by taxpayer costs				$2.59				

This is a very informative table. It shows that for the primary program participants (considered to be the babies of 1978-80 followed up at age 15, rather than their mothers) the valued benefits were zero. [Though there was a value of $5,686 associated with reductions in child abuse and neglect,]

It also shows that the bulk of the valued benefit arises because a reduction in the young person's arrest rates to age 15 implied a saving with a present value of $14,476 because fewer would proceed to a lifetime criminal career. Moreover, there was a smaller saving of $1,961 through less maternal offending. Together, these account for 63% of the monetized benefit.

Weighting outcomes by valued benefits eliminates studies with unvalued outcomes

The second column in the table below, showing ""Number of effect sizes included in the analysis" shows that for the three NFP studies the numbers are 1, 2 or 3 as might be expected.

The second-last column shows the weighting they received in the benefits-cost analysis, where, if the weight is .000 then it is reasonable to call it "eliminated".

Table C.1a (continued)
Meta-Analytic Estimates of Standardized Mean Difference Effect Sizes
Many of these programs have evaluated other outcomes than those shown.
This table includes our analysis of only those outcomes directly related to our estimates of monetary benefits.

Type of Prevention or Intervention Program (and its effect on different outcomes)	Number of Effect Sizes Included in the Analysis	*Results Before Adjusting Effect Sizes*					***Adjusted Effect Size Used in the Benefit-Cost Analysis, see Appendix B***	Notes to Table
		Fixed Effects Model			Random Effects Model			
		Weighted Mean Effect Size & p-value		Homogeneity Test	Weighted Mean Effect Size & p-value			
		ES	p-value	p-value	ES	p-value	ES	
Minnesota Smoking Prevention Program, and its effect on:								(9)
Tobacco (prob of initiation)	1	-.242	0.000	na	na	na	**-.121**	
Tobacco (regular use)	1	-.242	0.000	na	na	na	**-.121**	
Multidimensional Treatment Foster Care (vs. regular group care), and its effect on:								
Crime	2	-.804	0.000	0.464	na	na	**-.306**	
Multi-Systemic Therapy (MST), and its effect on:								
Crime	6	-.349	0.000	0.000	-.332	0.040	**-.169**	
Nurse Family Partnership for Low Income Women, and its effect on:								(1)
Crime (Mother's)	1	-.724	0.001	na	na	na	**-.359**	
Public Assistance (Mother's)	3	-.142	0.016	0.042	-.183	0.124	**.000**	
High School Graduation (Mother's)	2	.072	0.261	0.765	na	na	**.000**	
Substance Abuse (Mother's)	3	-.010	0.872	0.075	na	na	**.000**	
Employment (Mother's)	2	.102	0.172	0.274	na	na	**.000**	
Crime (Child's)	1	-.378	0.069	na	na	na	**-.188**	
Child Abuse and Neglect	1	-.883	0.000	na	na	na	**-.438**	
K-12 Test Scores (Child's)	2	.129	0.040	0.413	na	na	**.087**	

As can be seen easily enough, the surviving variables are:

- Crime (Mother's), 1 study (Elmira NY)
- Crime (Child's), 1 study (Elmira NY)
- Child Abuse and Neglect, 1 study (Elmira NY)
- K-12 Test Scores (Child's), 2 studies, very small weighting

So in brief, the evidence is almost entirely limited to the "crime ecology" of Elmira NY, from about 1980-95, which we don't know, but which is occurring in a place (the United States) that puts people in prison at about 5-6 times the Australian rate. How much of that would be transportable to Australia is anyone's guess.

CONCLUSIONS

When differences in outcomes (such as premature avoidable mortality) are the common final result of many different factors, it is asking a great deal of “cost effectiveness” analysis to decide between programs in (say) housing, or environmental health, or education, or employment, or primary, secondary and tertiary health services. There will be advocates for each, there will be some evidence for each, and there will be scientific-economic arguments for each. It is no substitute for thinking.

- None of this says that the NFP is a bad thing. However, it should not be elevated to any special status as against other programs on the evidence available.

Appendix : Identification

For decades, epidemiologists and others concerned with Aboriginal health have argued that we need to be able to identify Aboriginal people in health data collections - and in death data - so as to be able to have good information to guide policy and service development. Up to a point that is true, but in other ways it is misleading, and can even be an excuse for inertia.

Most Aboriginal health indicators are a ratio of two numbers. One, the numerator, is the number of identified Aboriginal people with a particular risk factor, or illness, or the number who died, in a particular time period. The other, the denominator, is typically the number of people (of that age sex, locality, etc) who identified as an Aboriginal and/ or Torres Strait Islander in the Census (or a suitable projection or other estimate of that population). If Aboriginal people are more likely to self-identify in the Census than they are to be identified in the data that becomes the numerator, then typically the rate of exposure to risk factors, or illness, or death, will be under-estimated.

In many cases, even when this is so, the gap in rates between Aboriginal people and other Australians is so large that ignoring the data because of "under-identification", or deferring action until the data are better, is not justified. After all, in many cases we know that the gap is at least a large as the one we have observed.

Thus we have indicated a number of ways in which the Committee can consider this issue that are more productive than simply saying that improved identification in important, and some very practical steps that can be taken.

Example #1 : Under-identification in Hospital data, and estimated expenditure

Table A3.3: Estimated under-identification adjustments for admitted patient data, public hospitals, 2004–05

State/territory	1998–99	2001–02	2004–05[a]
New South Wales	1.30	1.30	1.13
Victoria	1.25	1.25	1.20
Queensland	1.20	1.20	1.12
Western Australia	1.06	1.06	1.03
South Australia	1.10	1.00	1.21
Tasmania	n.a.[b]	n.a.[c]	n.a.[c]
Australian Capital Territory	1.44	1.30	1.70
Northern Territory	1.00	1.00	1.00

(a) Estimated from the 2007 hospital audit.

(b) A 1997 survey of outpatient services was used in place of admitted patient data.

(c) The Tasmanian Department of Health and Human Services Aboriginal Health and Wellbeing Steering Committee advised that no under-identification adjustment be used.

Source: AIHW health expenditure database.

There is a serious question surrounding the current practice of estimating expenditure on Aboriginal health by the use of the adjustment factors in the previous table, which comes from the 2004-05 expenditure report of the AIHW.

In effect, in 2004-05 NSW could only prove 88% (that is 1.00/ 1.13) of the reported inpatient expenditure by producing records that said the person identified as Aboriginal.

In the United States, the Indian Health Service wouldn't pay the bills in the other 12% of cases. In fact there wouldn't be any bills, since there's no-one to bill for if there's no identified record.

Both the adjusted and unadjusted data are "true" in different ways. One is true if we want to estimate how much we probably do spend, of which 88% is documented (for inpatient care) and 12% is not. The other is true, in all circumstances: for example, if we wanted to use the same inpatient records to do some other analysis.

The problem with using a survey (as the AIHW does) to fill these data gaps, is that it reduces incentives to improve identification in data. In the 2004-05 data, Tasmania said it didn't want a correction applied. The results are instructive. Tasmania's real data is obviously unusual.

