

This publication was rescinded by National Health and Medical Research Council on 17/9/2004 and is available on the Internet ONLY for historical purposes.

Important Notice

This notice is not to be erased and must be included on any printed version of this publication.

- This publication was rescinded by the National Health and Medical Research Council on 17/9/2004. The National Health and Medical Research Council has made this publication available on its Internet Archives site as a service to the public for historical and research purposes ONLY.
- Rescinded publications are publications that no longer represent the Council's position on the matters contained therein. This means that the Council no longer endorses, supports or approves these rescinded publications.
- The National Health and Medical Research Council gives no assurance as to the accuracy or relevance of any of the information contained in this rescinded publication. The National Health and Medical Research Council assumes no legal liability or responsibility for errors or omissions contained within this rescinded publication for any loss or damage incurred as a result of reliance on this publication.
- Every user of this rescinded publication acknowledges that the information contained in it may not be accurate, complete or of relevance to the user's purposes. The user undertakes the responsibility for assessing the accuracy, completeness and relevance of the contents of this rescinded publication, including seeking independent verification of information sought to be relied upon for the user's purposes.
- Every user of this rescinded publication is responsible for ensuring that each printed version contains this disclaimer notice, including the date of rescision and the date of downloading the archived Internet version.

Promoting the Health of Indigenous Australians

**A review of infrastructure support for Aboriginal and
Torres Strait Islander health advancement**

Final Report and Recommendations

December 1996

National Health and Medical Research Council

RESCINDED

NHMRC

© Commonwealth of Australia 1997

ISBN 0642272298

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgement of the source and no commercial usage or sale. Reproduction for purposes other than those indicated above, requires the written permission of the Australian Government Publishing Service, GPO Box 84, Canberra ACT 2601.

The strategic intent of the NHMRC is to work with others for the health of all Australians, by promoting informed debate on ethics and policy, providing knowledge based advice, fostering a high quality and internationally recognised research base, and applying research rigour to health issues.

Publications approval number: 2091

RESCINDED

This document is sold through the Australian Government Publishing Service at a price which covers the cost of printing and distribution only.

National Health and Medical Research Council documents are prepared by panels of experts drawn from appropriate Australian academic, professional, community and government organisations. NHMRC is grateful to these people for the excellent work they do on its behalf. This work is usually performed on an honorary basis and in addition to their usual work commitments.

Publications Production Unit (Public Affairs, Parliamentary and Access Branch)
Commonwealth Department of Health and Family Services

Produced by the Australian Government Publishing Service

RESCINDED

Preface

Despite many new and welcome developments, Australia is yet to achieve a comprehensive national system for promoting the health of the population. The situation is all the more tentative when one considers the very real need for provision of specialised infrastructure to support the planning, delivery and evaluation of health promotion programs appropriate to Aboriginal people and Torres Strait Islander people. It was for this reason, and the strong desire of the National Health and Medical Research Council to consult directly and appropriately with Aboriginal people and Torres Strait Islander people themselves, that a separate review of infrastructure supports for Aboriginal and Torres Strait Islander health advancement was undertaken as part of the Health Australia Project. The Council is greatly indebted to Ms Sandra Angus, who was ably assisted by Ms Marilyn Wise and the Project Advisory Committee, for the production of this landmark and culturally attuned report.

The larger review of infrastructure support for national health advancement has essentially two goals:

- to identify steps to be taken to make Australia's infrastructure for national health advancement among the best in the world; and
- to recommend actions to strengthen the capacity of Australia's health sector to lead, enable, and support the development and delivery of effective interventions to promote, protect and sustain the health of all Australians.

A separate final report, with its recommendations, has realised these goals with respect to the more generic level of infrastructure development. This report complements and extends those findings through the identification of issues that are specifically relevant to Aboriginal and Torres Strait Islander health and by making targeted recommendations which reflect a broad consensus of Aboriginal views achieved through extensive consultation. The report provides an important and timely opportunity for all Australians to listen to what the Indigenous people of this country have to say about what is needed to advance their future health.

C. D'Arcy J. Holman
Chair, NHMRC Health Advancement Standing Committee
December 1996

A review of infrastructure support for Aboriginal and Torres Strait Islander health advancement

Project Team

Ms Sandra Angus

Ms Marilyn Wise

Project Advisory Committee

Dr Wendy Brady

Mr Chris Coomer

Mr Brian Dixon

Ms Anne Flood

Ms Mavis Golds

Mr Richard King

Ms Maureen Kirk

Ms Ester Rose Manson

Ms Beryl Meiklejohn

Ms Leanne Mick

Mr Philip Mills

Ms Deborah Reid

Ms Trudi Sebasio

Ms Juanita Sherwood

Ms Denise Troon

Project Executive

Professor D'Arcy Holman

Professor Don Nutbeam

Ms Judith Dwyer

Dr Tony Adams

NHMRC Health Advancement Standing Committee

Professor D'Arcy Holman (Chair)

Professor Chris Del Mar

A/Professor Rob Donovan

Ms Judith Dwyer

Ms Sophie Dwyer

Dr Colin Mathers

A/Professor Terry Nolan

Professor Don Nutbeam

Professor Beverley Raphael

Ms Rosalie Viney

Dr Rae Walker

RESCINDED

Promoting the Health of Indigenous Australians-Final report and recommendations

Contents

Preface	i
The Project Team	ii
The review of infrastructure support for national health advancement: terms of reference	v
Acknowledgements	vii
Abbreviations used in this report	ix
Executive Summary and Recommendations	xi
Part 1: The consultation with Aboriginal and Torres Strait Island health personnel, organisations and communities	1
Part 2: A brief review of the health of Aboriginal people and Torres Strait Island people	3
2.1 Underlying causes of Aboriginal and Torres Strait Islander health status	4
Part 3: Rhetoric or reality? Past and present policies act as barriers to better health gains	11
3.1 Aboriginal policy	11
3.2 Infrastructure and funding for Aboriginal and Torres Strait Islander health	12
3.3 The National Aboriginal Health Strategy	15
3.4 Other initiatives	15
Part 4: Improving the health of individuals and of the population: providing health services and promoting health	17
Part 5: Infrastructure for promoting Aboriginal and Torres Strait Islander health	19
5.1 Principles of good practice in promoting Indigenous health	19
5.2 Infrastructure for health promotion program delivery	19
5.3 In summary: limited infrastructure for health promotion	22

RESCINDED

Part 6:	Findings from the consultations	25
6.1	Acknowledgement of the effect of their history on the health of Aboriginal people and Torres Strait Island people today	25
6.2	Extended health policy framework developed with strong Aboriginal and Torres Strait Islander participation	25
6.3	Effective systems at national, State/Territory and local levels to design and deliver health promotion programs	26
6.4	More transparent processes to identify priorities and allocate resources for promoting health	26
6.5	Organisational support for health promotion	27
6.6	Partnerships within the health sector and with other sectors	28
6.7	Research, evaluation and dissemination of good practice	30
6.8	Workforce development	31
Part 7:	Conclusion	35
Appendices		
Appendix 1:	Feedback on the first round of the consultation process	35
Appendix 2:	Participation versus consultation	39
Appendix 3:	People who contributed	42
References		51

The review of infrastructure support for national health advancement

The National Health and Medical Research Council's Health Advancement Standing Committee was commissioned to undertake a comprehensive review and analysis of past and current health promotion initiatives in Australia. The review was intended to inform the preparation of a report by the Committee detailing a range of actions to strengthen health promotion activity. A specific consultation with Aboriginal people and Torres Strait Island people was established as a major component of the review. This Report addresses the issues from the perspective of (and in the words of) Aboriginal people and Torres Strait Island people.

Terms of reference

1. The Health Advancement Standing Committee will review the current systems within which health promotion occurs, and assess existing health promotion initiatives and evidence-based strategies to develop a detailed plan for the long-term future role of health promotion in Australia. The final report should identify key recommendations for future health promotion activity in all important areas.

This report should make particular reference to:

2. Improving the infrastructure in support of health promotion in areas such as:
 - data collection and surveillance;
 - research, including recommendations to facilitate the conversion of knowledge gaps to funded national research projects;
 - policy and program planning, including policy and legislative frameworks;
 - health promotion financing models, including reviewing funding and purchasing models to develop a funding strategy for health promotion, and addressing the impact of existing health care financing models on health promotion;
 - program implementation, program administration and coordination, and organisational structures for health promotion planning and delivery;
 - evaluation, including the development of accountability and performance measures (outputs and outcomes), developing proxy criteria for those interventions which may be disadvantaged by the need for 'evidence-based' measures (such as community development strategies), recommendations on systems for evaluating and monitoring of progress against program or health status goals, and/or commissioning baseline measurement of some issues over time to assist with the design of further studies;
 - intersectoral action, that is, activity within and across all relevant sectors (i.e. not only the health sector) to promote healthy public policy;
 - workforce training and education; and
 - information dissemination and uptake.
3. Considering these structural issues in relation to their appropriate application to the range of health promotion issues, such as health/illness/injury concerns, health status inequalities, population groups, environments, and national health goals, targets and strategies.

RESCINDED

4. Identifying the roles and responsibilities of all relevant agencies with an interest in health promotion (including agencies in the non-health sector). This includes: Commonwealth agencies (with particular reference to the Public Health Division of the Commonwealth Department of Health and Family Services, the Australian Institute of Health and Welfare, the National Health and Medical Research Council, and the Australian Health Ministers' Advisory Council), State and local interests, non-government organisations, academic institutions, and professional groups.
5. Promoting best practice in health promotion and illness and injury prevention, with due regard to the particular needs of various population groups.
6. Ensuring equality of access to appropriate and affordable health promotion information and services.
7. Maximising all Australians' opportunity to participate effectively in decisions affecting their health.
8. The final report should:
 - detail a range of options for future health promotion action in Australia;
 - make specific recommendations in line with the infrastructure issues raised in term of reference 2 above; and
 - advise on the interaction of these structural issues with current policy frameworks (e.g. national health goals, targets, and implementation strategies and the National Health Policy), and the broader systems within which health promotion activity occurs.

The report will ensure that health promotion models are fully examined and presented as options for future consideration in the context of a national uniform framework for improving the health of all Australians. As such, it will contribute to the transposition of health promotion for an adjunct to primary and acute care, to a legitimate, effective and equal partner in improving population health status.

Acknowledgements

Many people have helped develop the ideas for the content of this final Report. The NHMRC Health Advancement Standing Committee would like to thank all the people who gave their time so willingly to speak with Ms Sandra Angus and the Project Team during the preparation the Discussion Paper and this final Report.

Particular thanks is given to the Aboriginal Community and Ton-es Strait Island Community and Aboriginal and Torr-es Strait Islander Advisory Committee, whose voluntary and continuing support and thoughtful advice have proven invaluable to Ms Angus in the course of preparing this paper.

The Project Team would also like to thank Ms Corina Belevi and Ms Anthea Ellison at the National Centre for Health Promotion for their support in our work.

Abbreviations used in this report

ACCHO	Aboriginal Community Controlled Health Organisation
AHC	Aboriginal Health Council, South Australia
AHRC	Aboriginal Health Resource Cooperative, New South Wales
AICHS	Aboriginal and Islander Community Health Service
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Services of the Northern Territory
ATSIC	Aboriginal and Torres Strait Islander Commission
Health personnel	all Aboriginal and Torres Strait Island health workers, including health promotion officers, specialist health educators, alcohol and drug workers, and sexual health workers
NACCHO	National Aboriginal Community Controlled Health Organisations
NAHS	National Aboriginal Health Strategy
NATSIS	National Aboriginal and Torres Strait Islander Survey
NHMRC	National Health and Medical Research Council
IPHERP	Public Health Education and Research Program
QAIHF	Queensland Aboriginal and Islander Health Forum
TAHS	Tasmanian Aboriginal Health Service
VACCHO Inc	Victorian Aboriginal Community Controlled Organisations, Inc.
WAACCHO	Western Australian Aboriginal Community Controlled Health Organisations

However, what Illich is demanding is reflection by those in power: ‘that the question to be asked first is not what can this advantaged society do to that disadvantaged society?’

‘Instead, it is: what can it do both to itself and together, to address the imbalances?’

Illich I. Deschooling society. New York: Perennial Library, 1972. Cited in: Hunter E. Aboriginal health and history. Cambridge: Cambridge University Press, 1993.

Indigenous definition of health

Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities.¹

Executive Summary

The National Health and Medical Research Council's Health Advancement Standing Committee was commissioned to undertake a comprehensive review and analysis of past and current health promotion initiatives in Australia. The review was to provide recommendations for a range of actions to improve the range and effectiveness of action to promote the health of Australians. A specific consultation with Aboriginal people and Torres Strait Island people was established as a major component of the review. This Report addresses the issues from the perspective of (and in the words of) Aboriginal people and Torres Strait Island people.

Aboriginal people and Torres Strait Island people belong to two different races each of which has a different history, culture and tradition. Each group of people may have totally different issues from the other so it is important not to group the populations together as if they were one. The consultation for this report endeavoured to include as many Aboriginal people and Torres Strait Island people as possible who work in the area of Aboriginal and Torres Strait Islander health.

In Queensland, in particular, there are groups of South Sea Island people who also have their own history, culture, traditions and specific issues. This group of people has not been consulted specifically for the purpose of this document.

The Report is based upon the results of extensive consultation with and feedback from more than 1 000 Aboriginal and Torres Strait Island health personnel from both the community-controlled and government sectors around the country. Indigenous cultures are so diverse that no single person can be expected to know or include all information about the factors that have an impact on the health status of these groups, or on improving health outcomes. However, this consultation revealed considerable agreement about the broad issues that need to be addressed. The review also identified actions that are necessary if the health of Aboriginal people and Torres Strait Island people is to improve.

The Report highlights the extent to which the history of colonisation has affected and continues to affect the current health status Aboriginal people and Torres Strait Island people in Australia. The health of Indigenous Australians continues to be much poorer than that of their non-Indigenous counterparts, although there have been some improvements. However, compared with improvements in the health of indigenous populations in other nations, there is much yet to be achieved in Australia.

