

Robyn Williams: And we begin with the first keynote, or three keynotes reports on Developments and Commitments in Indigenous Health. Could I ask the three speakers to come and join us on stage, Dr Mick Adams, Dr Shannon Springer and, once more, Dr Jenny May, and as they do so, I'll tell you who they are. Dr Mick Adams is President of the National Aboriginal Community-Controlled Health Organisation. He's been working in the health industry for over 30 years. He's worked on both state and community-controlled health service sectors and been a representative on local state and national boards and has been nominated as a representative to advocate for both Aboriginal and Torres Strait Islander health issues on national boards and national and international conferences.

Dr Shannon Springer is a member of the Board of the Australian Indigenous Doctors Association. He is from Mackay and moved to Brisbane to play football later enrolling in Bachelor of Applied Health Sciences in the Indigenous Primary Health Care at the University of Queensland. Dr Jenny May is the Chairperson of the National Rural Health Alliance, a GP and academic from Tamworth in northern New South Wales. So, first of all, Dr Mick Adams.

Reports on developments and commitments in Indigenous health

Mick Adams¹, Shannon Springer², Jenny May³

¹National Aboriginal Community Controlled Health Organisation, ²Australian Indigenous Doctors' Association, ³National Rural Health Alliance

Mick Adams: Good morning everybody. First of all I'd like to pay my respect to the elders past and present, traditional of this land. Also I'd like to acknowledge my countrymen from the Cape area and countrymen and relations and also from the Northern Territory. Just to give a brief outline of NACCHO. NACCHO is a peak body for Aboriginal community control health service. We have over 140-odd members throughout Australia. We are the main deliverers of primary health care to Aboriginal people throughout Australia. We've been fighting for better health outcomes for people for many years. The latest campaign of closing the gap was launched by NACCHO and coalition of committed organisations over the past two years. We've aimed to achieve health equality for Aboriginal people to give us the control of our destiny that will help us achieve closing the gap. I hope today you here can be part of that campaign and supporting community-controlled health services.

The most recent development affecting our sector is last Tuesday's federal government. NACCHO overall welcomes the Aboriginal health budget announcement. They've primarily put in place the COAG Aboriginal health package that was announced last year. This is worth about 806 million new money, supposed to be, over four years and we welcome them as a significant leap forward in funding for Aboriginal health. In pure economic terms, a significant boost to comprehensive Aboriginal health care services which now will reap the rewards enlisting the long-term costs to the whole health system. COAG packages targeted chronic diseases, strengthening primary health care services, training, access to specialists, access to medicine and prevention programs. New measures announced on Tuesday included 131 million over three years for the Northern Territory Aboriginal health service, 58 million for improving ear and eye health service over four years and 11 million over four years for dental in rural and regional areas.

There are better incentives to encourage health professionals to work in remote areas, but often these government initiatives come as news to NACCHO, which as a peak body for Aboriginal community-controlled health service, has not been consulted about them. Often there are glaring mistakes and a lack of awareness by governments of what is working and what is not working. We are not consulted as part of shaping decisions that cost us all dearly in lost opportunity and wasted dollars. NACCHO is concerned over aspects of the COAG package as detail emerges. Aboriginal community-controlled health service are

being marginalised in favour of Aboriginal health funds going to mainstream GP services of which most do not see Aboriginal peoples.

The Prime Minister in Close the Gap statement this year said that COAG package is directed to mainstream health services because they provide a majority of care to Aboriginal peoples. The evidence shows the best investment in Aboriginal health is through our sector in the front line of primary health care in urban, rural and remote communities. The government should be expanding the size and numbers of community-controlled health services, not marginalising our sector. Health equality and closing the gap has always been more than just about statistics. It covers a range of quality of life issues such as poor housing, disadvantage in education, employment, life opportunities that impacts on health outcomes and are known as the social determinants of health. But Close the Gap is very much about the needs of Aboriginal people to be able to stand proudly, in control of our lives as a strong vibrant society.

Part of that control we want is in health and the rights to determine the design and delivery of our health services. It means that Aboriginal communities setting priorities at national, state and local levels while working in partnership with government and with the professional expertise available in the health sector. It is evidenced from international studies that structural change giving Aboriginal people more control of their societies and services will make the biggest change in health outcomes over time. Certainly NACCHO and our partners from Close the Gap see community control of our health services as a central part of closing the gap. It will empower our communities by leading to better outcomes overall. We need performance benchmarks for governments to ensure our services have the resources to fully match our community health needs. The model of community-controlled primary health care services incorporating the expertise of health professionals and the communities they serve has been successful.