Table 2.11: Expenditures by state and territory governments[a], total and per person, 2004–05

	ABORIGINAL		OTHER	
	%	$/ person	%	$/ person
State/ Territory Direct spending	66%	*$3,100*	31%	*$1,250*
Direct spending (as reported in dissection below)	67%	***$3,148***	34%	***$1,361***
NSW	*16.2%*	***$2,618***	*12.1%*	***$1,456***
VIC	*3.5%*	***$2,701***	*8.3%*	***$1,327***
QLD	*15.0%*	***$2,546***	*5.3%*	***$1,108***
WA	*11.7%*	***$3,844***	*3.3%*	***$1,369***
SA	*4.8%*	***$4,011***	*3.0%*	***$1,567***
TAS	*0.7%*	***$891***	*0.8%*	***$1,285***
ACT	*0.6%*	***$3,209***	*0.8%*	***$1,897***
NT	*14.2%*	***$5,461***	*0.3%*	***$1,629***

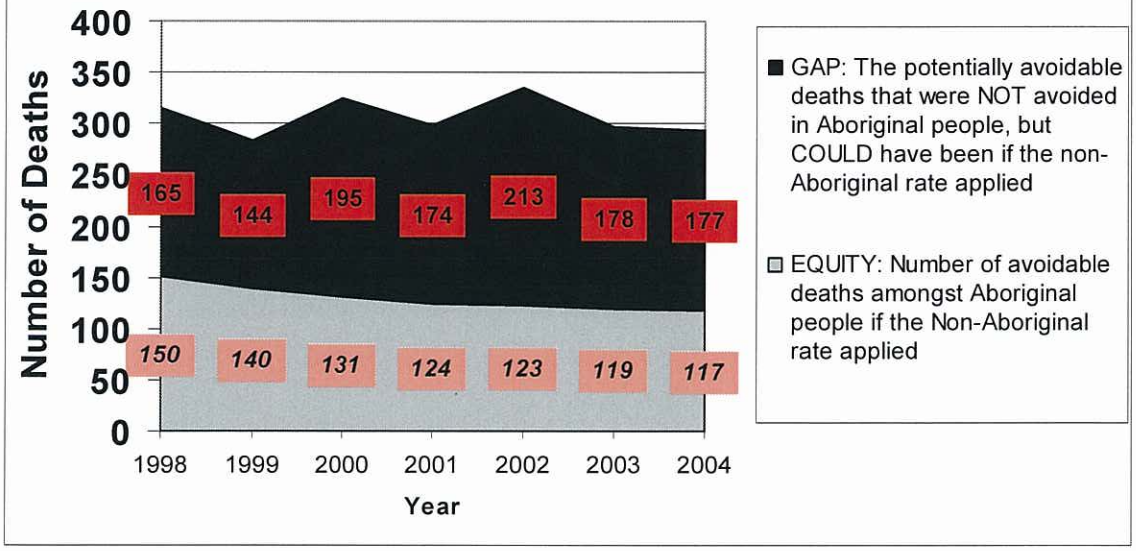
More detail on Tables of this kind can be found in another Appendix, where the AIHW reports have been simplified them down to the "take home messages" that are the only things anyone but a specialist wants to know. States and Territories spend about 67% of all the money that is spent on health care for Aboriginal people and most of that is in hospital care. There is

enormous variation across jurisdictions in how much is spent per person, and some of this is real, and some of it - possibly a great deal - is just bad data and "estimates" based on bad data. This is unlikely to improve rapidly, when errors can be "adjusted", and there is no incentive to improve them.

Example #2 : Large gaps are meaningful even with under-identification

Since NSW Health does report death data despite identification problems in NSW - though NSW data is not usually reported nationally - it is possible to draw up the figure below from published information.

Number of potentially avoidable deaths amongst Aboriginal people under 75, and the GAP between this and the number if they were prevented as well as for non-Aboriginal people, NSW, 1998-2004.
(Source: NSW Health, Chief Health Officer's Report, 2006)



Even though we know the GAP shown is a minimum because of under-identification, the data are usable, if any one cares to.

Now, since most people die in hospital, unless they are identified in the hospital at the time, this can, and does, carry through into non-identification on the death certificate from the doctor.
So on the one hand, Treasurers and Health Ministers met in January under COAG auspices and want to improve costing, and on the other hand we all want to reduce the GAP shown above, and to have some confidence that it is really happening, and not just reducing because hospitals aren't asking the necessary questions on admission. The most direct way to deal with this in a

serious and purposeful attempt to close gaps is to get serious about data, like Tasmania, and place incentives on identification.

A possible approach to this is as follows:

- In "Two Ways Together" mode, NSW Health and the AHMRC launch a campaign to improve reporting of Aboriginality in data collections.
- Alongside that, that NSW Health should not accept "adjustments", and only report the care that can be proven to have been delivered to an Aboriginal person
- That NSW Health act to address issues where the proven treatment rates for Aboriginal people don't line up with the populations of Aboriginal people in those Areas.

There are other things that can be done, to assist us to have a constructive debate about health care rather than an argument about bad data.

- The Bureau of Crime Statistics and Research (BOCSAR) has created a linked database, (see results below) and so too has the Centre for Epidemiology and Research in NSW Health, via the Centre for Health Record Linkage (CheReL).
- It is thus possible to identify records that on at least one occasion have recorded that the person identified as Aboriginal -- truly, or even if it happens to be a data entry error or something similar - and encourage hospitals not to send in inconsistent data.

There are many things that can be done to make it hard, or even impossible, for people to take a line of least resistance and assume that the person isn't Aboriginal rather than ask. It is then up to each individual how they reply.

> Like Lillian and other murris I know only too well what it is like to grow up aboriginal in australia and to experience racism. The racism directed toward murris in this society has been a constant reminder to me that I belong to a black family. Yet growing up blonde, blue-eyed, and fair-skinned, I certainly cannot deny my english and irish heritages. Nor can I deny the opportunities I have been afforded as a result of my whiteness and being mis/taken as white in this racist society.[60]

[60] Holland, Wendy Mis/taken identity (PDF file, source not on hand. 1996, Chapter 5, p. 97)

CRIME AND JUSTICE
Bulletin

NSW Bureau of Crime Statistics and Research

Contemporary Issues in Crime and Justice *Number 78*

August 2003

Contact with the New South Wales court and prison systems: The influence of age, Indigenous status and gender

Don Weatherburn, Bronwyn Lind and Jiuzhao Hua

This bulletin describes the construction of a reoffending database based on linking court appearance records for the same individual. The database provides a facility for tracking and examining patterns in recidivism in New South Wales. The database is used to examine the level of contact with the criminal court and prison systems in New South Wales. It is found that over a five-year period about 6.5 per cent of the New South Wales population appeared in court on a criminal matter. Over a one-year period the proportion is 1.9 per cent. Rates of contact with both the court and prison systems are higher for males than for females and are generally highest for 20-24 year-olds, often substantially so. Indigenous residents of New South Wales have very high rates of contact with both the court and prison systems. In just one year 12.8 per cent of the Indigenous population appeared in court and 2.2 per cent were given a custodial penalty. For Indigenous males aged 20-24, the proportion with a court appearance in the one-year period was 41.3 per cent and the proportion given a custodial penalty was 10.0 per cent.