In the views of those people who were consulted in preparing this Report, four principles must underpin the development of the infrastructure support needed for Aboriginal and Torres Strait Islander health advancement in Australia. These are:

1. acknowledgement by non-indigenous Australians that Aboriginal people and Torres Strait Island people have a right to their history, including the effects of colonisation on the health of Aboriginal people and Torres Strait Island people today;
2. the inclusion of Aboriginal and Torres Strait Island communities and individuals in all levels of decision making which affect their lives in general and their health in particular, through a community development approach;
3. the need for any initiatives to promote the health of Aboriginal people and Torres Strait Island people to be integrated with culturally effective, high quality, accessible primary health care services; and
4. the need for Indigenous and non-Indigenous Australians (and their organisations) to encourage the development of partnerships to improve Aboriginal and Torres Strait Islander health.

The review highlighted the extent to which the improvement of the infrastructure to support Aboriginal and Torres Strait Islander health advancement depends upon the development of more holistic, coherent and cohesive systems to plan and implement both effective primary health care services and health promotion

programs. It is impossible, in the views of the people consulted during the review, to separate these two issues. Nonetheless, this review has focused primarily on the need for infrastructure to promote health-in addition to the infrastructure for primary health care services.

The review identified many actions already being undertaken by Aboriginal and Torres Strait Island communities to improve their health. The positive outcomes of these and the processes by which they have been developed need to be recognised and encouraged. A companion volume is to be published of case studies that highlight principles of effective health promotion practice in both Aboriginal communities and Torres Strait Island communities.

The review found that the positive actions (some of which are highlighted in the case studies) that have been taken by many Aboriginal and Torres Strait Islander communities would be more sustainable with the support of strong national, State/Territory and local infrastructures. In addition, the consultation highlighted the need for additional infrastructure support to increase the range and effectiveness of action to promote Aboriginal and Torres Strait Islander health. There is much to be gained from the forging of strong partnerships not only between Aboriginal health personnel, among Indigenous health organisations (government and community-controlled) but also between these groups, the mainstream health sector, and other sectors. These partnerships must be between equals and based on recognition of the interdependence of the partners. The guidelines in Appendices 1 and 2 can assist in ensuring the development of such partnerships.

The recommendations outlined in this report identify specific steps that need to be taken to build the capacity of the health sector to support the work of Aboriginal and Torres Strait Island health personnel working in partnerships (with their communities, with their peers, with other sectors and with the mainstream health system) to achieve improved Aboriginal and Torres Strait Islander health.

The terms of reference specified the components of an effective infrastructure. These have been confirmed by this review and the analysis of the case studies. The recommendations include action in the areas of:

- health policy development;
- setting priorities and allocating resources;
- program design and organisational support;
- partnerships within the health sector and between the health and other sectors;
- monitoring and surveillance;
- research, particularly intervention research, and evaluation;
- information dissemination and uptake;
- workforce development; and
- access to health care services.

The consultation did confirm the importance of each of the components of infrastructure that had been identified in the terms of reference for the review. However, the Aboriginal people and Torres Strait Island people who were consulted were almost unanimous in their view that any action to promote their health must be based on an understanding of their history since colonisation, and its effects on their health not only in the past, but today.

The issues outlined in this report, therefore, outline, from an Aboriginal and Torres Strait Islander perspective, the determinants of health. The development of the infrastructure support recommended in this report is based on this analysis.

The issues raised in the review and consultation

Millions of words have been spoken and written about ways to improve Aboriginal health. This review has attempted to acknowledge all that has gone before, particularly the efforts of Aboriginal people and Torres Strait Island people.

One of the first actions that can be taken by the ‘mainstream’ therefore, is to ensure that Aboriginal people and Torres Strait Island people have the opportunity to develop a strong voice with which to speak directly on their own behalf.

The issues identified in this review have all been identified before. This report is another attempt by Aboriginal people and Torres Strait Island people to speak about what they want and need in order to improve their health. That Aboriginal people and Torres Strait Island people have been willing to speak again is a manifestation of the strength of their cultures, of their willingness to seize the opportunity and to take the risk, again, of speaking out. The challenge now is to act upon what has been said, to turn the rhetoric into action and to address the public health problem rather than to continue to describe it.

The issues listed below have been identified through a culturally sensitive process of consultation. The first issue arose from the consultation and review. While the issue itself and the recommendations fall outside the ambit of the terms of reference, there was a very clear mandate from the people and organisations consulted that this issue underpins all the other actions recommended. Each subsequent recommendation has been linked to a specific term of reference.

In all, the Aboriginal people, Torres Strait Island people, the organisations consulted, and the literature that was reviewed in preparing this document pointed to the need for:

Acknowledgement of history

- public acknowledgment of the history that determines the health of Aboriginal people and Torres Strait Island people today;

Extended policy framework to provide a mandate for promoting health, developed with strong Aboriginal and Torres Strait Islander participation

- development of an Aboriginal health policy framework that provides a mandate for and direction to initiatives to promote the health of Aboriginal and Torres Strait Islander populations in addition to policy that focuses on developing and extending culturally effective, accessible health care services;
- strong Aboriginal and Torres Strait Islander voices in the development of Aboriginal and Torres Strait Islander health policy, program delivery and resource allocation;
- a mandate and incentives for health services and individual health personnel to engage in action to promote health. This will mean developing career structures and pay scales that recognise training, ensure the availability of jobs following training, and ensure support for people who have undertaken training to apply their new learning in their work environments;
- vertical and horizontal equity* in funding for health care services and for additional programs to improve Aboriginal and Torres Strait Islander health and well-being;
- secure, long-term investment in both the infrastructure and major programs needed to promote health and in culturally effective health care services;

Effective health promotion program design and delivery

- recognition that, for many communities, the physical/structural environment (remoteness, climate, access to home refrigeration, store food choices, for example) is often not conducive to the adoption of ‘healthy’ lifestyles;

RESCINDED

documentation and dissemination of principles to guide the development of programs to promote Aboriginal and Torres Strait Islander health;

- recognition that the vast diversity of Indigenous communities means that greater attention is necessary to ensure that policies and programs are implemented in ways that are relevant to the different communities and their cultures;

Organisational support for promoting health at national, State, Territory and local levels

- clear lines of responsibility and accountability for funding and programs to promote health and for provision of health care services on the part of different levels of government, and on the part of the different organisations that provide health care and health promotion services to communities; extended organisational capacity to deliver effective health promotion programs in communities. Health workers, in many cases, are overworked and under-resourced and time spent on acute care often precludes or minimises opportunities to engage in activities to promote health;

Partnerships and intersectoral action

more active partnerships between Aboriginal and Torres Strait Island communities, the Indigenous health sector (both government and community controlled) and between these groups and sectors such as education, housing, justice, employment, and the environment;

- encouragement to form partnerships between Indigenous health personnel and non-Indigenous health workers and organisations;

Monitoring and surveillance

- indicators that are relevant to Aboriginal and Torres Strait Islander views of health and its determinants;
- monitoring and surveillance systems with particular reference to environmental and social determinants of Aboriginal and Torres Strait Islander health;

Research and evaluation

- an extended research base that helps to identify (from the viewpoint of Aboriginal people and Torres Strait Island people), the causes of health problems, and culturally effective methods of resolving them;
- increased funding for Aboriginal and Torres Strait Islander research and for training and support for Aboriginal and Torres Strait Island public health researchers;
- accurate information about current levels of health promotion program delivery;
- a nationally agreed framework for evaluation of Aboriginal and Torres Strait Islander health promotion;

Access to health care services

- access to culturally effective primary, secondary and tertiary health care services.

Workforce development and support

- professional training, and ongoing education in health promotion for the Aboriginal and Torres Strait Island health workforce;
- resources and support for networking among health workers.

Recommendations for action

The recommendations that follow have been derived from the voices of more than 1 000 Indigenous health personnel and of a range of non-Indigenous health personnel, including the members of the Health Advancement Standing Committee.

The three major findings have been that:

- there is an ongoing need to work in more participatory ways with Aboriginal people and Torres Strait Island people who have the skills, abilities and life experiences to know what is acceptable in their own communities. Aboriginal people and Torres Strait Island people should be recognised as the experts here, but the review has highlighted the need to develop strong partnerships between mainstream health institutions and agencies and Indigenous health institutions, agencies, and communities;
- there is a need to invest in the infrastructure support for Indigenous health advancement if the action that is necessary to promote the health of Aboriginal and Torres Strait Islander populations is to be sustained; and
- all efforts to promote the health of Indigenous Australians must begin with an understanding and acknowledgement of the effects of their history on their health today.

With the exception of the first three recommendations each has been linked with the relevant term of reference.

1. Public acknowledgment of the determinants of Aboriginal health

The Aboriginal and Torres Strait Islander health personnel consulted in preparing this report made it very clear that public acknowledgement of the effects of their history on the health of Indigenous Australians is a prerequisite for improving their health. They recognised that acknowledgement, on its own, cannot overcome the effects of history. Nonetheless, the people consulted during this review emphasised again and again that public acknowledgement is the first step toward an improvement in their health and well-being.

It is recommended that

- the Federal Minister for Health and the National Aboriginal and Torres Strait Islander Health Council commission the Council to develop a public statement acknowledging the significance of the history of colonisation for the health of contemporary Aboriginal Australians;
 - all documents published by the Department of Health and Family Services with regard to Aboriginal and Torres Strait Island people's health include a preface that sets out the effects that colonisation has had on the health of Aboriginal and Torres Strait Islander populations; and
- all documents published by State and Territory health departments with regard to Aboriginal and Torres Strait Island people's health include a preface that sets out the effects that colonisation has had on the health of Aboriginal and Torres Strait Islander populations.

2. Ensure strong Aboriginal and Torres Strait Island voices are engaged in developing health policy, setting priorities, and allocating resources

The review highlighted the need for the inclusion of Aboriginal and Torres Strait Island voices in the development and implementation of Australia's actions to identify and solve public health problems. The Commonwealth and State/Territory governments are currently engaged in the development of a National Public Health Partnership to:

involve both levels of government (Commonwealth and State) in jointly setting objectives, priorities and performance standards and funding the system; with the Commonwealth taking a leadership role in relation to public health standards and health research, and the States primarily responsible for managing and coordinating the provision of services and for maintaining relationships to most providers.³

RESCINDED

This proposal was agreed to by the Council of Australian Government in June 1996. The Partnership represents an important step toward a more systematic, cohesive national approach to identifying and solving public health problems.

The objectives, roles and structures of the National Public Health Partnership have not been finalised, but it will have major significance in determining future priorities for action, resource allocation, and policy direction in relation to public health in Australia. It is processes such as this in which a strong Aboriginal voice is required. The National Aboriginal and Torres Strait Islander Health Council is a representative body that could collaborate with the Partnership to ensure that Aboriginal and Torres Strait Islander perspectives and needs are considered directly in the formation of the Partnership and its work program.

In 1995 the Australian Health Ministers in each state signed agreements with National Aboriginal Community Controlled Health Organisations and the Aboriginal and Torres Strait Islander Commission aimed at improving the health of Aboriginal people and Torres Strait Island people. These Framework Agreements aim to improve health outcomes through the better allocation of increased resources, improved access to health services, and better cooperation with all levels of government. The Agreements set out the roles, responsibilities and lines of accountability of each of the major organisations involved in planning, delivering and evaluating programs and services to diagnose, treat, and prevent illness in Aboriginal and Torres Strait Islander populations and to promote their health.⁴

It is planned that these Agreements will result in the establishment of a State/Territory health forum in each jurisdiction. The forum will include representation from Commonwealth and State/Territory health departments, key State/Territory health organisations, NACCHO (through its State/Territory affiliates) and ATSIC and will focus particularly on the development of regional planning processes, including the identification of gaps and opportunities in service provision, and priorities to improve health services and environmental health in the region. The forum will also provide a mechanism for consultation and will undertake wide canvassing of key stakeholder groups.⁵

For Aboriginal people and Torres Strait Island people living and working at community level, there are extensive demands to be involved in a range of planning and decision-making forums, and the results from the effort are not obvious to them. Clarity is needed so that organisations and people know what decisions they are being called upon to make, so that when decisions about direction, programs, and funding are made they can be acted upon, and so that people at each level are clear about what they are accountable for achieving.

The Agreements, the National Aboriginal and Torres Strait Islander Health Council and the National Public Health Partnership offer mechanisms to increase coordination and cooperation and to achieve greater effect.

It is recommended that:

- The National Public Health Partnership collaborate with the National Aboriginal and Torres Strait Islander Health Council to ensure the involvement of Aboriginal people and Torres Strait Island people in the development of:
 - the National Public Health Partnership Work Program;
 - the proposed Public Health Outcome Funding Agreement; and
 - the delineation of national, Commonwealth and State/Territory roles and responsibilities in the area of public health including health promotion.

TOR: 2.3,7

3. Invest in health promotion program delivery infrastructure

Most of the current infrastructure for Aboriginal and Torres Strait Islander health focuses on the provision of health care services, largely at the primary health care level. Both government and community-controlled organisations in all States and Territories have begun to develop a more definitive approach to promoting health. However the review found that most health personnel were carrying out activities to promote health in

addition to their clinical work, often with very limited time and almost no additional resources.⁶

The review has confirmed that the capacity to deliver high quality, effective action to promote health depends upon there being a well developed infrastructure to direct and support the action.⁷

The remaining recommendations highlight components of the infrastructure to promote Aboriginal and Torres Strait Islander health and propose steps to be taken to develop these. Without such an infrastructure it will be almost impossible to deliver the extensive, sustained, high quality action by all parts of the health sector (and other sectors) that is necessary to promote Aboriginal and Torres Strait Islander health.

It is recommended that:

- The National Aboriginal and Torres Strait Islander Health Council, in partnership with the National Public Health Partnership:
 - require all States and Territories to develop and implement an Aboriginal and Torres Strait Islander health policy (in collaboration with State/Territory and community controlled Aboriginal and Torres Strait Island communities and organisations); (TOR 2.3)
 - develop minimum standards that specify the infrastructure necessary at the Commonwealth level and in each State and Territory to support the development and implementation of effective action to promote the health of Aboriginal people and Torres Strait Island people; (TOR 2.5)
- the Commonwealth Department of Health and Family Services continue to provide resources for national secretariat support for peak organisations including NACCHO to enable them to contribute a national, community-controlled organisational perspective to the Aboriginal and Torres Strait Islander Health Council and to other bodies and sectors that develop and contribute to national health policy; (TOR 7)
- at regional and area levels, agreements be developed between the State/Territory NACCHO affiliate organisation and State/Territory health authorities defining roles and responsibilities (including joint responsibility) and lines of accountability for promoting health. The agreements should specify the development of a defined public health/health promotion program focused on improving Aboriginal and Torres Strait Islander health that is an integral, but specifically funded component of the primary health care program. (TOR 2.4, 4)

Such agreements would recognise the need for active community involvement in the processes of setting priorities, planning and implementing interventions, and in evaluating the process and impact of interventions. The agreements should help facilitate the development of partnerships among major service provider organisations (including mainstream health services), thereby ensuring that the best use is made of resources, including the expertise of the health personnel in different organisations.