The government boost in significant training for Aboriginal health professionals is very welcome, but it doesn't fill the current vacancy of our ability to attract new graduates. In his statement of the 10th, the government signed, they say that crucial to ensuring equal access to health services is ensuring that Aboriginal peoples are actively involved in deciding delivery and control of these services. The government talks the talk. We are yet to see them make good on their genuine partnership in health. We don't shy away from working with general practice in general, so we look forward to working in partnership with other health professionals.

I think we need to deliver or develop a framework that we could enhance and work together to improve the health and welfare of Aboriginal peoples. I think this would mirror the framework agreement that states and territory health departments and NACCHO affiliates that have and has been established and working over the past 10 years. So I'll close there because we had a short 10-minute thing. Thank you.

Shannon Springer: Good morning. First and foremost I'd like to acknowledge the traditional owners of the country that we're gathered on today. I would like to acknowledge their ancestors both past and present. I'd like to acknowledge the other indigenous people in the room today, the AIDA Secretariat, the rest of the Board and our members.

I just wanted to take a few moments to introduce myself. My name is Shannon Springer. I'm currently the Secretary on the Australian Indigenous Doctors Association. Like you heard earlier, I grew up in Mackay. When I left school I moved to Brisbane to play football, but that didn't really turn out too well. At the same time I was doing a degree in indigenous primary health care and completed that and then had the confidence to go on to do medicine at James Cook University. It's actually quite humbling to have gone through a place like James Cook and coming back and seeing a lot of the staff here, and addressing this assembly is quite humbling.

I wanted to put this light up quickly just to acknowledge our traditional healers or our Ngungkaris. As indigenous doctors we don't separate ourselves from our culture and our culture is thriving and just to outline that indigenous point of view in terms of health is very holistic. It's based on spiritual, cultural and emotional perspectives and this certainly shapes the way that indigenous people see their world. What I wanted to do is briefly outline a perspective both as an indigenous person and an indigenous doctor that's worked in multiple health care delivery systems from AMSs to private general practice to the hospital sector.

AIDA is certainly proud to offer a source of leadership across the nation on indigenous health particularly in terms of the Close the Gap campaign. I would also like to acknowledge the other members including Tom Calma, who's the Aboriginal and Torres Strait Islander Social Justice Commissioner from the Australian Human Rights Commission. Obviously NACCHO, CATSIN and more recently we welcome the formation of the Australian Indigenous Psychology Association which has just recently joined the committee.

There have been a number of key milestones that have occurred over the Close the Gap campaign as we've launched from the national apology on February 13, 2008. We've seen from 18 to 20 March 2008 the formation of a set of targets and a commitment from the government to achieve these targets on the statement of the 10th and most recently the formation of the National Healing Foundation by Gregory Phillips.

I'm not going to dwell too much on the statistics because most people in this room would be quite familiar with it, but just to recap. There are 26 per cent of indigenous Australians live in areas that are remote or very remote compared to non-indigenous Australia, therefore, access to a lot of those people is quite significant. Over half of them in discrete Aboriginal communities are located more than 100 kilometres from their nearest hospital. Now, if we look at the doctors per capita we can see that in major cities in 2005 that there were 335 medical practitioners per 100,000. The first one is in major cities. The second one is in remote and very remote areas of 148 practitioners per 100,000. In contrast, there is even greater difference in specialist clinicians with 122 per 100,000 in major cities compared to the population in the remote and very remote areas of 16 per 100,000.

However, the recent budget was quite welcoming in terms of addressing rural remote services, particularly in attracting GPs to rural remote areas and their retention. We do need a whole of health multidiscipline agenda to address indigenous health. Currently as it stands, as Mick was saying, there's 141 Aboriginal community-controlled health services across Australia. There are 7361 general practices. There are 129 indigenous doctors, 22,868 general practitioners and whilst Aboriginal community-controlled health services do see or have over 300,000 patients on their books, there is a sector of the community that needs to be seen by the private and government health services.

This brings us to what we should be aiming for. At the moment, what we're aiming for is 129 indigenous GPs and specialists, 161 dentists, 2570 nurses, 275 pharmacists and a culturally competent non-indigenous workforce along with our indigenous health workers, which make up our multi-discipline workforce. In the last 10 years we haven't been doing too bad. We can see here from '96 to 2006 indigenous GPs have jumped from 41 to 82 compared to, I think, the mainstream GPs is about 23 per cent increase. Registered indigenous nurses rose by 71 per cent. Indigenous students enrolled in the health field rose from 29 per cent, which is encouraging.

As we can see, the government is committed to putting money where it's actually needed. We know that the previous budget of \$1.6 billion and the new moneys added on this budget are specifically looking at adult health checks, chronic disease management, improving access to PBS medicines, children and family centres, ear and eye and dental care. I just wanted to leave it at that, but a few key messages that I wanted to end on is that we do have to strengthen the education and health portfolios to develop and

resource quality regional and state Aboriginal and Torres Strait Islander health workforce plans. National funding evaluation frameworks need to translate into state and regional joint planning implementation and obviously we need more workforce planning mechanisms that address the needs in our rural remote areas. On that note, what really goes with that is building in capacity for those people in rural remote areas to have the capacity to address Aboriginal and Torres Strait Islander needs. I'll leave it at that.

