

Submission to the
House of Representatives
Standing Committee on Family and Community Affairs
Inquiry Into Indigenous Health

October 1997

Term of Reference a)

Ways to achieve effective Commonwealth coordination of the provision of health and related programs to Aboriginal and Torres Strait Islander communities, with particular emphasis on the regulation, planning, and delivery of such services.

Regional Planning

Congress seeks open and collaborative relationships with all levels of government, particularly when it comes to the planning of health service delivery. It is in the area of regional planning, we believe, that the current system can best be improved.

We have, either by ourselves or in conjunction with other community controlled health services in the Northern Territory put forward a model of planning that includes all major players: the Commonwealth government (Department of Health and Family Services / ATSIC), the Territory Government (Territory Health Services), and the non-government sector (Aboriginal Medical Services Alliance Northern Territory)¹.

This forum for the “key players” must be organised on a regional level – in the Northern Territory, for example, there would be two regions, Central Australia and the Top End – and provided with a competent secretariat and enough resources to allow regular meetings. **These regional forums would provide the basis for planning of health service delivery, and would ensure that both levels of government and the non-government sector would be “pulling in the same direction.”** This would prevent the kind of situation currently occurring in Central Australia with petrol-sniffing funding – around half-a-dozen reports, projects and committees have been established with little or no coordination between them, without the benefit of in-depth health experience, and with little prospect (in our view) of making any long-term impact on the problem.

¹ See for example: Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), *The Way Forward*. Unpublished paper 1995

Territory Level Planning: the necessity of Framework Agreements

In our view, one of the most important things undertaken by the Commonwealth Department since it accepted responsibility for Aboriginal and Torres Strait Islander health is the development of framework agreements for each State and Territory. These agreements set out the roles and responsibilities of the key players in Aboriginal health – the Commonwealth, the State / Territory, and the community-controlled sector. They establish clear funding and accountability processes, and are essential for unravelling the “bureaucratic maze” that has grown up around Aboriginal health administration.

The Victorian experience is instructive here: the Framework Agreement for that state has recently led to a collaborative approach between the major players, a welcome change from the governmental buck-passing and conflict that all too often characterises Aboriginal health.

What is of most concern to Congress is that **the Northern Territory Government refuses to sign a Framework Agreement**. The NT Health Minister, Denis Burke has refused to sign the Agreement with the Aboriginal Medical Services Alliance Northern Territory² (AMSANT) because he asserts that AMSANT is “not representative”. This misses the point. The community controlled health services do not claim to represent everyone; instead, they claim unparalleled experience in the field of Aboriginal primary health care and an understanding of the principles that must underlie successful service delivery. It is on the basis of this experience and understanding that AMSANT and its members have been successful. Also important is the fact that community controlled health services do not just represent the people of the communities in which they are based. On the one hand, they provide services to people from all over Central Australia. On the other, in Congress’ case at least, Aboriginal people from anywhere in Central Australia can vote in the AGM and be elected to the Cabinet. Thus, while we do not speak for everyone, we speak with the authority that comes from experience and from genuine and direct accountability to the community.

The Framework Agreements form the basis of an open and collaborative approach between the major players in Aboriginal health. **If the Commonwealth Government wishes to see an open and collaborative approach to solving the problems of Aboriginal health, then they must provide leadership to ensure that the Northern Territory Government signs the Framework Agreement.**

National Level Planning: the National Aboriginal and Torres Strait Islander Health Council

The National Aboriginal and Torres Strait Islander Health Council (NATSIHC) is an important forum at the national level to strengthen cooperation between government and the community in the field of Aboriginal health. While the Council is still in its infancy, we believe it needs to be strengthened in the following ways:

1. The Chairperson of the National Aboriginal Community Controlled Health Organisations (NACCHO) should represent NATSIHC as an observer at AHMAC meetings. This would help maintain Aboriginal health as a priority at the highest levels.
2. There should be a requirement for all Divisions of the Commonwealth Department of Health and Family Services to report annually in writing to NATSIHC on their particular activities to

² AMSANT was established in October 1994 to represent the dozen community controlled health services in the Northern Territory. The organisation has been very active in lobbying for healthy public policy, and played a leading role in campaigning for the transfer of responsibility of Aboriginal health to Commonwealth Health. Congress is a leading member of AMSANT.

improve Aboriginal health. This would encourage all parts of the Department to see Aboriginal health as part of their responsibility, rather than adopting the view (apparently widely held at the moment) that OATSIHS alone deals with Aboriginal health matters.