4. Strengthen the capacity of primary health care services to promote health

Primary health care is widely agreed to be the most appropriate model of service provision for providing health services (diagnosis, treatment) for Aboriginal communities and for providing the base from which to develop public health/health promotion programs and services.^{8 9 10}

The National Aboriginal Health Strategy advocates a primary health care philosophy as the appropriate approach to Aboriginal and Torres Strait Islander health programs, and recognises Aboriginal and Torres Strait Islander health workers as the link between communities and the health system, as central to continuity of care, and to community development and education towards self management.”

The Queensland Aboriginal and Torres Strait Islander Health Policy, for example, identified seven key areas for future action, of which the first three are:

- community control of primary health care services;
- participation; and

RESCINDED

culturally appropriate service provision.

These fit with the primary health care model used by the Central Australian Aboriginal Congress¹² and recommended by Bartlett and Legge.¹³ The model integrates several important prerequisites for improving Aboriginal health:

- community control of planning, management and delivery of services (whether the service is developed under the auspice of NACCHO or State/Territory government);
- the provision of preventive and acute health care services;
- the use of community development to underpin the development of all services and programs, including those to promote health; and
- the need for programs that are specifically designed to improve environmental health.

Community development, in this context, is a process to ensure that Aboriginal people are in control of decisions that are made about actions taken to improve their health.

While the primary health care infrastructure does offer a significant base from which to promote health, many of the health personnel consulted during this review had experienced difficulties in carrying out high quality, sustained health promotion. The demands of acute care, the ways in which their work was organised and rewarded, and the lack of resources for training were barriers to the development of more effective practice.

To enable them to undertake more effective health promotion, the health personnel agreed that there is a need for a mandate for them to engage in activities to promote health that are not connected, directly, with the provision of health care services. This is in addition to the training and resources that they also require. While a mandate or policy can seem to be a subtle component of infrastructure at some levels, in practice, without such a mandate the urgency of the needs of people requiring treatment often means that the work of promoting health must be set aside.

It is recommended that:

- the Commonwealth, States and Territories, through the Framework Agreements reached to improve the coordination of delivery of health services to Aboriginal people and Torres Strait Island people, agree on the following as a minimum infrastructure for primary health care services to support action to promote health:
 - a community controlled management group that outlines needs, plans services and programs, and allocates funds;
 - primary clinical care services that meet a set of nationally agreed standards;
 - access to secondary and tertiary clinical and support services (such as hospitals, medical and public health specialists);
 - public health and health promotion services to address physical and social environmental health issues (in collaboration with other sectors), and to work with the community to improve health literacy and skills.

This infrastructure will need to be supported by training for community members to ensure that they are equal partners in planning services; by data that is presented in ways that communities are able to use effectively; and by funding that recognises that community development is a critical feature of effective action to solve public health problems.

TOR 2.5

RESCINDED

5. Build effective partnerships within the health sector, with communities, and with other sectors

Intersectoral alliances

The health of Aboriginal people and Torres Strait Island people can only improve when all the sectors and settings that have an impact on their lives are engaged in working with Aboriginal and Torres Strait Island communities to bring about change. It will be necessary for Departments of Education, Employment, Housing, and Justice, for example, to work with Aboriginal and Torres Strait Island health personnel and the health sector to ensure that the decisions made by these sectors contribute to the health of Aboriginal people and Torres Strait Island people.

The process

Empathy and understanding are essential to create effective alliances for health.¹⁴ This is particularly true for Aboriginal people and Torres Strait Island people, who must be engaged in setting priorities, as well as in planning and delivering programs and services.

Most people consulted in the course of this review confirmed the need to build alliances as an essential 'next' step toward developing more effective services and programs to promote the health of Aboriginal people. In the view of the people consulted, alliances are needed between:

- the Commonwealth Department of Health and Family Services, the State/Territory health authorities, and the National Aboriginal Community-Controlled Organisations;
- community-controlled and State/Territory Aboriginal health services;
- health service providers (government and/or community-controlled) and their communities;
- health service providers (Indigenous and non-Indigenous), communities, and other sectors (at the local level);
- State/Territory health authorities, NACCHO, and other sectors (at the State/Territory and national levels).

The review also highlighted the need for a focus on action to promote health in addition to the need to improve people's access to high quality health care services. While the need for culturally effective health care services is an essential prerequisite for improving the health of Aboriginal people and Torres Strait Island people, health care services are not sufficient, on their own.

The holistic approach to their health taken by Aboriginal people and Torres Strait Island people, and the complexity of the determinants of health mean that a 'whole of government' approach will be required to improve the health of Indigenous Australians. That it is possible to achieve effective action through collaboration has been demonstrated in several important projects undertaken by and with Aboriginal and Torres Strait Island communities.¹⁵

Working with other sectors to promote health requires sensitive action by the health sector.¹⁶ However, above all, Aboriginal people and Torres Strait Island people themselves must be engaged as equal partners in making all decisions about actions that affect their health and well-being. The proposed health forums that are to be established in each of the States and Territories as part of the recent Agreements reached between the Commonwealth and States/Territories, NACCHO (through the State/Territory affiliates) and ATSIC offer a mechanism to ensure strong Aboriginal and Torres Strait Island voices in decisions affecting their health made by the health sector and/or other sectors.

It is recommended that:

- the State/Territory health forums:
 - define priorities and assign responsibilities for working with other sectors at State/Territory level to develop policies and programs designed to improve Aboriginal health. This would include working with the Departments of Housing, the Environment, Education for example;

- develop mechanisms by which communities will participate in decisions made by other sectors that affect their health;
- the National Public Health Partnership Work Program establish an ongoing relationship with the National Aboriginal and Torres Strait Islander Health Council to identify opportunities to work jointly to develop and implement intersectoral action with particular reference to the needs of Aboriginal and Torres Strait Island communities.

TOR 2.7

6. Monitoring and surveillance

The Australian Institute of Health and Welfare has identified three main areas in which further work is needed to improve national information on the health of Aboriginal people and Torres Strait Island people. The first is to improve the identification of Indigenous people in all health and vital statistics collections.

The second is to improve the capacity of national household surveys to yield Aboriginal and Torres Strait Islander data, and to ensure that the questions included in the surveys will provide information that is of value to Indigenous people themselves.

Finally, the need is to continue to produce information that allows the links among employment status, land tenure, housing and health to be explored, as was achieved in the National Aboriginal and Torres Strait Islander Health Survey in 1994.¹⁷

Above all, the health personnel consulted pointed to the need for Aboriginal people and Torres Strait Islander people to be partners in the development of monitoring and surveillance systems pertinent to their health.

It is recommended that:

- designated funding be provided to enable the Australian Bureau of Statistics to continue to conduct regular national health and risk factor surveys for Aboriginal and Torres Strait Island people;
- the Australian Institute of Health and Welfare be provided with additional funding to work with Aboriginal and Torres Strait Islander communities to develop a plan to improve all aspects of information about their health and its determinants and about access to health services.

TOR 2.1

7. Research and evaluation

The consultation revealed widespread concern about the lack of appropriate research available to assist Aboriginal and Torres Strait Island communities to make decisions about priorities for and effective action to promote health. Both the focus of much research in their communities and the research process have been questioned by Aboriginal people and Torres Strait Island people. In this, as in so many other areas of infrastructure support, it will be necessary to act to develop the capacity of Aboriginal people and Torres Strait Island people to define their research questions and to undertake the research themselves.

In addition to the need for more relevant research, there is a continuing need for evaluation of action to promote Aboriginal and Torres Strait Islander health. The review highlighted the lack of knowledge about programs that have been developed and implemented already, and about the amount and type of resources that are allocated to promoting health. The review also highlighted the need for culturally relevant program evaluation models¹⁸ that can be used by health personnel with their communities to monitor program quality, and to identify outcomes.¹⁹

A system to monitor the inputs to programs to promote health and the volume and range of activity across the country will need to be agreed upon nationally (through the National Aboriginal and Torres Strait Islander Health Council), and be sufficiently flexible to account for differences in culture and program delivery.

It is recommended that:

- the NHMRC identify specific funding for research to support action to promote Aboriginal and Torres Strait Islander health amongst its priorities during its next triennium;
- the NHMRC establish a ‘research advisory group’ to assist Aboriginal and Torres Strait Islander communities to conduct research and evaluation of actions to promote health;
- the NHMRC allocate specific funding for research proposals from Aboriginal and Torres Strait Island communities;
- the NHMRC ensure that its guidelines do not exclude Aboriginal people and Torres Strait Island people from undertaking research;
- the NHMRC regularly review its guidelines for research in Aboriginal and Torres Strait Islander communities, promote good practice, and ensure that its standards are met in all relevant proposals for funding;
- the NHMRC include amongst its criteria for proposals for research among Aboriginal people and Torres Strait Island people, evidence of a partnership between the researchers and the community in which the research is to occur;
- the NHMRC seek to include Aboriginal and Torres Strait Islander representation on each of its Committees or Working Groups during its next triennium;
- the National Aboriginal and Torres Strait Islander Health Council commission a project to develop a system to identify activities being undertaken to promote Aboriginal and Torres Strait Islander health and the resources allocated to this; and
- the National Aboriginal and Torres Strait Islander Health Promotion Network, in collaboration with the Council of Remote Area Nurses of Australia Inc., and the *Aboriginal and Islander Health Worker Journal* endorse and disseminate guidelines on evaluating Indigenous health promotion projects.

TOR 2.2, 2.6

8. Improving the cultural sensitivity and effectiveness of mainstream health services

The consultation found that many Aboriginal people and Torres Strait Island people must use mainstream health services that are culturally insensitive, ineffective, or inappropriate to their needs. Their experience found that there is continuing and widespread lack of understanding of the needs of Aboriginal people and Torres Strait Island people among non-Aboriginal health professionals—particularly understanding of the way in which historical events underpin much of the ill health experienced by Aboriginal people and Torres Strait Island people. The review pointed to the need for continuing effort to improve the cultural effectiveness of the services offered by all mainstream health services to their Aboriginal clients and patients.

It is recommended that:

- all professional preparation courses for health professionals include assessable instruction on the history and culture of Aboriginal people and Torres Strait Island people and on their needs from the health care system;
- all institutions that are involved in training health professionals be audited regularly by the Department of Employment, Education and Training to assess the extent to which they have succeeded in training Aboriginal and Torres Strait Islander health professionals;

* *The Nganampa Health Service, in collaboration with the Australian Community Health Association’s CHASP program and the Menzies School of Health Research, has done considerable work in developing standards for Aboriginal Health*

- the Australian Community Health Association and the Australian Council on Healthcare Standards be funded to develop appropriate standards for the delivery of services (including health promotion) to Aboriginal and Torres Strait Island clients and patients of mainstream services;
- the National Aboriginal and Torres Strait Islander Health Council commission a project to develop standards for the health care and health promotion services delivered by community controlled and government Aboriginal health services;*
- the National Aboriginal and Torres Strait Islander Health Council commission the development of training programs to support Indigenous health professionals to take up management roles in mainstream as well as in Indigenous-specific services;
- that State/Territory health authorities provide training and support for mainstream health professionals to work more closely with their local Aboriginal and Torres Strait Island communities; and
- the NHMRC, in collaboration with the National Aboriginal and Torres Strait Islander Health Council, develop and disseminate guidelines for survey research in Indigenous communities, for collaboration with Aboriginal people and Torres Strait Island people, and on protocols for contact with communities.

TOR 2.1, 2.2, 2.8

9. Build on and disseminate principles for effective health promotion program development and delivery

This review identified many examples of effective programs to promote the health of Aboriginal people and Torres Strait Island people. There is a newly emerging set of principles²⁰ to guide governments, communities and individuals wanting to promote the health of Aboriginal people effectively. The case studies prepared in conjunction with this project highlight principles of good practice and the infrastructure support necessary to ensure effective, sustainable health promotion in Aboriginal and Torres Strait Island communities.

It is recommended that:

- the National Aboriginal and Torres Strait Islander Health Promotion Network be supported to facilitate the exchange of information about effective Aboriginal and Torres Strait Islander health promotion programs, to contribute to the development of professional practice, and to provide professional support to Aboriginal and Torres Strait Island health personnel working to promote health;
- the *Aboriginal and Islander Health Worker Journal* be provided with additional funding to provide a special section in each issue highlighting an Aboriginal or Islander health promotion program; and
- the National Aboriginal and Torres Strait Islander Health Council commission the development of a 'web site' to enable Aboriginal and Torres Strait Island health personnel access to national and international information on Indigenous health promotion.

TOR 2.9

10. Workforce development

While Indigenous health personnel are increasingly expected to deal with complex and difficult problems, the rate at which they are acquiring professional skills as well as their levels of remuneration do not appear to be keeping pace with the rising expectation.²¹ It is important not to imply that Aboriginal and Torres Strait Islander health can be improved simply by ensuring that all members of Aboriginal and Torres Strait Island populations have access to education or by improving the training of Aboriginal and Torres Strait Island health personnel. However, education and training are necessary components of the infrastructure to support action to promote health.

Workforce development is required at several levels to ensure that Aboriginal people and Torres Strait Island people are employed throughout the health workforce.

There is a need to ensure that all Aboriginal and Torres Strait Island children, adolescents, and adults have access to schooling and support so that they achieve levels of literacy and skills that are the equivalent of their non-Indigenous counterparts.

Aboriginal children and Torres Strait Island children, adolescents and adults should be encouraged and supported to continue their schooling to levels sufficient to enable them to undertake training and professional education generally in areas such as nursing, medicine, teaching, and particularly in public health and health promotion.

Tertiary institutions that offer such courses need to ensure that they are appropriate to the needs of Aboriginal and Torres Strait Island students, that they are accessible and flexible, and that support networks are in place. The institutions also need to ensure that Aboriginal people and Torres Strait Island people are encouraged to enrol and that they are supported throughout their course of study.