Figure 2: Frequency distribution of number of court appearances in previous five years
Indigenous persons who appeared in court in 2001

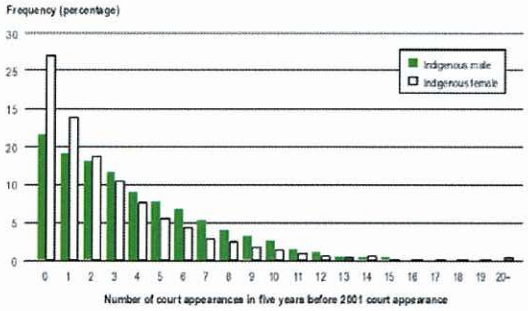


Figure 1: Frequency distribution of number of court appearances in previous five years
Persons who appeared in court in 2001

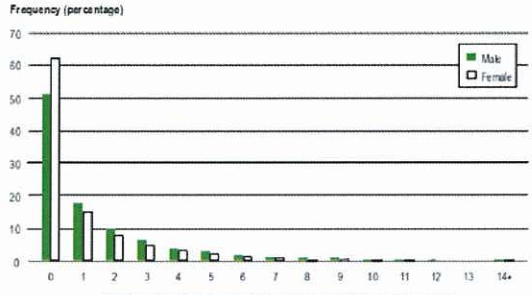


Figure 4: Frequency distribution of number of prior imprisonment episodes
Indigenous persons given a custodial penalty in 2001

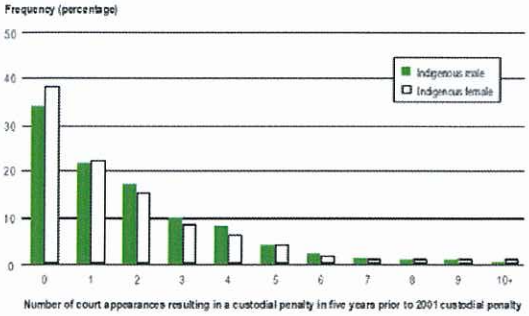
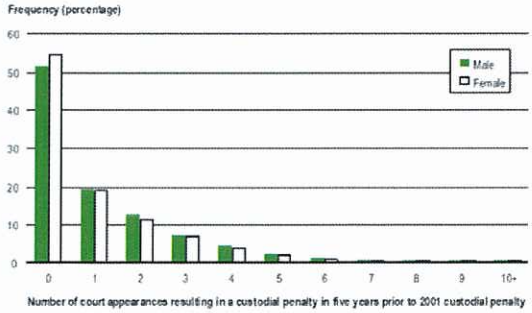


Figure 3: Frequency distribution of number of prior imprisonment episodes
All persons given a custodial penalty in 2001



Appendix : United Nations Declaration on the Rights of Indigenous Peoples (UN–DRIP)

United Nations Declaration on the Rights of Indigenous Peoples

The General Assembly,

Guided by the purposes and principles of the Charter of the United Nations, and good faith in the fulfillment of the obligations assumed by States in accordance with the Charter,

Affirming that indigenous peoples are equal to all other peoples, while recognizing the right of all peoples to be different, to consider themselves different, and to be respected as such,

Affirming also that all peoples contribute to the diversity and richness of civilizations and cultures, which constitute the common heritage of humankind,

Affirming further that all doctrines, policies and practices based on or advocating superiority of peoples or individuals on the basis of national origin or racial, religious, ethnic or cultural differences are racist, scientifically false, legally invalid, morally condemnable and socially unjust,

Reaffirming that indigenous peoples, in the exercise of their rights, should be free from discrimination of any kind,

Concerned that indigenous peoples have suffered from historic injustices as a result of, inter alia, their colonization and dispossession of their lands, territories and resources, thus preventing them from exercising, in particular, their right to development in accordance with their own needs and interests,

Recognizing the urgent need to respect and promote the inherent rights of indigenous peoples which derive from their political, economic and social structures and from their cultures, spiritual traditions, histories and philosophies, especially their rights to their lands, territories and resources,

Recognizing also the urgent need to respect and promote the rights of indigenous peoples affirmed in treaties, agreements and other constructive arrangements with States,

Welcoming the fact that indigenous peoples are organizing themselves for political, economic, social and cultural enhancement and in order to bring to an end all forms of discrimination and oppression wherever they occur,

Convinced that control by indigenous peoples over developments affecting them and their lands, territories and resources will enable them to maintain and strengthen their institutions, cultures and traditions, and to promote their development in accordance with their aspirations and needs,

Recognizing that respect for indigenous knowledge, cultures and traditional practices contributes to sustainable and equitable development and proper management of the environment,

Emphasizing the contribution of the demilitarization of the lands and territories of indigenous peoples to peace, economic and social progress and development, understanding and friendly relations among nations and peoples of the world,

Recognizing in particular the right of indigenous families and communities to retain shared responsibility for the upbringing, training, education and well-being of their children, consistent with the rights of the child,

Considering that the rights affirmed in treaties, agreements and other constructive arrangements between States and indigenous peoples are, in some situations, matters of international concern, interest, responsibility and character,

Considering *also* that treaties, agreements and other constructive arrangements, and the relationship they represent, are the basis for a strengthened partnership between indigenous peoples and States,

Acknowledging that the Charter of the United Nations, the International Covenant on Economic, Social and Cultural Rights[61] and the International Covenant on Civil and Political Rights as well as the Vienna Declaration and Programme of Action,[62] affirm the

[61] Original Note 1 See resolution 2200 A (XXI), annex.
[62] Original Note 2 A/CONF.157/24 (Part I), chap. III.

fundamental importance of the right to self-determination of all peoples, by virtue of which they freely determine their political status and freely pursue their economic, social and cultural development,

Bearing in mind that nothing in this Declaration may be used to deny any peoples their right to self-determination, exercised in conformity with international law,

Convinced that the recognition of the rights of indigenous peoples in this Declaration will enhance harmonious and cooperative relations between the State and indigenous peoples, based on principles of justice, democracy, respect for human rights, non-discrimination and good faith,

Encouraging States to comply with and effectively implement all their obligations as they apply to indigenous peoples under international instruments, in particular those related to human rights, in consultation and cooperation with the peoples concerned,

Emphasizing that the United Nations has an important and continuing role to play in promoting and protecting the rights of indigenous peoples,

Believing that this Declaration is a further important step forward for the recognition, promotion and protection of the rights and freedoms of indigenous peoples and in the development of relevant activities of the United Nations system in this field,

Recognizing and reaffirming that indigenous individuals are entitled without discrimination to all human rights recognized in international law, and that indigenous peoples possess collective rights which are indispensable for their existence, well-being and integral development as peoples,

Recognizing also that the situation of indigenous peoples varies from region to region and from country to country and that the significance of national and regional particularities and various historical and cultural backgrounds should be taken into consideration,

Solemnly proclaims **the following United Nations Declaration on the Rights of Indigenous Peoples as a standard of achievement to be pursued in a spirit of partnership and mutual respect:**

Article 1 Full Enjoyment of Other Human Rights and Fundamental Freedoms

Article 1

Indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration of Human Rights[63] and international human rights law.

Article 2 Freedom from Discrimination

Article 2

Indigenous peoples and individuals are free and equal to all other peoples and individuals and have the right to be free from any kind of discrimination, in the exercise of their rights, in particular that based on their indigenous origin or identity.