Term of Reference (b)

Barriers to access to mainstream health services, to explore avenues to improve the capacity and quality of mainstream health service delivery to Aboriginal and Torres Strait Islander people and the linkages between Aboriginal and Torres Strait Islander and mainstream services.

Primary, Secondary and Tertiary Care

A source of considerable confusion in the past has been the distinction between primary, secondary and tertiary health care. Without a clear distinction between these levels of care, it is easy for confusion also to arise over who is responsible for the delivery and / or funding of each of these levels. Congress' position is relatively simple and based upon our own experience, and such international documents as the *Alma Ata Declaration*³.

Primary health care is the first point of contact between the general population and the health care system. Note that primary health care has a more narrow definition – which we would call selective primary health care – in which the focus is on specific technical / medical interventions that aim to address specific health issues. As such it largely focuses on treating individual, generally acute medical conditions. It forms only a part of *comprehensive primary health care* which has a broader, holistic approach to health problems and (to quote the *Alma Ata Declaration*):

includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.

For mainstream Australia, primary health care is provided overwhelmingly by private general practitioners, although this is generally of the narrower, selective rather than the broader comprehensive approach. In the field of Aboriginal health, as has been recognised by all major investigations into the health of our people⁴, it is comprehensive primary health care that is the most appropriate model for addressing Aboriginal ill health. As such, it is the recognised right of Aboriginal communities to maximise their participation in the design and running of primary health care services. Maximum participation (as recommended by the *Alma Ata Declaration*) can be defined as *community control*, as embodied by community controlled health services such as Congress.

It needs hardly be explained that this emphasis on Aboriginal community control of services is not an ideological but a practical position. Non-Aboriginal bureaucracies, even where they

³ *Declaration of the International Conference on Primary Health Care, Alma-Ata (1978).*

⁴ See, for example, the *National Aboriginal Health Strategy (1989)*, the *Royal Commission Into Aboriginal Deaths In Custody (1990)*, the *Second Report of the Aboriginal and Torres Strait Islander Social Justice Commissioner (1994)*, *Report into the Stolen Generation (1997)*

employ Aboriginal staff, do not have a good record in dealing with the health and social problems of Aboriginal people, as even the briefest look at the history of health service delivery in Australia shows. Continuing statistics reporting Aboriginal health status comparable only to the poorest of Third World Countries tell the same story.

Note that *the Commonwealth Government accepts responsibility for funding primary health care*. In the mainstream community, it does so through Medicare, thus ensuring community access to general practitioner medicine. For Aboriginal health, the Commonwealth has accepted responsibility for the funding of primary health care delivered by community controlled health services.

Secondary health care is inpatient hospital care. Hospitals are mainstream organisations that have to serve all members of the community. They therefore have the responsibility of ensuring that their care is both accessible and appropriate to all members of the population, including to Aboriginal people. *Secondary level services are the responsibility of the State and Territory administrations.*

Two major points may be made in relation to improving Aboriginal access to mainstream hospital services:

1. The gateway to secondary (hospital) care is generally through primary health care services. Therefore, a major way of improving Aboriginal and Torres Strait Islander access to secondary care is through strengthening primary health care services.
2. For many Aboriginal people, hospitals are frightening and intimidating places, often associated with death and shame. In recent years, hospitals in the Northern Territory have made efforts to become more appropriate to Aboriginal people. However, mainstream services such as hospitals rarely know how to become more appropriate; they can only learn through interaction with the community that they are serving. In our experience, hospitals interaction with Aboriginal controlled health services has proved the most powerful incentive for making their own service more appropriate for our people. Again, therefore, making secondary services appropriate for Aboriginal people is largely dependent on ensuring there is a strong, well-resourced primary health care sector.