Most Aboriginal and Torres Strait Islander health personnel are eager for new knowledge and were very interested in developing their knowledge and skills in health promotion and in undertaking training. The training required must be based upon respect for the knowledge and skills brought by Aboriginal people and Torres Strait Island people based on their own lives and that of their communities. As Bartlett and Legge point out, 'unless the drive and agency of Aboriginal people themselves is recognised and placed at the centre of policy making, program design and service delivery (and training) the technical power of experts will remain relatively ineffectual.'²²

There is, currently, no formally constituted professional body for Aboriginal and Torres Strait Island health personnel (at all), and none for people with specific roles and interests in health promotion. The National Aboriginal and Torres Strait Islander Health Promotion Network is an informal body made up of Aboriginal and Torres Strait Island health personnel who work in or have an interest in health promotion. The level of interest in the Network (which has met only twice) has demonstrated the need for a group that can offer professional support for people wanting to focus on health promotion in particular, opportunities to network and share experiences, and to contribute to the development of appropriate training. The National Aboriginal and Torres Strait Islander Health Council has established a Sub-committee on Workforce Issues and this promises to be an important body to coordinate national action to improve the training for and working conditions of Aboriginal health personnel.²³

The Public Health Association's Special Interest Group in Aboriginal Health also includes Aboriginal people with public health and/or health promotion interests. The Australian Association of Health Promotion Professionals, too, is an organisation that has the potential to provide local or regional support to Aboriginal health promotion workers in some, but not all, States/Territories.

Not only training is required. Training must be linked with access to jobs, to career structures and pay scales that recognise and reward training. The NHMRC's Aboriginal and Torres Strait Islander Health Standing Committee has developed a national training and employment strategy for Aboriginal and Torres Strait Islander health workers and professionals working in Aboriginal and Torres Strait Islander health.²⁴

A National Aboriginal and Torres Strait Islander Health Worker Competency Development Project has drafted national competency standards for Aboriginal and Torres Strait Island Health workers. However, among the six streams into which the 79 units of competency are grouped, there is no 'health promotion' stream. The focus of the other six is on working with individuals who require health care services. This is appropriate and necessary, but it does not appear to differentiate between the provision of these services and the different knowledge and skills that are required to promote health effectively.

It is recommended that:

- the National Aboriginal and Torres Strait Islander Health Council explore the opportunity to work with State/Territory Departments of School Education to ensure Aboriginal and Torres Strait Island children and adolescents have access to culturally effective schooling;
- the National Aboriginal and Torres Strait Islander Health Council, through its Sub-committee on Workforce Issues, commission a project in collaboration with the Department of Employment, Education

RESCINDED

and Training to review and develop programs to encourage and support Aboriginal people and Torres Strait Island people to undertake tertiary education and training in a wide range of disciplines, including health-related disciplines;*

- the Commonwealth Department of Health and Family Services, through the Public Health Education and Research Program (PHERP), ensure that there is at least one, nationally accredited course in Indigenous health promotion available in each State/Territory;
- the NHMRC continue its support for and promote a program (including scholarships and traineeships) to train and support Aboriginal and Torres Strait Islander researchers;
- that the courses in Indigenous Health Promotion be reviewed by the National Aboriginal and Torres Strait Islander Health Promotion Network, and the Public Health Association's Aboriginal Health Special Interest Group for relevance and technical accuracy;
- the National Aboriginal and Torres Strait Islander Health Worker Competency Standards be extended to include more comprehensive 'units of competency' in health promotion;
- the Commonwealth Department of Health and Family Services, through the Community Sector Support Scheme (formerly the Community Organisations Support Program) provide funding to employ a Coordinator to oversee the implementation of the recommendations in this report. The role would have a particular focus on workforce development and the person would:
 - contribute to the development of professional preparation and continuing education in promoting health for Aboriginal and Torres Strait Island health personnel;
 - ensure professional support for the Aboriginal and Torres Strait Islander health promotion workforce including the development of the National Aboriginal and Torres Strait Islander Health Promotion Network,
 - advocate for actions to support Aboriginal and Torres Strait Islander health advancement.

TOR 2.8

* The national Aboriginal and Torres Strait Islander Health Council's Sub-committee on Workforce Issues has begun to work on this.

Part 1:

The consultation with Aboriginal and Torres Strait Island health personnel, organisations and communities

The National Health and Medical Research Council's Health Advancement Standing Committee was commissioned to undertake a comprehensive review and analysis of past and current health promotion initiatives in Australia. The review was intended to inform the preparation of a report by the Committee detailing a range of actions to strengthen action to promote the health of the population. A specific consultation with Aboriginal people and Torres Strait Island health personnel from government and community controlled organisations was established as a major component of the review. The consultation with Aboriginal health personnel, organisations and communities began in February 1996 with the appointment of an Aboriginal Project Officer.

A Discussion Paper based on the first round of consultation was distributed for comment in August 1996. (The process and feedback from this consultation can be found in Appendix one and two). This Final Report has been amended to incorporate the feedback received on the Discussion Paper. The Report addresses the issues that need to be addressed from the perspective of (and in the words of) Aboriginal people and Torres Strait Island people.

The consultation process

At the second annual meeting of the Aboriginal and Torres Strait Islander Health Promotion Network in February 1996, a national Aboriginal and Torres Strait Islander Advisory Committee was formed to advise and support the Project Officer. Members of the Network outlined a range of issues that they considered necessary to address in order to improve the quality and effectiveness of action to promote the health of Indigenous Australians. Using formal and informal networks and advice on key stakeholders from the Advisory Committee, the Project Officer wrote to more than 300 Aboriginal and Torres Strait Islander community-controlled organisations, government departments and non-government organisations to invite them to participate in the consultation. Much of this correspondence was followed up with telephone calls.

Most people were more than willing to be involved and the number of people and organisations consulted then grew through other formal and informal networks. By the time of publication of this Report the consultations had encompassed all States and Territories, including the Torres Strait. More than 1 000 people (predominantly Indigenous) from government and community-controlled organisations had identified issues and recommendations that were included in the Discussion Paper. Following the second round of consultation, further comments were received both verbally and in writing for inclusion in the Final Report.

A series of case studies of examples of effective Aboriginal and Torres Strait Islander health promotion will be published in a companion document. Copies of both reports will be distributed to every person and organisation who has contributed to the consultation. It has also been possible to compile a database which lists Aboriginal and Torres Strait Island health personnel by their title, area of skill, specific program interest, educational achievements, and contact details.

In August 1996 a Discussion Paper was released for public comment. It was distributed to:

1. each person who had contributed to the consultation to date;
2. community leaders;
3. Office of Aboriginal and Torres Strait Islander Health Service, Commonwealth Department of Health and Family Services;
4. the Directors of Aboriginal Health in each State and Territory;
5. the National Chairman of NACCHO;
6. the State and Territory representatives of NACCHO;
7. the Chairperson of the Aboriginal & Torres Strait Islander Health Standing Committee of the NHMRC;
8. the Health Advancement Standing Committee of the NHMRC;
9. the Office of the NHMRC;
10. the administrators of all Aboriginal and Islander community-controlled health services;
11. Chairs of the State Tripartite Forums;
12. Aboriginal and Torres Strait Islander Commission;
13. Chair of the Queensland Aboriginal and Islander Health Forum;
14. State/Territory Directors of Public Health;
15. State/Territory Directors of Health Promotion; and
16. other interested parties on request.

The names of the individual people and organisations that have contributed to this review are listed in Appendix three.

Part 2:

A brief review of the health of Aboriginal people and Torres Strait Island people

The National Aboriginal and Torres Strait Islander Survey (NATSIS) was conducted by the Australian Bureau of Statistics in 1994 as part of the Federal Government's response to the Royal Commission into Aboriginal Deaths in Custody. It was the first national survey of its kind and its purpose was to provide information on the social, demographic, health and economic status of Aboriginal people and Torres Strait Island people across Australia.²⁶

Among its findings were the fact that from 1988 to 1994, the rate of death from all causes decreased by about 10 percent among Australians as a whole, but remained steady among Aboriginal men, and increased among Aboriginal women. It also found that although the prevalence of risk factors for ill health among Aboriginal people and Torres Strait Island people remained high, some noticeable improvements had been:

1. age-standardised death rates from cardiovascular disease declined by 19 percent among Aboriginal males between 1985 and 1992;
2. death from lung cancer was declining among Aboriginal men, although not among Aboriginal women;
3. alcohol-related deaths are declining;
4. deaths from car accidents declined by 27 percent in men between 1985 and 1992, although they remained stable in women;
5. deaths from homicide declined by 50 percent in men in the same period, although they remained stable in women;
6. the number of deaths from pneumonia, which to some extent is a disease of poverty and poor social status, remained stable; and
7. the infant mortality rate continued to decline, but the rate of decline appeared to have slowed.²⁷

Age-specific death rates are higher for Aboriginal people and Torres Strait Island people than for other Australians at virtually every age, but the contrast is most marked at 25-54 years. At these ages, Aboriginal people and Torres Strait Island people die at rates 5 to 7 times higher than those experienced by other Australians.²⁸ Between 1988 and 1994 the gap between Aboriginal and total Australian mortality rates widened, especially for women.

Maternal and infant mortality rates are higher than for non-Indigenous Australians. Infant mortality has declined markedly over the last 25 years, but the rates are still three or four times higher for non-Aboriginal Australia and rates of hospitalisation are extremely high among Aboriginal children.²⁹ Increased rates of stillbirth, neonatal and postnatal deaths accompany low birth weights. Although maternal death is an uncommon event, it is substantially more common among Aboriginal women and Torres Strait Island women than among other Australian women. About 30 percent of maternal deaths occur in Aboriginal women and Torres Strait Island women who constitute only about 3 percent of confinements.³⁰

Admission rates to hospitals have been found to be 60 percent higher for Aboriginal men and 50 percent higher for women than would be expected for other Australians (and this is likely to be a substantial underestimate of actual morbidity).³¹

Rates of hospitalisation for specific diseases such as asthma, diabetes, trachoma, ear/hearing problems, kidney disease, and circulatory diseases and respiratory diseases are much higher than those of the non-Indigenous population.³² Communicable diseases such as haemophilus influenzae continue to have a much greater impact among Aborigines than among other Australians.³³ Sexually transmitted diseases and the threat of the spread of HIV/AIDS are of growing concern.³⁴ Mental health is one of the important health problems among Aboriginal people and Torres Strait Island people. In particular, trauma and grief have been identified as some of the most serious, disabling and distressing issues faced by Aboriginal people-both as a cause of mental health problems and as major problems in their own right.³⁵ While mental health is recognised as an issue by some health care service providers and the wider community it has not been addressed using culturally effective strategies.³⁶

Although the proportion of Aboriginal and Torres Strait Islanders who drink alcohol is lower than the national average, those who do drink are likely to drink enough to harm themselves,³⁷ and the proportion of Aboriginal and Torres Strait Islanders who smoke is more than double the national average.³⁸

Despite these obvious health disadvantages, 88 percent of Aboriginal people and Torres Strait Island people who were surveyed in the National Aboriginal and Torres Strait Islander Health Survey considered themselves to be in good, very good, or excellent health. Another 10 percent described their health as fair, and only percent considered themselves to be in poor health.³⁹

In summary, Aboriginal people and Torres Strait Island people start life smaller and finish it earlier. They experience greater levels of illness throughout their lives, and because of their more limited life expectancy, often do not reach the age of retirement. As a result, most Indigenous people do not receive the age pension. While the health of Indigenous populations in other industrialised nations has improved significantly in recent decades to the point where they are approaching the average health of those nations, the health of Aboriginal and Torres Strait Island peoples, particularly adults, has declined.⁴⁰

Indigenous definition of health

*Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life. Health services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities.*⁴¹

For Aboriginal people, health is holistic. The determinants of good health include a wide variety of structural, environmental, economic, social and biological factors-such as the right to live in permanent, safe houses, have access to a clean water supply, to participate in the employment market and the education sector, and the right to live without experiencing racism.⁴²

The relationship between socioeconomic advantage and health status has been recognised formally for at least 200 years. The inverse association between socioeconomic level and risk of disease is one of the most pervasive and enduring observations in public health.⁴³ There is also a strong association between unemployment and high rates of arrest,⁴⁴ a fact that is of particular significance to Aboriginal people given that one in four adults is unemployed. Many Aboriginal people and Torres Strait Island people experience socioeconomic disadvantage, and all have experienced forced social and cultural change.

2.1 Underlying causes of Aboriginal and Torres Strait Islander health status

The history of the subordination of Aboriginal people by the dominant, non-Indigenous culture has determined and continues to determine the health status of Aboriginal people and Torres Strait Island people in Australia today although the effects of colonisation continue to be, by and large, trivialised or disregarded.⁴⁵

Much has already been written about Aboriginal people and their health. Report after report has documented the poor health status of Aboriginal people and Torres Strait Island people, the enormous difference in life expectancy compared with their non-Indigenous counterparts, and the extent of their social and economic deprivation.⁴⁶⁻⁵⁰ However, the information that is almost always missing from such reports and what Aboriginal people implore non-Indigenous people to learn and understand, is the explanation (*from an Aboriginal perspective*) of the reasons underpinning the poor health status of Aboriginal people and communities and why their poor health persists.

Aboriginality *is not just* skin-based. Living, believing and belonging to a complex system where kinship is the strength of their race, Aboriginal people have a pride in their community which often extends to national membership. With the arrival of Europeans in 1788 and their notion of terra nullius, the lives of Aboriginal Australians were to change forever. Massacres, genocide, dispossession from land, the barring from access to traditional food, religion and spirituality led to the breakdown of both cultural support systems, and family. The Aboriginal population declined from approximately 300 000 in 1788 to an estimated 150 000 people 200 years later. At the time of the 1967 census, this figure had risen to 161 000 and steadily rises each year, with relocation of family, a new sense of pride and/or self-identification.⁵¹ In 1991, the estimated Aboriginal and Torres Strait Islander population was 265 459, an increase of 16.6 percent from 1986.⁵²

The past 208 years have taken away Indigenous people's land, soul, identity and spirituality, leaving them dependent on welfare from government organisations, with some Aboriginal people not knowing who they are, or where to go, particularly as some find it hard to find meaning in the white way of doing things.⁵³ Despite the continuing presence of this legacy in Aboriginal people's lives the resulting disabilities are often 'invisible' to mainstream health care providers, health researchers and government departments.⁵⁴

There are very few Aboriginal families who have not experienced State intrusion into family life, who do not feel a continuing sense of loss and grief from episodes in their personal, family and community histories which were in various ways part of the colonial processes of dispossession, institutionalisation and control. Few have received any kind of culturally effective grief and loss counselling.⁵⁵ Aboriginal Australians have known massacres, have had their family unit destroyed, have direct links with 'the lost generation',⁵⁶ and have had their children stolen for adoption by white Australians. The lack of acknowledgment of these facts by the dominant culture, together with the lack of respect for and ignorance of people and a history that is documented to be more than 50 000 years old, continues to be a major barrier to progress for Indigenous people. As well, the people consulted pointed out that living always with the fear of a renewed emergence of cultural hatred continues to undermine the health status of Aboriginal people.