Jenny May: Thank you. I'd just like to acknowledge the traditional owners of the land on which we are gathered and to thank them very much for the warm welcome yesterday. I just want to talk to you today about what the role of the Alliance and, I guess, the rural sector is in the developments and commitments that we've seen in indigenous health. I guess at every National Rural Health Conference, as Louise told us yesterday, since 1991 we've talked about indigenous health as a core and major theme. Alliance has had NACCHO and ATSIC as foundation members since its inception and AIDA since 2005 and it has also co-opted members of the indigenous community as NRHA councillors. But it has been the role of the Alliance to stand beside and with its indigenous organisation and try and contribute in partnership.

The Alliance has had the capacity through its broad church of health service providers and consumers and its talented secretariat to promote and support the cause, but it has to be said that the Alliance has not looked for this leading role with the belief that Aboriginal organisations and individuals need to be the leaders with the appropriate support that we can muster. The Alliance has advocated on both political and bureaucratic stages and, as you know, in its conferences and other activities has endeavoured to create or enable a strong indigenous voice to be heard such as at this conference. Much of this is behind the scenes work using Alliance expertise to try and engage policy makers and assist. I think it's also fair to say that it's been active in searching for the reasons why indigenous health outcomes have been so much poorer than their non-indigenous rural counterparts. I think this is obviously about confronting the social determinants of health and also recognising the very siloed approach that funding and policy development requires.

So, as most of you know and our two speakers have described, the Close the Gap campaign arose following the release of Tom Calma's social justice report in March 2006 and the steering group which saw NACCHO and AIDA with other human rights and indigenous organisations taking the lead and lobbying other organisations and politicians to consider signing up to the campaign. A rural health action plan was adapted at the Albury conference in 2007 and was basically modelled on an open letter that appeared in The Australian in December 2006 which called for the health equality for Aboriginal and Torres Strait Islander peoples within our generation. This was endorsed, as already mentioned, by 30 leading indigenous and non-indigenous health and human rights organisations.

These recommendations you see on your screen were endorsed and discussed by the indigenous workshop and then endorsed by you as delegates at the 9th conference in Albury in March 2007. Shortly after the conference the Close the Gap campaign was formally launched in April 2007 and prior to the election in 2007 it became ALP policy. Following continuing efforts of the Close the Gap Committee and the sector and a change of government, the statement of intent was signed by Prime Minister Rudd and Leader of the Opposition, Brendan Nelson, in March 2008 as well as presidents and chairs of the four main indigenous health peak bodies, presidents and COs of four mainstreamed health peak bodies and Tom Calma. Subsequently, it has been endorsed by both the Victorian and Queensland Governments and I understand other state governments are to follow.

So what's happened to those actions? Well, if we look at 1, 3 and 4, those three proposed actions reflected directly in the statement of intent. The statement of intent also commits us to working collectively to systematically address the social determinants of health taken up in number 6. As Shannon has mentioned, one of the first jobs of the National Health Equality Council has been to address the support for the development of the indigenous workforce and work towards those targets that Shannon showed

us. Other recent initiatives include actions in terms of a national indigenous workforce plan and support for mentoring. The other two actions, numbers 5 and 6, are seen in the indigenous health inequality targets and also figure in the COAG agenda. I thought I'd mention to you what those COAG targets are.

And they are: obviously to close the 17 year old gap within a generation in terms of health outcomes and inequalities; the infant mortality gap for indigenous children under 5 halved within a decade; to halve the gap in literacy and numeracy between Aboriginal and Torres Strait Islander peoples and other students within a decade; to halve the gap, similar gap, in employment outcomes and to halve the gap in year 12 attainment by 2020; and finally, to provide all Aboriginal and Torres Strait Islander 4 year olds in remote communities with access to preschool programs. These are ambitious, important targets and, as we well know, figure far more than in health.

So there's been no shortage of opportunities for the Alliance to focus and support on indigenous health in the two years since the conference. In our attempts to support the Close the Gap action plan we have focused on the importance of these actions through the myriad of lengthy submissions that many of you have also been involved in to these many inquiries. Specifically, the Alliance nominated indigenous health as the key challenge to the Health and Hospitals Reform Commission and supported the specific indigenous performance indicators in the Beyond the Blame Game report as well as in the primary care strategy. As part of our advocacy, we've sought the non-health forums also, the House of Reps inquiries into new regional development funding, the Department of Education, Employment and Workplace Relations work on expanding the Commonwealth Scholarships Program and the Senate inquiry into regional and remote indigenous communities. Much of the Alliance's work will continue in its behind the scenes capacity.