Lastly, **tertiary health care is specialist care** generally provided through large teaching hospitals in large urban centres. It includes such areas as coronary artery graft surgery and renal transplantation. *Tertiary level services are jointly the responsibility of the State / Territory and Commonwealth administrations (through Medicare).*

Until the conditions of poverty and disadvantage under which Aboriginal people still live are addressed, it should be expected that a more effective and well-resourced primary health care sector will in fact lead to greater (and not lesser as some argue) use of secondary (hospital) resources. Comprehensive primary health care services are the only services which aim to address holistically the problems facing the Aboriginal community, including those of poverty and lack of access to services. Ultimately, it is only by strengthening the Aboriginal community sector that the health problems of the Aboriginal community can be effectively and permanently prevented.

Term of Reference (c)

The need for improved education of medical practitioners, specialists, nurses and health workers, with respect to the health status of Aboriginal and Torres Strait Islander people and its implications for care.

There is a view amongst some practitioners (as well as possibly amongst some academics, bureaucrats and politicians) that the solution to Aboriginal health problems is simple: that, in effect, there is an easy medical-style “fix” for Aboriginal ill-health. This view is often supported by the popular perception of the success of specific medical interventions in Aboriginal communities for some conditions (for example, trachoma). In addition, the success in containing the HIV/AIDS epidemic is also sometimes cited as a model that can be applied to Aboriginal health. Congress believes both these issues need to be addressed.

Is there a simple medical solution to Aboriginal ill-health?

Unfortunately, there is not. The following points are crucial to a rational and scientific understanding of the health problems facing our people.

1. Over the last thirty years or so, **there have been some important shifts in the nature of Aboriginal ill health.**
2. Over this period, **childhood morbidity (that is, illness) has remained relatively constant.** This is because children are being born and growing up in the same environment of poverty and disadvantage as their parents and grandparents
3. However, **childhood mortality has dropped significantly.** For example, in 1973-75 the Aboriginal infant death rate was approximately 60 to 70 per 1,000 live births; in 1991 the rate was approximately 20 to 25 per 1,000 live births⁵. This improvement is largely due to better access to primary health care services, and through them to secondary (that is, hospital) care.
4. Despite improvements in child mortality, **Aboriginal life expectancy has not improved significantly over the last thirty years.** In some cases, the gap in age-standardised mortality between the Aboriginal population and the Australian population as a whole is widening – in other words, by this measure of health, Aboriginal health is *worsening* relative to the Australia population, not improving⁶.
5. This is because **adult mortality, and in particular young adult mortality, has increased** during this period⁷.
6. **The causes of increased adult mortality are many and various, but in general they are “lifestyle” related.** They are to do with alcohol and other substance abuse, with violence, with dietary and nutrition matters, and with a whole host of psychological, social, economic and political factors, none of which can be addressed by any specific, discrete medical intervention. We reproduce the table below to illustrate this point.

Top five causes of years of potential life lost before age 65 among Aboriginal men and women aged 15 to 64 years in the Northern Territory, 1979-1991.⁸

Men	Total years of potential	Percentage of
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⁵ Bhatia K and Anderson P 1995 *An overview of Aboriginal and Torres Strait Islander health: present status and future trends*. Australian Institute of Health and Welfare. Canberra. See also Kunitz S, ‘Public policy and mortality among Indigenous populations of Northern America and Australasia’ *Population and Development Review* 16(4), 1990.