Fundamental to improving the health of Aboriginal people and Torres Strait Island people, the harm caused by the process of colonisation must be acknowledged and accepted. Hunter, in his review, pointed out that despite the rhetoric of self-determination, Aborigines remain largely dependent on, and thus controlled by, European institutions, with Europeans central in terms of controlling access to the records and artefacts of the past, adjudicating claims to land, defining standards by which Aborigines are judged⁵⁷ and expecting Aboriginal people to assimilate to European culture. Aboriginal people and Torres Strait Island people are still required to access, adapt to and accept programs and services that are not culturally sensitive and that do not acknowledge or provide for their different languages, or their different cultural and health needs.

2.1.1 Destruction of hunter-gatherer lifestyles

The records of early explorers, the findings of studies among Aborigines pursuing a semi-nomadic lifestyle today, and studies of other isolated hunting and gathering groups elsewhere strongly support the assumption that, prior to occupation and colonisation, Aborigines were generally in good health. '...this life, carried out in small groups, would have contributed to good health by discouraging the evolution of communicable disease.'⁵⁸ Aboriginal lifestyles were based on hunting and gathering and much of communities' energy was channelled into the hunting for and gathering of foods. The environment was unpolluted and treated with respect.

The average Australian Aborigine was probably as well off as the average European in the 1800s in terms of their access to nutritional food, shelter and warmth. Aborigines had the clearest advantage in food. Almost

everywhere in Australia they ate foods which would have been rare luxuries to European peasants or town labourers, and at the same time they had plenty of the starchy foods which were the main course at most European tables.⁵⁸

As far back as the 1970s the Federal Government recognised that one of the main problems for Aboriginal people was the number of widespread health problems which had arisen out of the disruption of their traditional lifestyles.⁵⁹ In earlier times, all Aboriginal people had defined roles and responsibilities that were valued by their communities. They were skilled hunters and gatherers, and specific people were responsible for upholding the lore, looking after the children, storytelling, medical practice, and more. Everyone's skills were acknowledged and respected, and everyone contributed something of importance to Aboriginal society. Today, by comparison, much of the work that was once undertaken by Aboriginal people in and for their communities is undervalued or considered to be worthy only of voluntary effort.

Nearly one in four Indigenous Australians is unemployed and employment equity is far from being achieved. It is worth noting, too, that the rate of unemployment would be twice as high without the large number of Indigenous people who have chosen to work through the Community Development Employment Program which is in effect 'working for the dole'.⁶⁰

2.1.2 Disruption of language and culture

Identity and culture are inseparable. Mediating between social forces and changes in behaviours at a population level is the individual. Individual identity formation is contingent on the way the group(s) to which the individual belongs, constructs and articulates its defining characteristics.

Many Aboriginal languages and roles have been lost, while all have been devalued by the wider Australian community and Aborigines must of necessity now use the forms and constructions of English and mainstream society to reach a substantial audience.^{61 62}

Given the enormity of the experience of invasion, the Aboriginal capacity for survival and adaptation has been remarkable. It has survived despite the efforts of non-Indigenous actions and policies (either deliberately or implicitly) to destroy it.

2.1.3 Creation of unhealthy living and social conditions

Soon after they arrived in Australia, colonial administrators set aside reserves that separated Aboriginal people from their land and from contact with the outside world. It has been estimated that as late as 1961 nearly one-third of all Australians recorded as being of Aboriginal descent lived in settlements.⁶³ The settlements, including missions and reserves, were inappropriate and unhygienic and provided not only poor facilities for dealing with survival but also for coping with any health problems that arose.⁶⁴

Forced to live in reserves, missions, and government settlements, Aboriginal people were prevented from maintaining family contact and from leaving the mission without permission, and were not permitted to continue a wide range of the social activities that were a central part of their traditional cultures.

Poor nutrition resulted directly from the confinement of Aboriginal people to reserves, missions, or settlements. They were prevented from hunting and gathering traditional foods. Only a limited range of food of poor nutritional quality was supplied and tobacco was introduced (sometimes in payment for work).

At a more sinister level, in some areas natural drinking water was laced with poison.⁶⁵

There is some evidence that Aboriginal people in a wide variety of regions used psycho-active substances before the first European settlement on their land. A variety of factors served to control the quantity, distribution and ingestion of these drugs.⁶⁶ With European settlement, however, these controls were removed. The alcohol and drug abuse resulting from dispossession and colonisation, State intrusion, removal of children and breakdown of family units has added to problems associated with low socioeconomic status and forced, rapid social change.⁶⁷

RESCINDED

Promoting the Health of Indigenous Australians-Final report and recommendations

Particularly, but not only, in remote Australia, where locational factors compound socioeconomic disadvantage, parental roles were further compromised in the confusion of changes including dislocation, entry into the cash economy, unemployment, and the consequences of alcohol.⁶⁸

Indigenous societies were subdued through systematic intrusion into their fundamental social unit—the family. Colonisation invariably challenged and inevitably disrupted the equilibrium of traditional family roles and structures by assaulting both economic and sacred life—the abiding relationship to land.⁶⁹

Today there are still Aboriginal communities that do not have access to clean water or healthy food.⁷⁰ A housing needs survey conducted by the Aboriginal Development Commission in 1987 reported that one-third of Aborigines across Australia are either homeless or living in substandard conditions, and not all were in remote areas. Access to remote communities is invariably poor, with inadequate roads that are often impassable during flood periods.⁷¹ Unsealed roads during the hot dry season billow a fine powdery red dust which permeates every home, office and medical service, making its way into eyes, throats and lungs resulting in symptoms which cause trachoma, asthma and respiratory diseases to name just a few problems.

Deprivation continues in the 1990s

In the community of Jerrinja Nunda in New South Wales the windows are falling out of resident Delia Lowe's house, the electrical switches are dangerous and an unfinished drain at her mother's house turns into a swamp when it rains. There is only one private bus to Nowra and back each day, and Lowe estimates the unemployment rate at 90-95 percent at the Orient Point community. Delia chooses to live at Jerrinja Nunda and pays rates in the same way as do other Australians. Her community, however does not have kerbs and gutters. Here the roads are classified as being on private land and money for that had to come from 'black' money designated by the Federal Government.

The local mayor claimed that the establishment of new roads and services would undoubtedly lead to a raise in the community's rates.

Delia's mother vividly remembers her stormy street marching days when Aboriginal people from all over Australia marched for land rights. She and those who marched in the 1960s had no idea that they would still be fighting for basic rights and services thirty years later.⁷²

This is only one of many examples of communities throughout Australia.

Summary taken **from** The Sydney Morning Herald, 30 May 1996: p.5

2.1.4 Introduction of new diseases and devaluation cultural responses to health problems

In addition to the suffering and ill health caused by dispossession and disruption of their lifestyles, Aboriginal people suffer today from introduced diseases which were not known by any tribe prior to 1788.⁷³ Chronic conditions such as diabetes, cardiovascular disease, and respiratory diseases are leading causes of premature death and morbidity among Aboriginal and Torres Strait Island communities, while epidemics of infectious disease clearly had a major effect on reducing the Aboriginal population following colonisation.⁷⁴

Effective traditional medicines and healing were (and remain) virtually unrecognised and/or undervalued today by non-Aboriginal people even when a growing body of research has found them to be of value for some health problems.⁷⁵

2.1.5 Subordination caused by racism

Aboriginality is itself a health hazard. Despite the introduction of the *Racial Discrimination Act 1975*, racist practices continue in Australia.⁷⁶ Many of the racist notions and philosophies that Europeans brought with them in 1788 still apply today. Many non-Indigenous Australians are not aware of or do not acknowledge that they hold on to and perpetuate these same racist notions in the 1990s.

Aboriginal people and Torres Strait Island people often have to and are expected to access culturally insensitive mainstream services for treatment, whether they be health services, education, housing, legal assistance, or employment. They often meet with barriers which have been bought about by many of the same racist notions and attitudes that were prevalent in 1788.”

Such attitudes and services deter and prevent Aboriginal people and Torres Strait Island people from accessing the mainstream health system, restrict them from retaining their culture and from making decisions to determine their own future.

2.1.6 Linking the past with the future: a fight for dignity

Even this brief overview of the history of Aboriginal Australians highlights the combination of factors that has determined (and continues to determine) their present-day health status. The taking away of ancestral land and removal of children caused psychological illness and spiritual despair; new diseases were introduced; sacred sites and the physical environment were destroyed, along with the essentially healthy lifestyles that had been enjoyed by Aboriginal people and Torres Strait Island people for more than 50 000 years.⁷⁸

The history of destruction and disease, removal and separation, dislocation and isolation, indoctrination and coercion is fundamentally one of denial-denial of Aboriginal feelings, rights and humanity. Separation remains important as historical fact and as lived reality, its significance reaching beyond those directly affected, with the shame and grief of having had children removed affecting many Aboriginal people and Torres Strait Island people today.⁷⁹

The history of Indigenous Australians means that improving Aboriginal and Torres Strait Islander health is not just a matter of medicines or hospitals. Charles Perkins points out that ‘It’s environmental health and housing and having an economic base. It’s the morale, psychology and culture of Aboriginal people.’⁸⁰ Aboriginal issues are not simple issues and one’s Aboriginality is always underpinned by complex personal, social, cultural, spiritual, historical and environmental factors. Unless these are recognised it will be impossible to improve the health of the Aboriginal population and to ensure that they take their place in a world freed from the inequalities that have been imposed upon them and many other minority groups.

Within the field of health promotion there has been considerable debate about the merits of individual behavioural strategies versus socioenvironmental and policy level changes to improve health.⁸¹ However it is now widely accepted that a range of strategies is needed to improve the health of populations.⁸² People need to have personal skills (knowledge, skills, a sense of well-being, self esteem, identity, control and determination) and to be actively included in the development of appropriate policy and changes in systems (education, health, housing, legal, employment etc.) in order to improve their health. The way forward has been expressed as cultural awakening, self-esteem and self-determination. But Aboriginal elders point out that Aboriginal people do not have an economic base-‘if we do not have jobs our so called health status will never improve’, and ‘everybody wants to put us on a training program-but there’s no jobs at the end’.⁸³

It will be essential to have Indigenous definitions and articulation of problems and local action to address these-in other words, a community development approach. However, ‘real change demands more than simple grass-roots development, which on its own may lead to solutions that remain at the grass-roots-low level change and further dependency.’⁸⁴

The need, now, is to build on the strengths of Aboriginal people and Torres Strait Island people so that they define the agenda for the mainstream agencies working with them and so that they have the support they need to develop partnerships to bring about the large-scale social change that is needed to improve their health.

RESCINDED

Another challenge is to ensure that the range of sectors that make decisions about the environment, housing, legal assistance, employment and education (for example), take responsibility for their actions in relation to the needs of Aboriginal people and Torres Strait Island people. This requires action from sectors other than health, but it is important that the health sector contribute to decisions made by other sectors and that, at every point, Aboriginal people and Torres Strait Island people are engaged in the decision-making process.

RESCINDED

Part 3:

Rhetoric or reality?

Past and present policies act as barriers to better health gains

3.1 Aboriginal policy

The oppression experienced by Aboriginal people in the early years following the colonisation of Australia has been continued through to the present day. Until the 1950s government policy was directed toward achieving segregation. From the 1960s the official formulation of policy by Federal and State Ministers for Aboriginal Affairs was directed toward achieving the goal of assimilation.

A referendum in 1967 gave the Commonwealth government power to legislate for Aborigines. In 1968 the Commonwealth government established the Office of Aboriginal Affairs, and in 1969 the States, which had tended to ignore the special health needs of Aborigines, agreed to establish special units funded by the Commonwealth.⁸⁵

Aboriginal people were granted full citizenship of Australia only in 1967, and only in 1993 was the legal principle of terra nullius overturned by the Mabo Decision.

Australian legislation between the 1950s and the 1970s within a policy framework of assimilation, forced 'mixed race people' to deny their Aboriginality in exchange for the same basic citizens' rights enjoyed by all other Australians. Even today those who claim their Aboriginality because of pride in their heritage and/or for self-identification are often accused wrongly by white Australia of seeking special treatment.⁸⁶

The legacy of this history is being carried in Aboriginal people's lives today. However, the languages spoken by mainstream health care providers, health researchers and government departments, do not have the categories for recognising or speaking about such damage.⁸⁷

Aboriginal people and communities fight to preserve their land and their rights under the law. In less spectacular ways, the law has been shown to be inadequate to protect the health of Aboriginal people. In one State it is only in the last four years that the State's Public Health Act has been enforced in remote Aboriginal communities, while in other parts of the country, local governments have not taken their responsibility for environmental protection and maintenance to include the needs of Aboriginal communities.⁸⁸

The Royal Commission into Aboriginal Deaths in Custody (1989) and the *Native Title Act 1993* represented a new policy era—the move toward reconciliation. The National Inquiry into the separation of Aboriginal and Torres Strait Island children from their families and the establishment of the Council for Aboriginal Reconciliation are also part of this process. However, the implications of these processes for the health and well-being of Aboriginal people are still being worked out and the consultation revealed that there are real fears that even these initiatives are under threat. So far, there have been no major changes in levels of resources or in overall policy directions that are likely to have obvious positive consequences for the health and well-being of Aboriginal people and Torres Strait Islander people.

3.2 Infrastructure and funding for Aboriginal and Torres Strait Islander health

Aboriginal people belong to a poor minority in a wealthy country. Many Aboriginal people live in remote or traditional locations in communities of various sizes, from the highly urban to the extremely remote; and they tend to be found at the bottom of most scales of well-being.⁸⁹

Historically, the States were responsible for Aboriginal affairs. The referendum in 1967 gave the Commonwealth government power to legislate for Aborigines. However, there is no treaty that formalises the relationship between Aboriginal Australians and the Federal Government and this has resulted in the situation where neither the Commonwealth nor the States has assumed full responsibility for providing the services and programs needed to improve the health of the Aboriginal population.”