Article 3 Self Determination, Political, Economic, Social, Cultural

Article 3

Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

Article 4 Self-Determination, Internal and Local Autonomy and Finance

Article 4

Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions.

Article 5 Distinct Political, Legal, Economic, Social, Cultural + Mainstream

Article 5

Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State.

Article 6 Right to a Nationality

Article 6

Every indigenous individual has the right to a nationality.

Article 7 (1) Individual Life, Physical & Mental Integrity, Liberty, Security

Article 7 (2) Collective Freedom, Peace, Security, No Genocide, No Stolen Children

Article 7

[63] Original Note 3 Resolution 217 A (III).

1. Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person.
2. Indigenous peoples have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or any other act of violence, including forcibly removing children of the group to another group.

Article 8 (1) No Forced Assimilation or Destruction of Culture

Article 8 (2) Prevention of, Redress for Deprivation of Integrity or Lands, Assimilation, Propaganda

Article 8

1. Indigenous peoples and individuals have the right not to be subjected to forced assimilation or destruction of their culture.

2. States shall provide effective mechanisms for prevention of, and redress for:
(a) Any action which has the aim or effect of depriving them of their integrity as distinct peoples, or of their cultural values or ethnic identities;
(b) Any action which has the aim or effect of dispossessing them of their lands, territories or resources;
(c) Any form of forced population transfer which has the aim or effect of violating or undermining any of their rights;
(d) Any form of forced assimilation or integration;
(e) Any form of propaganda designed to promote or incite racial or ethnic discrimination directed against them.

Article 9 Right to Belong to a Community or Nation without Discrimination

Article 9

Indigenous peoples and individuals have the right to belong to an indigenous community or nation, in accordance with the traditions and customs of the community or nation concerned. No discrimination of any kind may arise from the exercise of such a right.

Article 10 No Removal without Prior Consent & Fair Compensation & Return Option

Article 10

Indigenous peoples shall not be forcibly removed from their lands or territories. No relocation shall take place without the free, prior and informed consent of the indigenous peoples concerned and after agreement on just and fair compensation and, where possible, with the option of return.

Article 11 (1) Practise & Revitalize Culture

Article 11 (2) Redress For Property Taken without Consent or Violation of Laws

Article 11

1. Indigenous peoples have the right to practise and revitalize their cultural traditions and customs. This includes the right to maintain, protect and develop the past, present and future manifestations of their cultures, such as archaeological and historical sites, artefacts, designs, ceremonies, technologies and visual and performing arts and literature.

2. States shall provide redress through effective mechanisms, which may include restitution, developed in conjunction with indigenous peoples, with respect to their cultural, intellectual, religious and spiritual property taken without their free, prior and informed consent or in violation of their laws, traditions and customs.

Article 12 (1) Practice Develop Teach Spiritual Traditions, Access, Repatriation

Article 12 (2) States to Assist Access and Repatriation

Article 12

1. Indigenous peoples have the right to manifest, practice, develop and teach their spiritual and religious traditions, customs and ceremonies; the right to maintain, protect, and have access in privacy to their religious and cultural sites; the right to the use and control of their ceremonial objects; and the right to the repatriation of their human remains.

2. States shall seek to enable the access and/or repatriation of ceremonial objects and human remains in their possession through fair, transparent and effective mechanisms developed in conjunction with indigenous peoples concerned.

Article 13 (1) Histories Languages, Traditions, &c, Place names &c

Article 13 (2) States to protect (1), Ensure Interpreters &c

Article 13

1. Indigenous peoples have the right to revitalize, use, develop and transmit to future generations their histories, languages, oral traditions, philosophies, writing systems and literatures, and to designate and retain their own names for communities, places and persons.

2. States shall take effective measures to ensure that this right is protected and also to ensure that indigenous peoples can understand and be understood in political, legal and

administrative proceedings, where necessary through the provision of interpretation or by other appropriate means.

Article 14 (1) Establish Control Education in Own Languages

Article 14 (2) Access to Mainstream Education without Discrimination

Article 14 (3) States to facilitate Access to Education in Own Languages

Article 14

1. Indigenous peoples have the right to establish and control their educational systems and institutions providing education in their own languages, in a manner appropriate to their cultural methods of teaching and learning.

2. Indigenous individuals, particularly children, have the right to all levels and forms of education of the State without discrimination.

3. States shall, in conjunction with indigenous peoples, take effective measures, in order for indigenous individuals, particularly children, including those living outside their communities, to have access, when possible, to an education in their own culture and provided in their own language.

Article 15 (1) Dignity and Diversity reflected in Education and Information

Article 15 (2) States to Combat Prejudice Eliminate Discrimination Promote Tolerance

Article 15

1. Indigenous peoples have the right to the dignity and diversity of their cultures, traditions, histories and aspirations which shall be appropriately reflected in education and public information.

2. States shall take effective measures, in consultation and cooperation with the indigenous peoples concerned, to combat prejudice and eliminate discrimination and to promote tolerance, understanding and good relations among indigenous peoples and all other segments of society.

Article 16 (1) Own Media in language & Access to Mainstream

Article 16 (2) State Media to reflect Diversity, Encourage Private media to do so

Article 16

1. Indigenous peoples have the right to establish their own media in their own languages and to have access to all forms of non-indigenous media without discrimination.

2. States shall take effective measures to ensure that State-owned media duly reflect indigenous cultural diversity. States, without prejudice to ensuring full freedom of expression, should encourage privately owned media to adequately reflect indigenous cultural diversity.

Article 17 (1) Full Rights Under International & Domestic Labour Law

Article 17 (2) States to Protect Children from Harmful Work

Article 17 (3) No Discrimination in Work

Article 17

1. Indigenous individuals and peoples have the right to enjoy fully all rights established under applicable international and domestic labour law.

2. States shall in consultation and cooperation with indigenous peoples take specific measures to protect indigenous children from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development, taking into account their special vulnerability and the importance of education for their empowerment.

3. Indigenous individuals have the right not to be subjected to any discriminatory conditions of labour and, inter alia, employment or salary.

Article 18 Choose Own Representatives for Decision Making on Rights

Article 18

Indigenous peoples have the right to participate in decision-making in matters which would affect their rights, through representatives chosen by themselves in accordance with their own procedures, as well as to maintain and develop their own indigenous decision-making institutions.

Article 19 States to Consult Cooperate in Good Faith & Obtain Free Prior Informed Consent

Article 19

States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them.

Article 20 (1) Maintain & Develop own Political Economic Social Systems

Article 20 (2) Full Fair Redress if Deprived of Means of Subsistence Development

Article 20

1. Indigenous peoples have the right to maintain and develop their political, economic and social systems or institutions, to be secure in the enjoyment of their own means of subsistence and development, and to engage freely in all their traditional and other economic activities.

2. Indigenous peoples deprived of their means of subsistence and development are entitled to just and fair redress.

Article 21 (1) Improve Economic & Social Conditions

Article 21 (2) States to Ensure (1) with Special Measures if need be

Article 21

1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.

2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities

.Article 22 (1) Particular attention to Elders Women Youth Children Disabilities

Article 22 (2) States to Protect Women Children against Violence Discrimination

Article 22

1. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration.