⁶ Bhatia and Anderson 1995, p32-33

⁷ Bhatia and Anderson 1995, p12-13

⁸ Cunningham, J and Condon, J *Premature mortality in Aboriginal adults in the Northern Territory, 1979-1991* The Medical Journal of Australia 1996, 165 (6): 309-312

	life lost<65	total
1. Motor vehicle accidents	5 994	17%
2. Ischaemic heart disease	3 415	10%
3. Homicide	2 594	8%
4. Pneumonia / Influenza	2 054	6%
5. Rheumatic Heart disease	1 234	4%
Women		
1. Homicide	2 140	11%
2. Rheumatic Heart disease	1 556	8%
3. Motor vehicle accidents	1 428	7%
4. Ischaemic heart disease	1 006	5%
5. Chronic obstructive pulmonary disease (exc. asthma)	943	5%

What this table measures is not what the leading causes of death amongst our people are, but what causes *the most years of life to be lost*. It reflects what many of our people see as the central tragedy of contemporary life in Aboriginal communities: that young-to-middle-aged adults are dying when they have potentially so many years ahead of them.

It must be noted that the only precise medical intervention to prevent any of these conditions is that for pneumococcal pneumonia, which would be only a portion of the fourth most serious causes of years of life lost for Aboriginal men: a vaccine is available to prevent this condition. Apart from that particular and minority case, we can say that **there is no simple, clear-cut medical intervention that prevents any of the top five causes of premature death for Aboriginal men and women.**

Congress believes that any attempt to understand Aboriginal ill health and form policy must be informed by these facts. Without an understanding of these statistics, and without the ability to listen to the voices and experience of Aboriginal people which they support, there is a danger that health practitioners and policy makers at all levels may adopt simplistic and one-dimensional medical solutions to the complex problems of Aboriginal health.

Will the success in the HIV/AIDS field work in Aboriginal health?

There is no doubt that Australia has responded well to the threat by HIV/AIDS to the population in general and to the gay community in particular. The success of this largely health-promotion based campaign has led some to assert that this success can easily be reproduced for Aboriginal health. The role of “experts” in this process has been put forward as central to its success.

First, while we are not experts ourselves on this issue, from what we know there was a considerable amount of community activity over the issue. It was the mobilisation and activism of the gay community in partnership with government and medical expertise that led to the success of Australia’s response to HIV/AIDS.

Second, and much more significant, the Aboriginal and gay communities are not comparable. Relative to Aboriginal people the gay community, in general, is made up of well educated, employed people who, prior to the onset of AIDS, could reasonably expect to live a good quality life into their seventies and beyond. AIDS has dramatically changed this situation and many Gay people respond by changing their behaviour because they want to be able to continue to live the long, enjoyable life they see as normal.

Aboriginal people are unfortunately not in the same situation. Many are living in a chaotic environment often lurching from crisis to crisis. Many are unemployed and have only limited education. Many are not in control of their future. Many are already dying from heart disease, violence, alcohol and diseases of nutrition. AIDS is not the single important threat to their lives. It is only one of a number of serious threats, and a fairly remote one at that. Aboriginal people have become used to living with death and grieving and the addition of one more threat to their health, however serious, is not going to have a great emotional, psychological, or “educational” impact.

Therefore, we believe that some valuable lessons can be learnt from the success of the response to the threat of HIV/AIDS in Australia. However, the lessons are to do with the necessity of building effective and equal partnerships between government, the community, and the medical profession, rather than the sole efforts of any one of these groups.

Term of Reference (d)

The extent to which social and cultural factors and location, influence health, especially maternal and child health, diet, alcohol and tobacco consumption.

Aboriginal “social and cultural factors and location”

There is one point that must be made very strongly. There is no doubt that Aboriginal “social and cultural” factors and “location” *do* influence the health of our people. There is no doubt that factors such as the remoteness of Aboriginal communities, cultural divisions between “men’s business” and “women’s business”, and the fact that many of our people speak English as a second (or third, or fourth) language, pose problems for Western-oriented service delivery. It is equally beyond doubt, however, that **to attempt to change Aboriginal “social and cultural factors and location” is to return to the assimilationist days of the 1950s.**

There is no question of a return to the past, when non-Aboriginal administrations (health or otherwise) attempted to change the inconvenient facts of Aboriginal life to suit their own demands. In the past, if the “location” of Aboriginal people was perceived as a problem, the solution was to change that location: the creation of reserves for our people was the result. If the “culture” was seen to be problem, our traditional language and religion were suppressed. If our

“society” was seen as a problem, than the solution was to remove children from that society: the Stolen Generations.