There has been cost-shifting between the Commonwealth and the States, and contradictions in policies and programming.⁹¹ In short, the provision of services, including health services, to Aboriginal people has developed on an ad hoc basis with minimal national guidance from public health professionals and with little in the way of a policy framework.⁹² Responsibility for Aboriginal health and for funding of services has continued to shift to and fro between different departments.⁹³

Although Aboriginal people pay rates in the same way as other Australians, the kind of land title held by many Aboriginal communities means that their roads are classed as being on private land and money for their repair and upkeep has to come from ‘black’ Federal Government money. This is an example of the problems caused by lack of clarity as to the roles and responsibilities of different tiers of government. State/Territory and Federal Governments have been able to shift (to each other) responsibility for paying for housing, sewage, electricity and other basic infrastructure with the dollar marked ‘Aboriginal’. Cost shifting and ownership of responsibility continues, resulting in Aboriginal communities’ needs not being met.

A recent report commissioned by the Australian Medical Association from Access Economics, a leading national economic analyst, showed that the 1995-96 federal budget allocation for Aboriginal and Torres Strait Islander health represents about \$370 per annum for each Aboriginal and Torres Strait Islander person in the population compared to \$1 034 per annum for each non-Indigenous person.” It is important to recognise, however, that the Aboriginal and Torres Strait Islander Health Programs are currently responsible, essentially, for the provision of primary health care services. They do not, therefore, represent the totality of Federal health funds accessed by Aboriginal people and Torres Strait Islander people.

There are no firm figures on the extent to which Aboriginal people and Torres Strait Islander people access primary care through Aboriginal Health Services as opposed to other services, and no firm figures on Aboriginal and Torres Strait Islander access to other (secondary and tertiary) health services provided through mainstream funding sources. Whatever view is taken of the funding provided for Aboriginal and Torres Strait Islander health, it is a myth that governments spend more on Aboriginal than on non-Aboriginal health. The Access Economics paper goes on to state:

It is open to question whether per capita comparisons or population-based resource allocation formulae really have any place at all in addressing fundamental issues of Aboriginal and Torres Strait Islander health. The real measure of equity in health funding should be equality of outcomes.⁹⁵

Community-controlled health services

The history of the development of health care services for Aboriginal people reveals the extent to which gross racism and discrimination prevailed. Aboriginal community-controlled health services were developed in the early 1970s (initially in urban areas) out of sheer necessity, in order to make primary health care services available to Aboriginal people who were otherwise not receiving any health care until they were seriously ill. The other sources of health care for Aborigines were general practitioners (once Medicare was established)

RESCINDED

who bulk-billed, public hospitals, and special health services for Aborigines, which were slowly developed in all States and Territories with Commonwealth grants. Such grants have long been contentious owing to the lack of accountability and transparency on the part of the States and the failure of the Federal Government to assess the performances of the States using these monies.⁹⁶

Aboriginal community-controlled medical services increased in number during the 1970s. It appears that the Commonwealth always intended these to be a step toward integrating Aboriginal people into mainstream services.⁹⁷

There are now 60 Aboriginal Medical Services throughout Australia. They are funded in the main by the Commonwealth Government and administered by representatives of local Aboriginal communities. The health services employ salaried doctors, dentists and nurses to provide professional services, to administer medicine. They rely on skilled Aboriginal health workers and volunteers. These culturally appropriate Aboriginal community-controlled Medical Services or Aboriginal and Islander Community Health Services (AMS, AICHS, ACCHO) deliver primary health care and health education. The most viable and successful community-controlled services have been those initiated by Aborigines themselves and shaped by the local needs and perceptions.⁹⁸

However, these services are still understaffed and/or underfunded. The community-controlled sector is also unsupported with respect to the development of professional leadership, planning, evaluation and research skills, professional development and information resources.⁹⁹

Government health services

The provision of Aboriginal health services, however, remains the responsibility of the Commonwealth, and the States and Territories. It is not clear who is accountable for what, and the ambiguity of policy regarding the role and purpose of community-controlled and State/Territory run services has created uncertainty and conflict. There has been no consistent national approach to the provision of Aboriginal and Torres Strait Islander health care services and no active, national approach to promoting the health of Aboriginal people and Torres Strait Islanders.

Mainstream services are often insensitive to the customs, beliefs and experiences of Aboriginal people.¹⁰⁰ Many Aboriginal people must frequently travel many miles to seek the culturally appropriate medical attention available from Aboriginal community-controlled Medical Services. The National Aboriginal and Torres Strait Islander Health Survey found that, in 1994, 30 percent of Aboriginal households in rural/remote areas did not have access to medical services or nursing staff within a 25 km radius, 35 percent did not have a community health centre within 25 km, and 52 percent did not have access to an Aboriginal Health Worker within a 25 km radius of their homes.¹⁰¹

Beyond the provision of health care services, however, there has been a very limited national effort to promote the health and well-being of Aboriginal people and Torres Strait Island people. There is no definitive information on the amount of health promotion work carried out by Aboriginal health personnel, or by mainstream health workers. There has been a growing interest in action specifically to promote health, but there has been limited and inconsistent funding, and, in most States, limited infrastructure to support this work.

The Aboriginal and Torres Strait Islander Commission

The Aboriginal and Torres Strait Islander Commission was established in 1990 with national responsibility for Aboriginal health. But the Commission lacked public health and medical expertise and the consultative and planning structures that were established (through regional councils) appeared to cut across those that had been recommended by the National Aboriginal Health Strategy.¹⁰²

RESCINDED

The Commonwealth Department of Health and Family Services Office of Aboriginal and Torres Strait Islander Health Services

In July 1995 the Commonwealth Department of (then) Human Services and Health resumed responsibility for Aboriginal and Torres Strait Islander health at the federal level. The primary focus of the Aboriginal and Torres Strait Islander health program is to fund Aboriginal and Torres Strait Islander health and substance misuse services. The program is also developing strategies to support the establishment of more-and more diverse-primary health care services; to encourage better access, cultural sensitivity and quality in mainstream services; to develop responses to particular health challenges such as diabetes and sexual health; and to address workforce needs for medical and nursing staff and Aboriginal health workers.

In 1995/96 the Office administered funds of \$111.6 million. The greatest portion (\$92 million) was earmarked for the 159 Aboriginal and Torres Strait Islander health services which are funded directly. Most of the rest (\$18 million) is funding for 88 substance abuse services.

The Office is now engaged in a range of programs. These include the direct funding of health services and substance misuse projects, consultation with communities both directly and through representatives networks such as NACCHO, the development of the Framework Agreements with the States/Territories and the subsequent strategic action plans, and workforce development. In addition, a range of initiatives is being undertaken to improve hearing health, and to improve the treatment and care for Indigenous people with mental health problems.¹⁰³

National Aboriginal and Torres Strait Islander Health Council

In May 1996, the Federal Minister for Health and Family Services announced the establishment of the National Aboriginal and Torres Strait Islander Health Council. The Council is a national advisory structure established to provide the Commonwealth Minister for Health and Family Services with broad policy advice on Aboriginal and Torres Strait Islander health issues.

Commonwealth/State/NACCHO/ATSIC Framework Agreements

The Commonwealth and States/Territories, the State/Territory affiliates of the National Aboriginal Community Controlled Health Organisations, and ATSIC have signed framework agreements that aim to improve health outcomes for Aboriginal people and Torres Strait Islander people through:

- improving access to both mainstream and Aboriginal and Torres Strait Islander-specific health and health-related programs which reflect the level of need;
- increasing the level of resources allocated to reflect the higher level of need of Aboriginal people and Torres Strait Islander people, including within mainstream services, and transparent, regular reporting for all services and programs; and
- joint planning processes which will inform the allocation of resources and allow for:
 - full and formal Aboriginal and Torres Strait Islander participation in decision making and determination of priorities;
 - improved cooperation and coordination of current service delivery, both Aboriginal and Torres Strait Islander-specific services and mainstream services, by all spheres of government; and
 - increased clarity with respect to the roles and responsibilities of the key stakeholders.¹⁰⁴

The lack of clear responsibilities, coupled with complex (and competing) organisational and financial structures has contributed to the lack of progress in promoting Aboriginal health. The Framework Agreements, together with the strategic action plans that will follow, have the potential to improve the delivery and effectiveness of services and programs to Aboriginal and Torres Strait Island communities across the country.

RESCINDED

3.3 The National Aboriginal Health Strategy

The National Aboriginal Health Strategy (NAHS) 1987 aimed to set in place actions to improve the health of Aboriginal Australians and to ensure that by the year 2001 Aboriginal people and Torres Strait Island people have the same level of access to health services and facilities as other Australians, specifically by improving health status through changes within the health system and through social and environmental changes.¹⁰⁵

The recommendations of the National Aboriginal Health Strategy included:

- reducing structural problems;
- empowerment and self-determination;
- improving service provision and access to services;
- information about health;
- monitoring of improvements;
- health promotion; and
- education and training support.¹⁰⁶

Although not all recommendations from the NAHS Report have been implemented, the Report provided a better focus for the expenditure of funds to improve health. The National Aboriginal Health Strategy Evaluation found that the health and well-being of Aboriginal people could be improved substantially only if the non-health sector components of any model are in place. It also found that part of the problem may lie in access to services and information. Only 28 percent of Aborigines live in capital cities with easy access to all mainstream health services, 50 percent live in towns and rural communities and the remainder in remote communities. There is great need for more and better information about the health and welfare of Aboriginal people and Torres Strait Islander people.

The NAHS evaluation found that improved information is needed for:

- the identification of health and welfare problems and at-risk groups;
- setting priorities for interventions and policies;
- planning programs and policies;
- monitoring changes over time; and
- evaluating the effectiveness of interventions.¹⁰⁷

The NAHS Evaluation Report also recommended that a workable, expert National Council for Aboriginal Health, involving Commonwealth, State/Territory Governments, ATSIC and NACCHO (be established) to provide policy advice at the national level and oversight the implementation and development of NAHS.¹⁰⁸

3.4 Other initiatives

Despite an overall history of neglect and oppression there have been some significant attempts to improve the health of Aboriginal and Torres Strait Island people:

- the introduction of the *Racial Discrimination Act-1975*;
- the introduction and continuation of the National Trachoma and Eye Health Program-1976;
- the Royal Commission into Aboriginal Deaths in Custody-1988;
- the development and endorsement of the National Aboriginal Health Strategy (NAHS Report-1989 and its evaluation in 1994);
- *the Native Title Act 1993*;

the Queensland Aboriginal and Torres Strait Islander Health Policy;

- the Northern Territory Aboriginal Health Policy;
- Aboriginal Health, Dreaming Beyond 2000: Our Future is Our History. The South Australian Aboriginal and Torres Strait Islander Health Policy and Strategic Framework;
- Torres Strait Health Strategy 1993–Our Health, Our Future, Our Decision;
- the National Health and Medical Research Council’s Aboriginal and Torres Strait Islander Standing Committee;
- the National Centre for Aboriginal and Torres Strait Islander Health Statistics, and the Aboriginal and Torres Strait Islander Health and Welfare Information Unit established by the Australian Bureau of Statistics;
- the National Aboriginal and Torres Strait Islander Health Council was established in 1996 to advise the Federal Minister for Health and Family Services. This is the implementation of one of the recommendations of the National Aboriginal Health Strategy; and
- Framework Agreements signed by the Commonwealth, State/Territory health authorities, NACCHO, and ATSIC to define roles and responsibilities in provision of health care services.

One of the most important casualties of the history of Aboriginal health policy has been that of trust-in governments, in non-Indigenous people generally, and, in some cases, in other Indigenous people. For obvious reasons, there is widespread scepticism, if not anger, among Indigenous people about the lack of success of previous efforts to improve their health. Without trust and a sense of having power to influence events and surroundings, it will be impossible to move forward. For Indigenous people to want for themselves the attainment of spiritual and physical well-being, the actions of government must mirror the recommendations they have endorsed already in the National Aboriginal Health Strategy.

This brief review outlines the effects that Aboriginal policy throughout the history of white settlement has had (and continues to have) on the health of Aboriginal people in Australia today. It also highlights problems that have arisen from Aboriginal health policy in particular and the structures and programs that have been established to provide and administer Aboriginal health services and programs.

Part 4:

Improving the health of individuals and of the population: providing health services and promoting health

Public health is defined as the efforts organised by society to protect, promote and restore the public's health. It is the combination of sciences, skills and beliefs that are directed to the maintenance and improvement of the health of all people through collective or social actions.¹⁰⁹ Health promotion has been defined as the combination of educational and environmental supports for actions and conditions of living conducive to health.¹¹⁰ It is considered to be that part of the field of public health practice that is concerned with solving public health problems.

Improving the health of the Aboriginal and Torres Strait Island populations requires action by all parts of the health sector as well as by other sectors. In addition to public health and health promotion, Aboriginal people and Torres Strait Island people require access to high quality health care services, including primary health care and secondary and tertiary services. Although health services do not compare with the many interactions between people and their environments in determining their levels of health¹¹¹ medical interventions are welcome when the individual's and the population's health balance has been severely disturbed and when the health potential of the individual and his or her immediate environment is insufficient to restore health.

Many Aboriginal people and Torres Strait people do not have ready access to high quality, culturally effective health care services. Given the high prevalence of both communicable and non-communicable diseases among Indigenous populations, this is, in itself, a source of concern. Many of the physical conditions that contribute to the poor health and limited life expectancy of Aboriginal people and Torres Strait Island people could be prevented (or at least cause more limited damage) if they were diagnosed and treated early and appropriately-ear infections among children being an obvious one of these.

There are significant differences between the health services required in urban and remote areas. The health profiles of the residents of remote communities are different from those of urban communities. In addition, the urban Aboriginal population is often more dispersed and transient. In these circumstances community organisation is often more difficult than in remote areas¹¹² making it more difficult to engage them in action to promote health and forcing Indigenous people in cities to use a variety of mainstream services that are not culturally sensitive.

The review confirmed that it will be possible to improve the infrastructure for promoting health only if it does not compete with the need for accessible health care services. Many Aboriginal people and Torres Strait Island people cannot rely on appropriate health care when they are ill, let alone access to preventive services (such as pap tests, blood glucose testing, optometry, or dental care) or to specific health promotion programs or strategies. The Aboriginal people and Torres Strait Island people consulted pointed to the need for a combination of community-controlled primary health care services, State/Territory-run primary health care services, and the continued effort to improve the sensitivity, cultural awareness and effectiveness of mainstream health services, including those provided by general practitioners.