Tom Calma, in his recent social justice report, notes the significance of four elements in getting this shift and momentum in moving the COAG and the Close the Gap agenda forward, and I think Mick and Shannon have already alluded to the really key importance of partnership between indigenous peak bodies, mainstream health bodies and non-government organisations. We need to speak with one voice and in that one voice we will create this opportunity for partnerships with the government, health sector and, really importantly, with civil society where we all have such a role to play.

The other big strength that he sees is the bipartisanship and therefore the potential assurance of state and federal co-operation. He also pointed to the real importance of developing specific targets in terms of health inequality so that we've got a really specific focus to work towards. Finally, he talked about the opportunity, which I mentioned this morning, that we have to roll the Close the Gap indicators and the health inequality targets into these many reviews and reforms of the health system as a whole. So the Alliance's commitment remains. The 2007 action plan does appear in print in a variety of commitments made by government and others, but I'm sure I, like you, think we need to maintain the rage as these actions turn into policies and programs. As Mick has alluded to, the devil will probably be somewhat in the detail.

So what are the plans? Well, there certainly needs to be, and it has been said there needs to be a comprehensive long-term plan of action to be developed. Primary care services and infrastructure need to be in place to correct the health disadvantage by 2018—not very far away. We need to take a real look at participation and partnership, as both Mick and Shannon have ascribed, and we need to measure, monitor and keep an eye on our joint efforts. I'm not telling you anything you don't know to say that there are some real issues and tensions out there. We've got to sort out about the role and resourcing, as Mick has described, of mainstream services in complementing community-controlled Aboriginal health services. We've got to work out about the intervention in the NT as a reality to evaluate and discuss.

We have significant issues in how and what models of care should exist in remote communities. There is much debate about what happens to all these billion dollar commitments in an economic downturn. All these issues are on your conference agenda and they demand your attention. As a sector, as an alliance, as communities and individuals we need to keep facing the fact that there is hugely disparate health outcomes for indigenous rural Australians. I think we need to look inside ourselves and our organisations and see that we are sharing this ambition of equivalent health status and life expectancy within a generation.

So I would like to leave you with this slide. If an individual sets an achievable goal and never gives up, they will achieve their goal or die trying. If a civilisation sets up an achievable goal and never gives up, they'll achieve their goal. What shall we do? It's all of our responsibility. Thank you.

Presenters

Dr Mick Adams is a descendent of the Yadhigana people of Cape York Peninsula in Queensland and has traditional family ties with the Grindji/Wardaman people of central-western Northern Territory and an extended family relationship with the people of the Torres Straits, Warlpiri (Yuendumu) and east Arnhem Land (Gurrumaru) communities. He spent his childhood growing up in Darwin's Parap Camp community.



Dr Adams has been working in the health industry for over 30 years. He has worked in both state and the community-controlled health service sector, has been a representative on local, state and national boards, and has been nominated as a representative to advocate for Aboriginal and Torres Strait Islander health issues on national boards and national and international conferences.

During the past 13 years Mick has been actively involved in addressing issues associated with the health and wellbeing of Aboriginal and Torres Strait Islander men. He has strived to ensure that men's health issues are promoted and placed on the national and international agenda through advocacy, research, publication and health management.

Dr Adams is currently completing a PhD in Public Health looking at the prevalence and impact of male sexual and reproductive health disorders on Aboriginal and Torres Strait communities. It's the first time such a study has been undertaken by an Aboriginal man with Aboriginal and Torres Strait Islander male populations.

He along with other Aboriginal male leaders has been highlighting his disappointment and speaking out against family violence and child abuse.

Dr Adams was awarded the 2006 Deadly Award for Outstanding Achievement in Aboriginal and Torres Strait Islander Health.

Jenny May is a practising GP from Tamworth in regional New South Wales, and is the Chair of the National Rural Health Alliance, the peak non-government organisation for rural and remote health. She has held Board positions for the last four years and represents the Rural Doctors Association of Australia on Council of the Alliance.



Dr May has an academic appointment with Newcastle University in the UDRH/Rural Clinical School based in Tamworth, providing education and research support to undergraduates, registrars and GPs. She is an examiner for the RACGP, a GP Supervisor and Chair of the Female Doctors group for RDAA. She

works at Peel Health Care, a not-for-profit entity established by the local Division of General Practice in response to workforce shortage.

Dr May practised for five years at Tom Price and Exmouth in the Pilbara region of Western Australia, and spent a year working in a remote community in British Columbia, Canada.

Her research interests include women's health, health service models and workforce issues in regional communities.