2. States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination.

Article 23 Determine Develop Priorities Strategies for Development

Article 23 Be Actively Involved Develop Determine Health Housing Other Programs

Article 23 Deliver Programs Through Own Institutions As Far as Possible

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24 (1) Traditional Medicines, Access all Social Health Services

Article 24 (2) Highest Attainable Physical Mental Health, States to Support

Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Article 25 Maintain Strengthen Spiritual Link with Lands Waters Seas for Future

Article 25

Indigenous peoples have the right to maintain and strengthen their distinctive spiritual relationship with their traditionally owned or otherwise occupied and used lands, territories, waters and coastal seas and other resources and to uphold their responsibilities to future generations in this regard.

Article 26 (1) Lands and Territories Resources

Article 26 (2) Own Use Develop Control Lands Territories Resources

Article 26 (3) State to Legally Recognise Lands Territories Resources Respectfully

Article 26

1. Indigenous peoples have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired.

2. Indigenous peoples have the right to own, use, develop and control the lands, territories and resources that they possess by reason of traditional ownership or other traditional occupation or use, as well as those which they have otherwise acquired.

3. States shall give legal recognition and protection to these lands, territories and resources. Such recognition shall be conducted with due respect to the customs, traditions and land tenure systems of the indigenous peoples concerned.

Article 27 Fair Open Independent Process to Adjudicate Land Rights

Article 27

States shall establish and implement, in conjunction with indigenous peoples concerned, a fair, independent, impartial, open and transparent process, giving due recognition to indigenous peoples' laws, traditions, customs and land tenure systems, to recognize and adjudicate the rights of indigenous peoples pertaining to their lands, territories and resources, including those which were traditionally owned or otherwise occupied or used. Indigenous peoples shall have the right to participate in this process.

Article 28 (1) Restitution or Just Compensation for Lands

Article 28 (2) Compensation is Equivalent Land or Money unless Agreed not

Article 28

1. Indigenous peoples have the right to redress, by means that can include restitution or, when this is not possible, just, fair and equitable compensation, for the lands, territories and resources which they have traditionally owned or otherwise occupied or used, and which have been confiscated, taken, occupied, used or damaged without their free, prior and informed consent.

2. Unless otherwise freely agreed upon by the peoples concerned, compensation shall take the form of lands, territories and resources equal in quality, size and legal status or of monetary compensation or other appropriate redress.

Article 29 (1) Conservation Protection of Lands Resources

Article 29 (2) States not to Dump Hazardous Waste without Consent

Article 29 (3) States to Monitor Maintain Restore Health as needed

Article 29

1. Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. States shall establish and implement assistance programmes for indigenous peoples for such conservation and protection, without discrimination.

2. States shall take effective measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples without their free, prior and informed consent.

3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

Article 30 (1) No Military Use of Lands Unless Significant Threat or Agreed

Article 30 (2) States to Consult Effectively before Military Use

Article 30

1. Military activities shall not take place in the lands or territories of indigenous peoples, unless justified by a significant threat to relevant public interest or otherwise freely agreed with or requested by the indigenous peoples concerned.

2. States shall undertake effective consultations with the indigenous peoples concerned, through appropriate procedures and in particular through their representative institutions, prior to using their lands or territories for military activities.

Article 31 (1) Maintain Control Protect Cultural Property

Article 31 (2) States to Recognize Protect Cultural Property Rights

Article 31

1. Indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions.

2. In conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights.

Article 32 (1) Determine Develop Priorities Strategies for Use of Lands

Article 32 (2) States to Consult Cooperate to Obtain Consent for Land Use

Article 32 (3) States to Provide Effective Mechanisms for Just Fair Redress

Article 32

1. Indigenous peoples have the right to determine and develop priorities and strategies for the development or use of their lands or territories and other resources.

2. States shall consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free and informed consent prior to the approval of any project affecting their lands or territories and other resources, particularly in connection with the development, utilization or exploitation of mineral, water or other resources.

3. States shall provide effective mechanisms for just and fair redress for any such activities, and appropriate measures shall be taken to mitigate adverse environmental, economic, social, cultural or spiritual impact.

Article 33 (1) Determine Own Identity without Loss of Citizenship

Article 33 (2) Determine Structure membership of Own Institutions

Article 33

1. Indigenous peoples have the right to determine their own identity or membership in accordance with their customs and traditions. This does not impair the right of indigenous individuals to obtain citizenship of the States in which they live.

2. Indigenous peoples have the right to determine the structures and to select the membership of their institutions in accordance with their own procedures.

Article 34 Promote Develop Maintain Own Institutions & Law

Article 34

Indigenous peoples have the right to promote, develop and maintain their institutional structures and their distinctive customs, spirituality, traditions, procedures, practices and, in the cases where they exist, juridical systems or customs, in accordance with international human rights standards.

Article 35 Determine Responsibilities of Individuals to Communities

Article 35

Indigenous peoples have the right to determine the responsibilities of individuals to their communities.

Article 36 (1) Maintain Develop Contacts Across State Borders

Article 36 (2) States to Consult Facilitate Contacts Across State Borders

Article 36

1. Indigenous peoples, in particular those divided by international borders, have the right to maintain and develop contacts, relations and cooperation, including activities for spiritual, cultural, political, economic and social purposes, with their own members as well as other peoples across borders.

2. States, in consultation and cooperation with indigenous peoples, shall take effective measures to facilitate the exercise and ensure the implementation of this right.

Article 37 (1) Recognition Observance Enforcement of Treaties

Article 37 (2) UN-DRIP not to Reduce Existing Treaty Rights

Article 37

1. Indigenous peoples have the right to the recognition, observance and enforcement of treaties, agreements and other constructive arrangements concluded with States or their successors and to have States honour and respect such treaties, agreements and other constructive arrangements.

2. Nothing in this Declaration may be interpreted as diminishing or eliminating the rights of indigenous peoples contained in treaties, agreements and other constructive arrangements.

Article 38 States to Consultatively Implement UN-DRIP including Law

Article 38

States in consultation and cooperation with indigenous peoples, shall take the appropriate measures, including legislative measures, to achieve the ends of this Declaration.

Article 39 States to Support UN-DRIP Financially Technically

Article 39

Indigenous peoples have the right to have access to financial and technical assistance from States and through international cooperation, for the enjoyment of the rights contained in this Declaration.

Article 40 Access to Prompt Just Fair Resolution Remedies for Infringement

Article 40

Indigenous peoples have the right to access to and prompt decision through just and fair procedures for the resolution of conflicts and disputes with States or other parties, as well as to effective remedies for all infringements of their individual and collective rights. Such a decision shall give due consideration to the customs, traditions, rules and legal systems of the indigenous peoples concerned and international human rights.

Article 41 UN to Support Implementation of UN-DRIP

Article 41

The organs and specialized agencies of the United Nations system and other intergovernmental organizations shall contribute to the full realization of the provisions of this Declaration through the mobilization, inter alia, of financial cooperation and technical assistance. Ways and means of ensuring participation of indigenous peoples on issues affecting them shall be established.

Article 42 UN Agencies States to Promote Monitor UN-DRIP

Article 42

The United Nations, its bodies, including the Permanent Forum on Indigenous Issues, and specialized agencies, including at the country level, and States shall promote respect for and full application of the provisions of this Declaration and follow up the effectiveness of this Declaration.