However the Aboriginal and Torres Strait Islander health personnel clearly identified the need for the further development of infrastructure to support specific initiatives to promote health.

The centrality of community development as the process by which to bring about change (in all structures, programs, and services) in Aboriginal communities and populations was highlighted both in this review and all the major documents that have underpinned its development.

It is also clear that to improve the health of Indigenous people will require significant changes in the physical, social, and economic environments within which they live and that these changes must be achieved with the full commitment and participation of Indigenous people, themselves.

There has been tension between these views in the development of Aboriginal health policy, with some policies advocating a primary focus on ensuring access to high quality health care services and others suggesting that, until it is possible to change the environments it is, at best, a 'band aid' solution to provide resources to improve health care services.

It is clear, however, that both are necessary. For many people, it is clear that feeling confident that they have access to health care when they are ill is an integral part of becoming and staying healthy.

No single approach can be sufficient to address the complex network of factors that determines Aboriginal and Torres Strait Islander health. In designing programs the issue is not to choose between individual approaches, but to determine and support the most promising **combinations** of approaches.¹¹³

Part 5:

Infrastructure for promoting Aboriginal and Torres Strait Islander health

5.1 Principles of good practice in promoting Indigenous health

An appropriate model for Indigenous health promotion is one which:

- acknowledges and addresses the effects of their history on the health and well-being of each community;
- is based on strengthening Aboriginal and Torres Strait Island cultures and identity;
- acknowledges Aboriginal and Torres Strait Island cultural influences on attitudes to health and illness; employs educational and environmental strategies that are suited to the particular setting in which the program is to take place;
- operates from the community level, involving Aboriginal and Torres Strait Island community members in each step of the process;¹¹⁴ and
- recognises the relationship between socioeconomic disadvantage and health status.

Many programs such as community housing, community education and community anti-alcohol programs have provided potentially useful tools to assist Aboriginal and Torres Strait Island communities to improve their health. However, there has been a lack of emphasis on enabling communities to use programs in ways that fit with their local perceptions and needs. Experience shows that, to succeed, such programs must use culturally effective structures and processes to enable significant involvement and control by Indigenous people. Without such control and involvement, programs actually weaken the strength of a community to solve its own problems.¹¹⁵ There is overwhelming evidence that people are more committed to initiating and maintaining changes that they helped design or adapt to their own purposes and circumstances.¹¹⁶

The medical model that has been used to define causes of illness and to guide the development of interventions is not appropriate for Aboriginal people and Torres Strait Island people. Their holistic understanding of health and its determinants means that programs need to account for the interaction between the health and well-being of individuals and their living conditions.

Indigenous people have long been taking action to improve their health. However, they have lacked consistent, substantial infrastructure support. The Pipalyatjara Project and the Old Mapoon Project are examples of the positive achievements that are possible.^{117 118} In both cases, successful collaboration has occurred between Indigenous and non-Indigenous people, and between these groups and a range of government and non-government sectors, including housing and the environment. Projects such as these highlight what it is possible to achieve if a partnership between equals is achieved (with respect for the contributions of all parties).

5.2 Infrastructure for health promotion program delivery

The States/Territories have developed different ways of delivering health promotion programs in Aboriginal and Torres Strait Island communities. In all States and Territories, both government and community-controlled agencies fund and implement health promotion programs. The Commonwealth, through the Office of Aboriginal and Torres Strait Islander Health Services, Department of Health and Family Services, provides limited funding for interventions to promote Aboriginal and Torres Strait Islander health.

Northern Territory

In the Northern Territory (where 27.1 percent of the population is of Aboriginal and Torres Strait Islander descent), the Territory Health Services, in collaboration with Aboriginal people, have developed and endorsed an Aboriginal Health Policy.

The Territory Health Services Corporate Plan has made a strong commitment to ‘strengthening public health services to deliver effective prevention and health promotion strategies with particular emphasis on populations with high levels of sickness and early death’. It is also committed to better support and equip staff to deliver results.

The Territory Health Services have provided special incentive funds to support health promotion activities in remote and rural Aboriginal communities. Aboriginal Health Promotion Officers provide support for Aboriginal Health Workers and communities in terms of preparing submissions and helping to identify projects.

Two Aboriginal Health Promotion positions are located in each of the five regions of the Northern Territory—Alice Springs, Tennant Creek, Katherine, Darwin and Nhunumbuy-Arnhem Land.

There has been a strong emphasis on developing appropriate training and support for the Aboriginal Health Promotion Officers and a Certificate VI course in Health Promotion Principles and Practice is now ready for accreditation. The Aboriginal Health Promotion Officers also teach an accredited course in health promotion for Senior Aboriginal Health Workers, who then apply their knowledge and skills in developing health promotion activities through their Community Health Centres.

The Anyinginyi Congress and the Central Australian Aboriginal Congress, are two of the community-controlled organisations in the Territory that have developed and implemented a wide range of health promotion and public health activities.^{119 120} These have targeted issues as widely varied as child care training, Health Worker training, alcohol misuse, and head lice. Anyinginyi Congress was instrumental in the successful legal challenges that led to alcohol restrictions being implemented in Tennant Creek.” The Aboriginal Medical Services of the Northern Territory is the Northern Territory affiliate of NACCHO, the peak body of community-controlled health services.

New South Wales

In New South Wales, a small Aboriginal Health Promotion Unit was established in the NSW Health Department in the late 1980s. Several designated Aboriginal Health Promotion Officer positions were created at that time. Not all the positions have survived successive changes in government policy and funding, although in each of the Health Service areas that includes a significant Aboriginal population, there is at least one Aboriginal Health Promotion Officer position.

The Aboriginal Health Branch of the NSW Health Department has, as part of its role, responsibility to provide Aboriginal communities with information and resources on Aboriginal health. The Branch has just completed a review of all existing health promotion resources and an updating of these will be carried out in consultation with other Central Units and Area Health Services. Locally based health promotion activities will be undertaken by Aboriginal Health Coordinators who have been given specific funding. Health promotion activities with State-wide significance and that require a high level of funding will be centrally administered by the Branch on the basis of submissions. The Branch also funds health promotion activities on a submission basis from community health organisations.

The Aboriginal Health Resource Cooperative in New South Wales is the peak body for community controlled health organisations in that State. The Aboriginal Medical Service in Redfern has a full-time public health coordinator and the service, like its counterparts throughout the State, conducts a variety of educational and community development programs. Programs on the issues of HIV/AIDS, antenatal education, parenting, and drugs and alcohol are some of those that have been developed and delivered in recent years.

New South Wales is currently working to develop community-determined local Aboriginal health plans as part of the Partnership Agreement signed in July 1995 between the NSW Health Department and the Aboriginal Health Resource Cooperative.

Western Australia

In Western Australia, the State Health Department has also established an Aboriginal Health Promotion Program structure that includes six Aboriginal Health Promotion Units in regions across the State. The Units conduct a range of culturally appropriate programs to address issues such as alcohol and drug use, nutrition, smoking, road safety, and HIV/AIDS. The program also includes training in health promotion for Aboriginal Health Workers.

In Western Australia, the health promotion foundation, Healthway, has provided funding for Aboriginal and Torres Strait Island health promotion projects. A special Aboriginal Health Promotion Projects Grants Scheme was established by Healthway in 1992.¹²²

The Western Australian Aboriginal Community Controlled Health Organisation (WAACCHO) is the State affiliate of NACCHO in Western Australia. The Kimberley Aboriginal Medical Service administers three Aboriginal Medical Services and has established a Public Health Program. The Program has been responsible for developing and implementing a range of programs to promote health, including reducing the spread of sexually transmitted diseases, improving the use of contraception, and screening people for conditions such as diabetes, or high blood pressure. The theatre group HEATWORKS (Health Education and Theatre Works), has proven to be a successful way to raise awareness of HIV/AIDS, diabetes and hypertension, alcohol and drug abuse, and self esteem among a wide range of Aboriginal people in the Kimberley. To their credit, the company has toured across Australia, despite the lack of continuous funding.¹²³

Queensland

The Queensland Aboriginal and Torres Strait Islander Health Policy Unit has, as part of its role, responsibility to provide Aboriginal communities with information and resources on Aboriginal health. The Queensland Health Department has developed an Aboriginal and Torres Strait Islander Health Policy that was acknowledged in Parliament in 1994.¹²⁴ The Policy identified several key areas for future action to improve the health of Indigenous people with particular emphasis on primary health care services controlled by communities as the point of program delivery. The Business Plan for implementing the policy was endorsed by Cabinet in 1996. The Aboriginal and Torres Strait Islander Health Policy Unit received almost \$3.5 million in 1996 to implement the policy-to implement programs across Queensland, including in the Torres Strait.

The Aboriginal and Torres Strait Islander Health Policy Unit funds (on a submission basis) projects of state-wide significance or that require a high level of resources. The Unit has signed a bilateral agreement with ATSIC, defining the roles and responsibilities of each.

Several of the regions in Queensland, particularly in the northern part of the State and in the Torres Strait have employed designated Aboriginal (or Torres Strait Islander) Health Promotion Officers and Aboriginal or Islander Regional Coordinators. This has enabled the development and implementation of a range of resources and programs.

In Queensland, too, there have been several initiatives to identify options for improving the training and support needed by Aboriginal Health Promotion Officers and Aboriginal Health Workers to develop their knowledge and skills in promoting health.

The Queensland Aboriginal and Islander Health Forum (QAIHF) is the Queensland affiliate of NACCHO. As in the other States and Territories, community-controlled services offer a wide range of programs to improve the health of Aboriginal people and Torres Strait Island people. Some of these include antenatal education, HIV/AIDS prevention, breast cancer and pap smear education, prevention of domestic violence, and education and assistance in treating diabetes.

South Australia

The Aboriginal Health Council of South Australia and the South Australian Health Commission have developed an Aboriginal Health Policy and Strategic Framework. Linking public and environmental health, primary health care, health promotion, and a social view of health in the pursuit of justice and equity, the Policy and Framework have provided the backdrop to action to promote Aboriginal health in that State.

The Aboriginal Health Division of the South Australian Health Commission has developed a Strategic Directions document which forms the basis of a mechanism to facilitate the above. The Aboriginal Health Division will gain two designated Health Promotion positions early in 1997 and will begin developing appropriate programs in conjunction with the Aboriginal Health Council, community members and Aboriginal Health Workers.

The Division will also work closely with the South Australian Health Commission's Health Promotion Unit and become more actively involved with national projects, relevant training programs, workshops and conferences.

A newly accredited course in Primary Health Care is providing wider opportunities for Aboriginal and Torres Strait health personnel in South Australia to participate in training to support their work in promoting health.

The Aboriginal Health Council of South Australia is the South Australian affiliate of NACCHO and is a signatory of a Memorandum of Understanding with the South Australian Health Commission, the Aboriginal Health Division and of the newly established Agreement on Aboriginal and Torres Strait Islander Health Partnership.

Victoria

The Victorian Department of Human Services has an Aboriginal Health Unit that is responsible for supporting Aboriginal health promotion in that State. The Koori Health Unit is responsible for coordinating the Commonwealth's Special Funding Program for Aboriginal and Torres Strait Islander HIV/STD/Hepatitis C initiatives in Victoria. Individual community programs are funded on a submission basis, from which two part-time sexual health community education prevention and promotion positions have been created, as well as positions in Mildura and Robinvale during the fruit picking seasons.

The Koori Health Unit, following community consultation, implements a variety of state-wide sexually-transmitted disease health promotion strategies, including train the trainer camps, interactive computer programs, and culturally specific puppet plays.

The Victorian Aboriginal Community Controlled Health Organisation Inc (VACCHO Inc) is the Victorian affiliate of NACCHO. The Victorian Aboriginal Medical Service employs a full-time Health Promotion Officer who is responsible for implementing a range of health promotion programs in the community.

Tasmania

There is an Aboriginal Health Unit within the Department of Community Services and Health, which is responsible, amongst other things, for overseeing and some funding of action to promote Aboriginal health. There are no designated Aboriginal Health Promotion positions.

The Tasmanian Aboriginal Health Service is that State's affiliate to NACCHO.

5.3 In summary: limited infrastructure support for health promotion

The history of Indigenous people in Australia continues to determine their health status today. Government policies that have had, variously, as their goals, segregation, protection, assimilation, or self-determination have failed to deliver the essential requirements for long-term improvements in Aboriginal health-access to safe

water; adequate housing; nutritious, affordable food; appropriate storage systems; and well maintained sewage and garbage disposal.¹²⁵ Nor have they been able to provide adequate, effective health care services to all Aboriginal people and Torres Strait Island people.

Indigenous people have not been empowered to speak and act on their own behalf. There are continuing barriers to the emergence of strong Indigenous voices about health policy.¹²⁶ Most of the focus of Aboriginal and Torres Strait Island health policy has focused the provision of health care services and has not provided the focus or mandate required to promote health. As a result, the systems and structures that have been established to implement Aboriginal health policy have not led to the development of a consistent, focused, sustained effort to promote Aboriginal and Torres Strait Islander health.

The lack of definition of the roles and responsibilities of different levels of government for Aboriginal and Torres Strait Islander health has contributed to the continuation of cost shifting and ownership of responsibility between Federal and State/Territory Governments (and between different sectors), while the availability of designated, Aboriginal funding has allowed mainstream health service providers to abdicate their responsibility for providing services (including health promotion) to their Indigenous communities.

Where services, programs or structures have been established this has rarely been in collaboration with Indigenous people or communities. There has been ignorance of the realities of Indigenous people's lives or living conditions, and/or the attribution of most problems to a lack of education on the part of Indigenous people. This is of particular concern when applied to the problems of environmental health, where there have been gross inadequacies in the design of housing and of the hardware for waste management, and of systems for maintaining these.¹²⁷ While these matters are the responsibility of sectors other than health, the consultation highlighted the need for the health sector to be engaged in developing solutions with communities and the other sectors.

Finally, there continues to be an overall lack of resources for promoting Aboriginal and Torres Strait Islander health as well as for health care services. The limited evidence currently available suggests that combined Commonwealth and State/Territory expenditure on health services to Aboriginal people remains well below the average per capita expenditure on health services to non-Aboriginal Australians.¹²⁸ With no independent economic bases, Aboriginal and Torres Strait Island communities have not had the resources to compensate for this lack of funding.