All this was done supposedly for our own good, because our location, society, or culture was seen as contributing to or causing some particular problem for our own health or welfare. It is essential, therefore, that there is clear recognition that **Aboriginal culture, society and community are given, and that non-Aboriginal structures have no part in determining or changing them; further, these facts of Aboriginal life should be actively supported as an integral part of the human rights of our people.**

We recognise that how and where our people live can cause contradictions and problems for Western-style service delivery: *hence the importance of those services being under Aboriginal control*. It is only when health services are under our own control that we can work out the contradictions between our traditional ways of life and those of the non-Aboriginal system on our own terms. The only alternative is to have “solutions” to these contradictions imposed upon us, solutions that have in the past required our people to give up their identity to fit in with the requirements of an alien system.

Strategies to tackle substance misuse

Substance misuse of all kinds (especially in the Northern Territory alcohol and petrol sniffing) are a major health problem for our people, strongly associated with the major cause of life years lost (see above).

Substance misuse and its attendant problems result from the dispossession, disempowerment and alienation of our people since the colonisation of Australia. **There is no one simple solution to this problem amongst our people.** Instead, whatever assists our people to have greater responsibility for and control over our own lives, will be contributing to the struggle against substance misuse.

A number of more specific points are:

- **Top Down versus bottom up strategies:** Congress argues that “community-based” programs addressing the health of our people should be under the control of our communities, *to the maximum extent desired by those communities*. Of course, this approach has the support of modern public policy, in the form of the National Aboriginal Health Strategy and the Royal Commission Into Aboriginal Deaths In Custody.

It is for this reason that Congress believes that the supporting of *Aboriginal community-controlled initiatives to address alcohol and other substance misuse must be given priority over government or other non-Aboriginal organisations*.

- **Improved Access to Primary Health Care Services.** Access for all our people to a well-resourced network of primary health care services is an essential basic requirement for our health to improve. This is especially true for our people who are misusing substances such as alcohol, petrol and tobacco for several reasons. First, a basic level of health care must be available to protect the health (as far as is possible) of those who are drinking, sniffing, smoking, etc. Second, there is now strong evidence that brief opportunistic interventions by doctors and other health professionals in the context of treatment for an associated clinical illness are as effective as mass media and public education strategies. Finally, primary health care services are the gateway, to a whole range of other health-related services; they play an important role in ensuring that our people are able to access other more specialised services.

- **Alcohol strategies of little or no proven benefit.** Recently (1995) the World Health Organisation (WHO) asked a team of leading experts on public health policy and alcohol issues to examine alcohol misuse strategies: the result was *Alcohol policy and the public good* (1995)⁹, probably the most up-to-date and comprehensive examination of the area. On the subject of school-based education, public education, warning labels, and advertising restrictions, they conclude (page 208) that:

There is no present research evidence which can support their deployment as lead policy choices or justify expenditure of major resources on school-based education or mass media public education campaigns, unless these are placed in the broader context of community action.(emphasis added)

Congress believes that continuing to place a strong emphasis on these types of strategies is wasting precious resources and failing to address the problem. Lastly, we call upon all people of good-will, both within and outside government, to back Aboriginal people in their continuing struggle for health and social justice. Alcohol abuse and the social disruption it causes will undoubtedly continue unless our efforts to take responsibility for the problem are supported.

- **Land and the Stolen Generation.** It is clear that much substance abuse amongst our people arises from poverty, dispossession and profound feelings of despair, anger, and alienation. Central to these feelings are the removal of people from their land and from their families. Without proper settlement of these injustices, this pattern will continue. Therefore Congress believes that a just, negotiated settlement of all Native Title claims and the immediate implementation of the recommendations of the Stolen Generation report are essential for the long-term health and well-being of our people.

Term of Reference (e)

The extent to which Aboriginal and Torres Strait Islander health status is affected by educational and employment opportunities, access to transport services and proximity to other community supports, particularly in rural and remote communities.