Article 43 UN-DRIP is Minimum Standard for Survival Dignity Well-being

Article 43

The rights recognized herein constitute the minimum standards for the survival, dignity and well-being of the indigenous peoples of the world.

Article 44 UN-DRIP Applies Equally to Males Females

Article 44

All the rights and freedoms recognized herein are equally guaranteed to male and female indigenous individuals.

Article 45 UN-DRIP does not Diminish Extinguish Present Future Rights

Article 45

Nothing in this Declaration may be construed as diminishing or extinguishing the rights indigenous peoples have now or may acquire in the future.

Article 46 (1) UN-DRIP not to Impair Territorial Integrity Political Unity of States

Article 46 (2) UN-DRIP operates within International Law and Human Rights

Article 46 (3) UN-DRIP Interpretation Principles incl. Good Governance and Good Faith

Article 46

1. Nothing in this Declaration may be interpreted as implying for any State, people, group or person any right to engage in any activity or to perform any act contrary to the Charter of the United Nations or construed as authorizing or encouraging any action which would dismember or impair, totally or in part, the territorial integrity or political unity of sovereign and independent States.

2. In the exercise of the rights enunciated in the present Declaration, human rights and fundamental freedoms of all shall be respected. The exercise of the rights set forth in this Declaration shall be subject only to such limitations as are determined by law, and in accordance with international human rights obligations. Any such limitations shall be non-discriminatory and strictly necessary solely for the purpose of securing due recognition and respect for the rights and freedoms of others and for meeting the just and most compelling requirements of a democratic society.

3. The provisions set forth in this Declaration shall be interpreted in accordance with the principles of justice, democracy, respect for human rights, equality, non-discrimination, good governance and good faith.

APPENDIX : The Health of the People in NSW, 1788 - 2007

Surgeon Worgan's Report on Aboriginal Health, 18 January - 11 July, 1788

Sirius,
Sydney Cove, Port Jackson
June 12th 1788.

Dear Richard.

I think I hear You saying, "Where the D—ce is Sydney Cove Port Jackson"? and see You whirling the Letter about to find out the Name of the Scribe: if so, pray spare your Labour, and attend to Me for half an Hour- …

July 11th 1788

… Having now given You some Account of what these Wildernesses are formed, I'll say a Word or two of their Inhabitants …

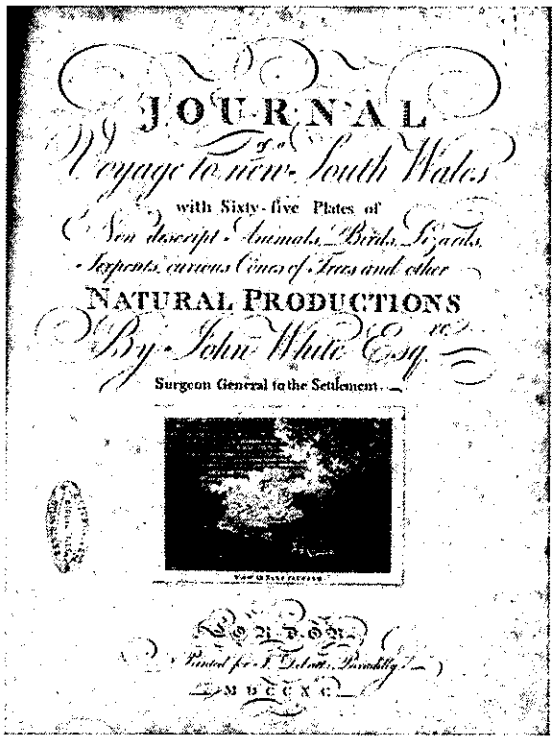
.. They seemingly enjoy uninterrupted Health, and live to a great Age …

Believe Me your very affectionate Brother

G B Worgan

Dr George Worgan was the Surgeon of the *Sirius,* the flagship of the First Fleet.

Surgeon-General White's Report[64] on non-Aboriginal Health, December 1786 - July 1788


JOURNAL
of a
Voyage to new South Wales
with Sixty-five Plates of
Non descript Animals, Birds, Lizards,
Serpents, curious Cones of Trees and other
NATURAL PRODUCTIONS
By John White Esq. &c.
Surgeon General to the Settlement.
MDCCXC

DEATHS BETWEEN DECEMBER 1786 AND JULY 1788

On the Passage
- Marines 1
- Marines' Wives 1
- Marines' Children 1

After the Landing
- **Marines 3**
- **Marines' Children 2**
- **Total 8**

On the Passage
- Male Convicts 36
- Female Convicts 4
- Convicts' Children 5

After the Landing
- **Male Convicts, including two murdered 22**
- **Female Ditto 8**
- **Convicts' Children 9**
- **Total 84**

Executed, by a sentence of the Criminal Court 4

Condemned to death by the Court, but pardoned by the Governor 6

Missing, including one Female 9

ESTABLISHMENT OF NEW SOUTH WALES

CIVIL DEPARTMENT

ARTHUR PHILLIP, Esq., Governor in Chief, Captain General etc. etc.

ROBERT ROSS, Esq., Lieut. Governor, and Commander of the Troops.

REV. RICHARD JOHNSON, Chaplain.

ANDREW MILLER, Commissary, and Secretary to his Excellency.

DAVID COLLINS, Judge Advocate.

JOHN WHITE, Surgeon.

D. CONSIDEN, First Assistant Ditto.

THOMAS ARNDELL, Second Ditto Ditto.

WILLIAM BALMAIN, Third Ditto Ditto.

WILLIAM BREWER, Provost Marshal.

H. T. AUGUSTUS ALT, Esq. Surveyor of Lands.

MILITARY DEPARTMENT

Captains JAMES CAMPBELL. JOHN SHEA.

Capt. Lieutenants MEREDITH. WATKIN TENCH.

First Lieutenants

G. JOHNSTON. JOHN CRESSWELL.

ROBERT KELLOW. JOHN POULDEN.

JOHN JOHNSTON. JAMES MAITLAND SHAIRP

THOMAS TIMMINS. THOMAS DAVY.

Second Lieutenants CLARKE. WILLIAM FEDDY.

JOHN LONG, Adjutant.

First Lieutenant JAMES FURZAR, Quartermaster.

First Lieutenant JAMES MAXWELL,

Second Lieutenant COLLINS

[Maxwell and Collins]

Returning to Europe for the recovery of their health.

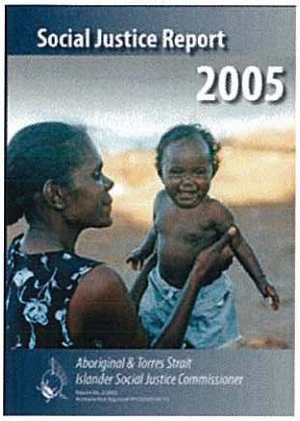
[64] *Journal of a Voyage to New South Wales, with sixty-five plates of non descript animals, birds, lizards, serpents, curious cones of trees and other natural productions* by John White Esquire, (1757/8-1832) Surgeon-General to the [First Fleet and the] Settlement [at Port Jackson] 1790.

Two Ways Together Indicator Report 2007 : Health Summary

Health

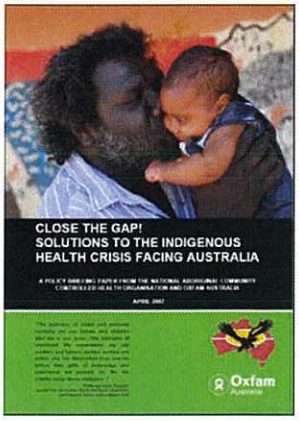
- Aboriginal people have a shorter life expectancy than the population as a whole. Aboriginal males in NSW have an average life expectancy of 60 years, 16.4 years less than all NSW males, and Aboriginal females in NSW have an average life expectancy of 65.1 years, 16.8 years less than all NSW females.
- The infant mortality rate for NSW Aboriginal infants, at 8.4 per 1,000 live births, is 79% higher than the total infant mortality rate. However, there has been a significant reduction in the gap between Aboriginal and total infant mortality rates. Part of this reduction in infant mortality may be attributable to the increasing percentage of Aboriginal expectant mothers making antenatal visits to health professionals within the first 20 weeks of pregnancy.
- Aboriginal people are more likely to report their health status as fair or poor than are non-Aboriginal people, and are more likely to report three or more long term health conditions. Hospitalisations for long term conditions, including diabetes and cardiovascular disease are higher for Aboriginal people than for the total NSW population and the gap in hospitalisation rates between the Aboriginal and total populations is increasing.
- While there is no significant difference in the percentage of Aboriginal and non-Aboriginal people who report engaging in risky alcohol consumption, Aboriginal people are 2 to 3 times more likely to be treated in hospital for alcohol related trauma or disease, and almost 5 times more likely to account for closed treatment episodes in drug and alcohol treatment programs. The gap in hospitalisation and treatment rates for the Aboriginal and total population is increasing.
- More than a quarter of Aboriginal people report high or very high levels of psychological distress, around twice the level of non Aboriginal people. The hospitalisation rate for self harm is 2.7 times higher for Aboriginal people than for the whole population, and the gap is increasing.
- Hospitalisation rates for whooping cough, measles and influenza in the Aboriginal population have fallen and are now level with the general population rate. However, other conditions that are generally amenable to prevention and early intervention through primary health care, including injury and poisoning, otitis media and dental disease, account for increasing hospitalisation rates for Aboriginal people.
- Hospitalisation rates for cardiovascular disease, diabetes, injury and poisoning, alcohol trauma and ambulatory care sensitive conditions are far higher in the Western NSW RCMG region, though these rates have been falling, in contrast to other regions, where rates have generally been rising. This may be associated with improved access to primary care in the Western region although no data on primary care services are available.

Planning To Close Gaps, 2005 - 2006 - 2007

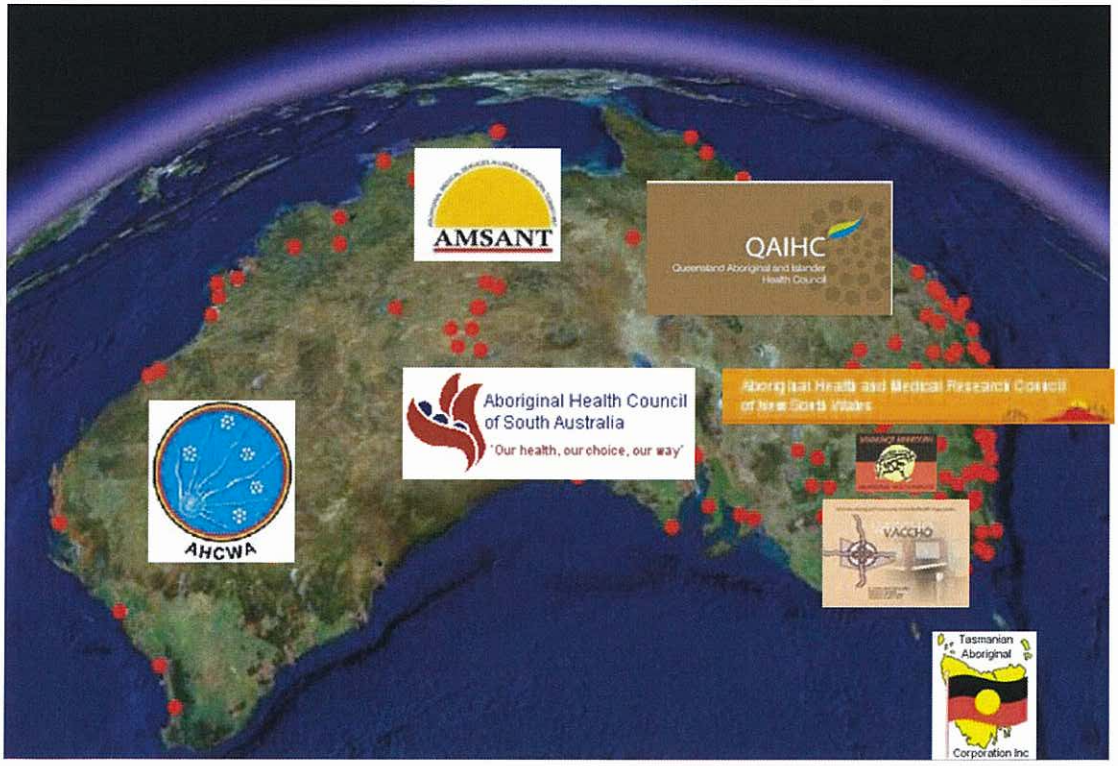


2006 – Second meeting – 14th July - Indigenous Issues Generational Commitment

COAG agreed that a long-term, generational commitment is needed to overcome Indigenous disadvantage. COAG agreed the importance of significantly closing the gap in outcomes between Indigenous people and other Australians in key areas for action as identified in the Overcoming Indigenous Disadvantage: Key Indicators Report (OID) released by COAG in 2003.