Community controlled health services have long recognised the links between poor health and the poverty in which so many of our people are forced to live. The poverty experienced by many of our people in Central Australia is economic – many people live without any income beyond that provided to them by their extended family, others are dependent on government pensions, a few obtain poorly paid and often intermittent employment, and fewer still find relatively well-paid and/or permanent jobs, almost always with Aboriginal community organisations. Unemployment on some communities runs as high as 80% to 90%. Under these conditions, sheer lack of money puts many families in a very vulnerable position as far as their health is concerned.

However, the poverty experienced by Aboriginal people is not just measurable in terms of individual income – it is also reflected in lack of access to the kind of resources that other Australians take for granted. Education is a good example: very few of the remote communities in Central Australia provide schooling for children beyond primary age. To obtain secondary schooling, most have to board in Alice Springs, with consequent separation from land and family. Unsurprisingly given the importance of family and country to Aboriginal people, many teenagers

⁹ Edwards G, Anderson P, Babor T, et al. *Alcohol Policy and The Public Good*. World Health Organisation, Oxford University Press, 1995

and their families are not prepared to make this move. As a result, for example, during the whole of 1996 only one Aboriginal person passed Year 12 in Central Australia. Given the well established link between education levels and future employment what hope do many of our kids have to get work?

Access to other services – from communication to housing, transport to health, aged care to electricity, water and sewerage – is similarly poor. All these things, which other Australians take for granted as part of their rights of citizenship, are either unavailable or difficult to access for many of our people.

The National Aboriginal Health Strategy and Royal Commission Into Aboriginal Deaths In Custody recognised the links between lack of infrastructure and social services and poor health in the Aboriginal community. Unfortunately, some organisations and individuals have interpreted the link between poor infrastructure and poor health in such a way as to conclude that all that is needed to improve Aboriginal health is better infrastructure on Aboriginal communities. Therefore, several important points must be made about infrastructure on Aboriginal communities.

1. **Unless infrastructure is both appropriate and maintained, it can end up causing health problems** on Aboriginal communities. For example, if houses are built, but they are not appropriate to the needs and culture of our people, they will not be used. At best, they are a waste of money. But if, in addition, no money has been allocated for maintenance of these houses, blocked toilets, broken windows, exposed electrical wiring and other hazards will soon occur, making the house a less, rather than a more, healthy place for people to live. Aboriginal comprehensive primary health care services are vital to ensure that physical infrastructure developments in Aboriginal communities do not create worse health problems than they solve.
2. **However good the physical and other infrastructure is, people still get sick.** Wealthy non-Aboriginal people living in the best suburbs of the most well-resourced cities in Australia still need (and have the right) to access health services, even if only occasionally. The same is true for Aboriginal people on remote communities – they still have the right to access primary health care services, whatever the state of infrastructure on their communities.
3. The situation for our people in terms of employment, education and access to services and physical infrastructure is so poor that it will realistically take years to bring these areas up to a standard that would be acceptable to the rest of Australia. In the meantime, **primary health care services are essential to address the additional ill health burden of the community** in the short and the long terms.

Term of Reference (f)

The extent to which past structures for delivery of health care services have contributed to the poor health status of Aboriginal and Torres Strait Islander people.

Congress, both on its own behalf and as a member of AMSANT, has argued and written extensively on the effects of “the bureaucratic maze” on effective and efficient delivery of primary health care. We were particularly concerned about the limited capability of ATSIC to properly address this area. In brief: ATSIC lacked expertise in health matters; had often to address “acute” issues such as Mabo and Reconciliation, leaving “chronic” problems like health at the bottom of the pile; Regional Councils were given much responsibility but few resources to tackle the problem; and ATSIC often became a source of conflict rather than collaboration between different sectors of the Aboriginal community.