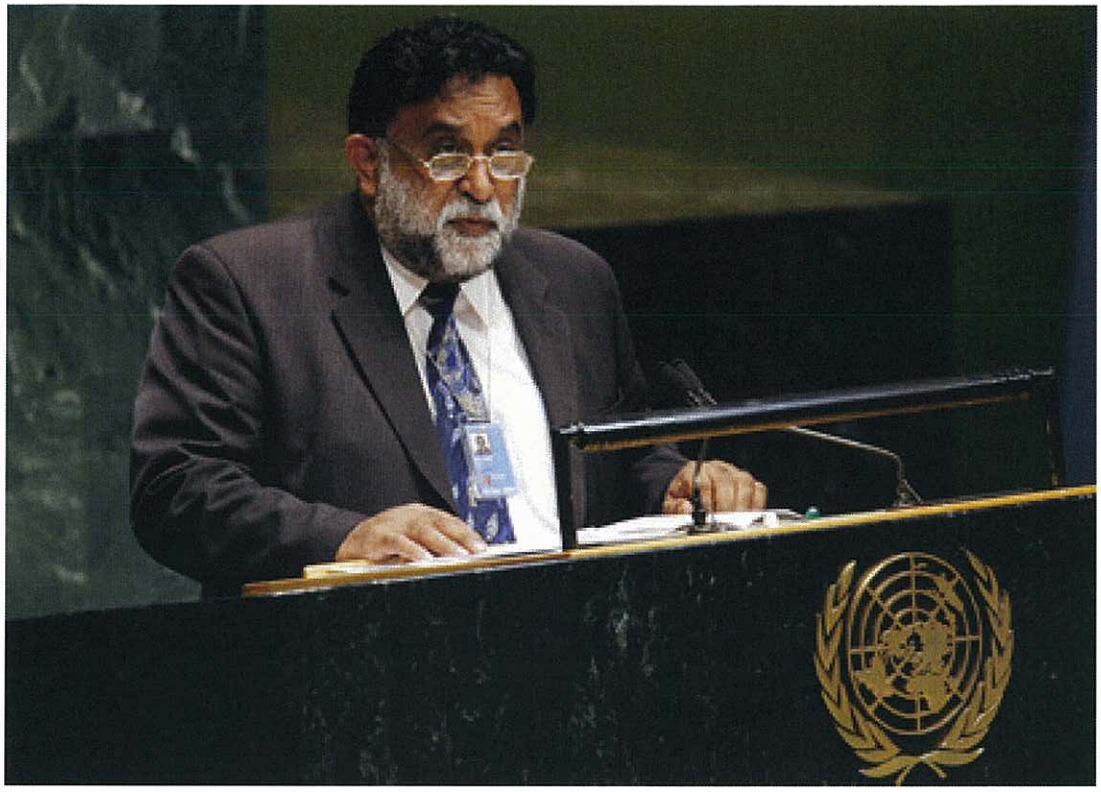


These pictures acknowledge the contribution of Mr Tom Calma in providing a specific vision for the achievement of Aboriginal social justice within a defined time-frame in his 2005 report; of the Council of Australian Governments in adopting the broader objective in closing all gaps; and of NACCHO and Oxfam Australia in promoting the Close The Gap initiative.



This picture acknowledges the National Aboriginal Community Controlled Health Organisation and its State Affiliates and members who have been working to close gaps since AMS Redfern opened on 29th July 1971.

The Right & Responsibility To Close Gaps, 13th September 2007



Mr Les Maleza thanking the 144 States who voted to endorse the United Nations Declaration on the Rights of Indigenous peoples, on behalf of the Global Indigenous Caucus, UN General Assembly, 13th September 2007

The *UN Declaration on the Rights of Indigenous Peoples* has set *"minimum standards for the survival, dignity and well-being of the indigenous peoples of the world".*

Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

APPENDIX : The Health of the People in NSW, 2008+

The AHMRC Aboriginal Health College, 29th January 2008

These pictures show the location[65] and model of the building for the AHMRC Aboriginal Health College on the former Prince Henry Hospital site, and her Excellency Professor Marie Bashir, AC, CVO, Vice Regal Patron of the College, at the site dedication on 29 January 2008 with the CEO of the AHMRC Secretariat, Sandra Bailey CM.

Contact

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- Anthony Carter A/Workforce Implementation Policy Officer acarter@ahmrc.org.au
- Terry Smith Manager Education and Training tsmith@ahc.edu.au

Phone 02 9212 4777

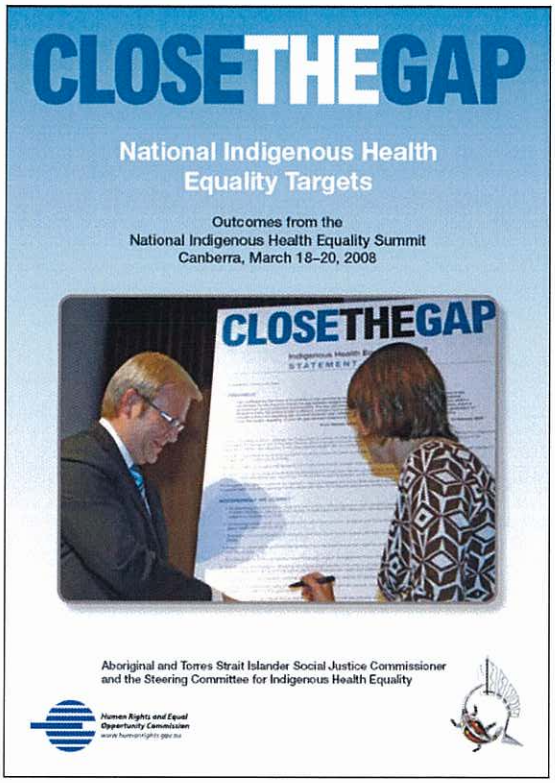
[65] Map: http://www.wikimapia.org/#lat=-33.9839545&lon=151.2460542&z=17&l=0&m=h&v=1

The Apology, 13th February 2008-08

Our challenge for the future is to embrace a new partnership between Indigenous and non-Indigenous Australians. The core of this partnership for the future is closing the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities. This new partnership on closing the gap will set concrete targets for the future: within a decade to halve the widening gap in literacy, numeracy and employment outcomes and opportunities for Indigenous children, within a decade to halve the appalling gap in infant mortality rates between Indigenous and non-Indigenous children and, within a generation, to close the equally appalling 17-year life gap between Indigenous and non-Indigenous when it comes to overall life expectancy.

The Prime Minister, the Hon. Kevin Rudd MP
Apology to Australia's Indigenous Peoples,
13 February 2008

The National Indigenous Health Equity Targets, March 15th-20th, 2008



1. Partnership Targets

This is a statement of intent – between the Government of Australia and the Aboriginal and Torres Strait Islander Peoples of Australia, supported by non-Indigenous Australians and Aboriginal and Torres Strait Islander and non-Indigenous health organizations – to work together to achieve equality in health status and life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by the year 2030.

We recognise that specific measures are needed to improve Aboriginal and Torres Strait Islander peoples' access to health services. Crucial to ensuring equal access to health services is ensuring that Aboriginal and Torres Strait Islander peoples are actively involved in the design, delivery, and control of these services.

We commit: To ensuring the full participation of Aboriginal and Torres Strait Islander peoples and their representative bodies in all aspects of addressing their health needs.

2. Health Status Targets

We share a determination to close the fundamental divide between the health outcomes and life expectancy of the Aboriginal and Torres Strait Islander peoples of Australia and non-Indigenous Australians.

The NSW Aboriginal Health Partnership Agreement, 30th April 2008

The Guiding Principles in NSW, 2008 - 2013

- The Aboriginal Health and Medical Research Council of NSW (AH&MRC) and the NSW Government, through its health portfolio, are equal members of the NSW Aboriginal Health Partnership (Partnership) established in 1995.
- The Partnership adheres to the principles espoused in the *National Aboriginal Health Strategy 1989* and continued in the *National Strategic Framework for Aboriginal and Torres Strait Islander Health - a Framework for Action by Governments*. In particular, the parties commit themselves to the practical application of the principles of Aboriginal peoples' self-determination, a partnership approach and the importance of inter-sectoral collaboration.
- The Partnership is also informed by the *Overarching Agreement on Aboriginal Affairs between the Commonwealth of Australia and the State of New South Wales;* the *NSW State Plan*, the *NSW State Health Plan* and the *NSW Aboriginal Affairs Plan Two Ways Together*.
- The Partnership acknowledges the principles in the *UN Declaration on the Rights of Indigenous Peoples* and the national targets for closing the gap in life expectancy, child mortality and other aspects of health inequity.