We have also long been concerned about both the capacity and the commitment of the Northern Territory government to address Aboriginal health. As we have seen with the recent election, race is highly politicised in the Northern Territory; this is not the best atmosphere in which to attempt to address Aboriginal health issues. Attempts at cooperation often get caught up in narrow political agendas; witness the recent conflict over the “Framework Agreement” in the Territory, where the NT Government remains the only mainland administration to refuse to sign an agreement that would begin to put in place the structures of accountability and cooperation between stakeholders that is an essential background to improvements in Aboriginal health.

Against this background, **the formation of Office of Aboriginal and Torres Strait Islander Health Services within Commonwealth Health, and consequent direct funding from Canberra, has proved a positive step.** The funding of community controlled health services is now more secure. Needless to say, more funds are needed – despite the common mis-perception, Aboriginal health has not been deluged with funds. The current system is not perfect – most importantly, the regional basis for health planning has not been resourced – but the new administrative arrangements continue to be an improvement on the old. Most important is to keep the process moving forwards. Any step backwards – devolving responsibility for Aboriginal health to States and Territories – would, we believe, be disastrous and will only be reflected in the continuing (and even worsening) ill health of Aboriginal and Torres Strait Islander people.

Cross Program Coordination

The transfer of Aboriginal health responsibility to the Commonwealth Department of Health and Family Services has improved access to resources for vital Aboriginal primary health care services. Nevertheless, there is a need to ensure that, building on this change, resources within Commonwealth Health are allocated in a manner which reflects the fact that continuing (or even worsening) Aboriginal ill-health is the most serious health problem facing Australia today. A number of specific strategies will be required:

- **Medical Benefits / Pharmaceutical Benefits.** While we welcome the recent changes to the Health Insurance Commission’s legislation enabling Aboriginal medical services to access MBS and PBS funds, further action will be required to address the inequitable distribution of Medicare and PBS funds to our people, resulting from the low proportion of health services provided by general practitioners in Aboriginal communities.
- **General Practice Strategy.** In the design and implementation of this strategy, the interests of Aboriginal people and community controlled health services has largely been ignored. This has meant important mainstream initiatives such as the Better Practice Program, the Divisions and Projects Grants Program and the GP Rural Incentives Program have only limited impact on Aboriginal health care delivery.
- **Aboriginal community input into vertical programs.** There are a large number of specialist (ie. body-part based) programs within Commonwealth Health which do not address the needs of the Aboriginal community. While there has been some recent success with the HIV/AIDS Strategy, there is a need to incorporate the needs of the Aboriginal community in the design of any vertical program.

Conclusion

Congress believes that the well-being of our people continues to be the major health problem facing Australia today. To have a section of the citizenship of the country that has a life-

expectancy of up to twenty years less than the general population is bad enough; to see that gap actually widening in the 1990s must alert non-Aboriginal Australia to the fact that something is seriously wrong.

We acknowledge the commitment made in recent years – from both sides of parliamentary politics – to address the ill health of our people. This commitment must be sustained and increased over the years to come: there are no simple and quick solutions to the problems we face. It may take years, decades or even generations for the health of our people to be restored to acceptable levels.

In the health sector, what is needed is a renewed and improved commitment to the principles of comprehensive primary health care under the control of the Aboriginal community. The rhetoric in this case is true: only the Aboriginal community can heal itself, but to do so it needs to work with non-Aboriginal government and expertise. Congress is committed to working towards collaborative, open partnerships with these other parties to develop a network of well-resourced, effective and appropriate primary health care services.

However, there also needs to be a recognition that the health of our people does not depend on the health sector alone. Our people must have access to education and employment, and to all the other services and infrastructures that non-Aboriginal Australia enjoys. Cuts to these services will affect our people as well as (and probably more than) the general Australian population. In addition, our special and continuing relationship to the land must be recognised and supported, and not denigrated and denied.

Congress has almost two-and-a-half decades of experience in delivering health care and advocating for the health of our people. Our experience tells us that improvements in the health of our people are possible, but that only an open, cooperative approach of the different sectoral interests and between government and community will be effective in ensuring that ill-health and poverty are not as endemic in our communities as they are now. In this paper we have tried to set out some of the groundwork for such an approach.

JOHN LIDDLE

Director

Central Australian Aboriginal Congress

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