This review revealed that there is relatively limited infrastructure yet in place to support the development of more effective programs to promote the health of Aboriginal people and Torres Strait Island people. It has also revealed that the current infrastructure for program delivery is fragmented and poorly supported by the mainstream health sector. The focus of most policy has been on the provision of health care services, with the consequence that priorities, funding, and the other components of infrastructure support that are necessary to promote health have been overlooked or underdeveloped.

The review¹²⁹ identified the components of the infrastructure support that is needed for effective action to promote health in populations. The consultation with Aboriginal and Torres Strait Islander health personnel reported in this document confirm the need for:

- health policy that focuses on improving the health of Australia's Indigenous population (in addition to providing high quality health care services);
- partnerships among Indigenous people and organisations, with non-Indigenous people, with the mainstream health system, and with sectors other than health;
- monitoring and surveillance to identify problems and to measure progress;
- research that identifies the reasons problems are occurring and that helps to select appropriate solutions;
- workforce development to ensure that the people who are responsible for delivering programs have access to training, ongoing education, career paths, and professional support networks;
- effective systems to deliver programs at national, State/Territory and community levels;
- active engagement with other sectors (e.g. housing, education, local government);

RESCINDED

evaluation to identify 'what works' and to identify the extent of the overall effort to promote health;

- a formal, transparent process to identify priorities and to allocate resources; and
- mechanisms and forums for effective community participation.

This review has confirmed the need for development of such an infrastructure to support the promotion of Aboriginal and Torres Strait Islander health.

In addition, the consultation with Aboriginal and Torres Strait Islander health personnel found that in addition to the infrastructure support outlined above, first priority was for widespread public acknowledgement of the history of Aboriginal people and Torres Strait Island people, and of the effects of their history on their health, today. Many, if not most, people consulted, saw this as a critical first step toward the development of the partnerships between Aboriginal people, Torres Strait Island people, non-Indigenous people and the institutions that affect their lives and health.

Although this step falls outside the ambit of the terms of reference for the review, the consultation has given a clear mandate for its inclusion in the recommendations of this report.

Part 6:

Findings from the consultations

The consultation with more than 1 000 Aboriginal and Torres Strait Islander health personnel confirmed the need for improved infrastructure support for action to promote Aboriginal and Torres Strait Islander health.

6.1 Acknowledgement of the effect of their history on the health of Aboriginal people and Torres Strait Island people today

The Aboriginal and Torres Strait Islander health personnel consulted in the course of preparing this report almost universally pointed to the effects of the history of Aboriginal people and Torres Strait Island people on their health, today. In their view, unless this is acknowledged by non-Indigenous Australians in general and the health sector in particular, it is unlikely that action to promote the health of Aboriginal and Torres Strait Island populations can succeed.

6.2 Extended health policy framework developed with strong Aboriginal and Torres Strait Islander participation

The review highlighted the lack of national policy to direct action to promote the health of Aboriginal people and Torres Strait Island people (in addition to providing accessible, high quality health care services). Without the mandate provided by a policy framework, it is difficult to set priorities for, and to allocate resources to the infrastructure and action necessary to promote Indigenous health-at national, State/Territory and local levels. There is a need, now, to focus on developing a more cohesive, national policy framework to enable Aboriginal communities and Torres Strait Island communities (in partnership with a wide range of government, non-government and community organisations) to take sustained and sustainable action to promote their health.

At the State/Territory level, Queensland, South Australia, and the Northern Territory have each developed an Aboriginal and Torres Strait Islander health policy in collaboration with Aboriginal and Torres Strait Islander organisations and people. Each represents a major step toward the development of an active partnership between the State and its Aboriginal population. There is a need for such policies (and implementation strategies) in each of the States/Territories.

A national policy framework would help to address the need for greater coordination of effort and cooperation between Commonwealth, State and local governments. The National Aboriginal and Torres Strait Islander Health Council appears to offer the opportunity to develop the policy framework and to recommend priorities for action.

Through the Framework Agreements reached with the Commonwealth, States/Territories, NACCHO, and ATSIC, there is a further opportunity to define roles and responsibilities with regard to promoting health in addition to those related to the provision of health care services.

The review highlighted the centrality of primary health care services to the infrastructure for promoting health. However, the health personnel pointed to the fact that their roles in providing health care services often precluded them from taking a more active role in promoting health.

Health organisations are often more concerned with providing treatment, rehabilitation, and palliative care services than with promoting health. They are not accountable for promoting health. Rather, they are accountable for the number of people treated, and the number of individual services provided. In turn, staff are not expected to engage in health promotion, are not rewarded for doing so, and receive little support or training for this kind of work.

Without the mandate provided by policy, and the resources (including funding, training and support, and research) it is difficult to ensure that there is a continuing focus on promoting health in Aboriginal and Torres Strait Islander communities.

6.3 Effective systems at national, State/Territory and local levels to design and deliver health promotion programs

The holistic view of health held by Indigenous people, coupled with the complex historical and contemporary determinants of the health status of Aboriginal and Torres Strait Islander populations means that to be effective, action to promote health must address a wide range of issues.

The consultation confirmed that active involvement of communities in setting priorities, in planning, implementing, and evaluating action is fundamental to all action to promote health in Indigenous communities. The diversity of cultures, languages, and living conditions of Aboriginal and Torres Strait Island communities requires all interventions to be tailored specifically to communities' needs.

There has been only limited opportunity, yet, to develop a clear set of principles to guide action to promote health in Indigenous communities. The consultation revealed a range of positive actions being taken currently to promote the health of Aboriginal and Torres Strait Island communities and the case studies that have been documented in the course of this review provide a substantial contribution to this body of knowledge.

The consultation highlighted the need to continue to document examples of effective health promotion in Indigenous communities in order to compile a more extensive body of evidence.

At present, however, the infrastructure to set priorities for action and to allocate resources to promote Indigenous health is limited. At local and State/Territory levels there has been some effort to develop a program delivery system. But with the notable exceptions of the Northern Territory, Western Australia, and North Queensland, the commitment to promoting health has been limited, with the consequence that the program delivery systems are limited, too.

At the local level, the Aboriginal Health Workers are a key component of an effective program delivery system. However, they require training and support from trained health promotion personnel. They require a mandate for their work in promoting health and designated resources.

At State/Territory levels, the need is for a system that is able to develop policy, to establish priorities, and to allocate resources according to criteria negotiated with each of the agencies responsible for delivering programs and services to defined populations at local levels. At the State/Territory level, too, there is a need for integrated action with other sections of the health sector (e.g. women's health, HIV/AIDS, drugs and alcohol), and for action with other sectors. The Agreements signed by the Commonwealth, States/Territories, NACCHO and ATSIC hold the key to the successful development of State/Territory level program delivery systems.

At the national level, the National Aboriginal and Torres Strait Islander Health Council and the National Public Health Partnership, working in concert, have the potential to set policy directions, establish priorities and allocate resources accordingly.

A key element of all the negotiations and agreements that arise from these is the extent of community level participation and the transparency of decision making processes.

6.4 More transparent processes to identify priorities and allocate resources for promoting health

Funding to promote Aboriginal and Torres Strait Islander health has been limited, inconsistent, and short term. The National Aboriginal Health Strategy identified a series of priority issues for action, but it is not clear that resources have followed the priorities, particularly in relation to promoting health and primary preventive activities.

RESCINDED

In both community controlled organisations and government health services, the need for resources to promote health must compete with the need to provide health care services. Without a policy that focuses on promoting health and preventing disease, without an infrastructure to deliver programs, and without sufficient resources (money, skilled staff, and organisational support) it will not be possible to achieve equality in the health outcomes achieved by Indigenous and non-Indigenous Australians.

At the local level, the review highlighted the lack of resources available to promote health-funding, training, research, and material support, such as computers and cars. Few of the health personnel or organisations consulted had separate, recurrent budgets for health promotion activities. Funding for community-controlled organisations, in particular, often depends upon the number of sick people accessing the service rather than on the cost of bringing about the changes required in the environment to prevent illness.

The personnel also pointed to the need for sufficient recurrent funding to allow programs to be developed and implemented over sufficient time to enable successful outcomes to be achieved. They also pointed out that lack of funding for permanent employment also prevents health personnel from planning their future and/or their own career paths and disrupts continuity of care.

But at national and State/Territory levels the per capita expenditure on Aboriginal and Torres Strait Islander health (largely on health care services) is lower than that on their non-Indigenous counterparts. The review highlights the extent to which there is a need to redress the current imbalance in expenditure on the provision of health care services, and to increase the level of funding available specifically to promote health. It is also clear that there must be a more equitable expenditure of 'mainstream' health funds on promoting Aboriginal and Torres Strait Islander health. There is an urgent and growing need for partnerships at national, State/Territory and local levels to enable more concentrated, more sustained and simply more action to promote Aboriginal and Torres Strait Islander health. This will mean redressing the current imbalance in the allocation of resources, in addition to the need for more funds to address the much greater needs of Aboriginal people and Torres Strait Island people.

There was little evidence of the use of strategic plans at community or regional/area level to guide the allocation of resources, and health personnel clearly identified the need for such plans to be developed-by health personnel from government and community-controlled organisations working in partnership with each other, their communities, and with mainstream health promotion services. Again, the development of such plans will require training and support for the health personnel involved.

6.5 Organisational support for health promotion

Health personnel from both government and community controlled organisations pointed to the need for their organisations, their managers and administrators to support health promotion activity and to support their workers to undertake training wherever possible.

'When no interest is shown by management in their work, frustration sets in and leaves workers feeling a sense of worthlessness'.¹³⁰ There is much that needs to be done to develop an effective infrastructure to support the development of an effective, Indigenous health promotion workforce which truly supports dedicated Aboriginal health personnel. Some workers who had had formal training wanted more support from their managers for work to account for and evaluate the health care services and health promotion programs that they develop.

Many of the issues are linked with an overall lack of resources-the multiple roles (including clinical work and health promotion) that Aboriginal health personnel are required to play in their communities, the isolation of many health personnel and lack of professional support and the lack of sufficient health personnel to carry out the work that is necessary (clinical as well as health promotion) mean that it is difficult for both managers and health personnel to undertake all the work that is needed.

Other issues are related to lack of knowledge about and respect for the work carried out by Aboriginal and Torres Strait Islander health personnel and community members. These included lack of recognition of the work done by volunteers, many of whom are elders, in Aboriginal and Torres Strait Islander communities. In addition, in the view of the health personnel, the administrators, both Indigenous and non-Indigenous, need to trust health personnel more and to support them in their work.

At the local level, often health personnel working in community-controlled organisations and health personnel in departments have no idea what the other is doing although they believe that by working together it would be possible to achieve improved results.

Many of the health personnel consulted pointed to that fact that they should be able to take their place as equals in an integrated Australian society and/or workforce. But many are being denied access to higher positions due to a perception that they are uneducated and so unable to hold positions of authority or to be involved in the design of suitable career structures. When Aboriginal health personnel are employed in the mainstream system their previous experience in the delivery of clinical service for example, (sometimes for as long as twenty years service) is often not formally recognised. Other work experience is overlooked. In addition, Aboriginal health personnel still face entrenched, institutionalised racism.

6.6 Partnerships within the health sector and with other sectors

6.6.1 Between Aboriginal health personnel in government and community controlled organisations

The health personnel agreed that there appear to be many ways in which community controlled and government organisations (at the local level) can work together to improve the range, quality and effectiveness of Indigenous health promotion. Health personnel requested that both health personnel who are working in community controlled organisations and health personnel who are working in government departments:

1. be allowed and encouraged to work together at each other's workplace, during the course of a usual working day (or days), to gain a thorough understanding of each other's role;
2. be given more autonomy to decide on the issues to be addressed in their communities and in working with communities to develop effective solutions;
3. meet regularly at rotating venues to discuss local issues and to update on each others work;
4. work together on joint projects and programs so as not to duplicate services and to exchange skills;
5. write and submit joint submissions for funding for joint projects so as not to compete for the same slice of the funding cake;
6. be encouraged and supported by community and administrators to participate in mainstream health promotion and other types of conferences;
7. work to increase communication across regions;
8. wherever possible, to coordinate program development and support;
9. support the development of Aboriginal health training units in each region; and
10. support community-controlled organisations.

At the national and State/Territory levels, the Framework Agreements signed between the Commonwealth, States/Territories, NACCHO and ATSIC were a much needed step toward clarifying the roles and responsibilities of each of those jurisdictions and agencies.

6.6.2 Between Indigenous and non-Indigenous Australians

Aboriginal health personnel themselves have stated repeatedly during this consultation that there is a need for the building of many partnerships. Although Aboriginal people will never forget the impact of colonisation and should never be expected to, and other barriers such as racism, paternalism, ethnocentrism and paternalistic attitudes survive and thrive, Aboriginal culture lives on. However, it seems that the health of Aboriginal Australians might begin to improve only by building partnerships not only with non-Indigenous people, but with Aboriginal health personnel across all departments and across government and community-controlled organisations.

RESCINDED

It is only by Australians working together to build understanding, trust and coexistence between Indigenous and wider communities that the health of Aboriginal people and Torres Strait Island people can be fundamentally improved.¹³¹ It is not enough, however, to appoint Aboriginal health personnel in isolation as a sole representative of the community in government positions they often face alienation and intimidation from their own community and other generalist health promotion personnel.

On a positive note, this review and case studies have identified many examples of successful partnerships between Indigenous and non-Indigenous people working to promote the health of Aboriginal people and Torres Strait Island people.

One recent example is an agreement between the Northern Territory University, the Royal Darwin Hospital, the Territory Health Services, and Flinders University in South Australia, that is intended to improve Indigenous people's access to medical training. The training program will use a curriculum that has been designed in collaboration with an Indigenous Advisory Group and students will have the opportunity to work in Aboriginal health organisations during their training. This is one example of many steps being taken in South Australia to improve Aboriginal people's and Torres Strait Island people's access to tertiary education. Strong partnerships between equals are fundamental to the success of such initiatives

The guidelines in Appendices two and three have been prepared for non-Indigenous people and organisations who wish to create healthy partnerships with Indigenous people.

An example of an effective partnership

The National Aboriginal and Torres Strait Islander Health Promotion Network

An effective working partnership between Indigenous and non-Indigenous health professionals began in February 1995. In association with the Seventh National Health Promotion Conference in Brisbane, the National Centre for Health Promotion and the National Heart Foundation of Australia initiated a meeting with Aboriginal and Torres Strait Islander health workers who were engaged in health promotion. From this meeting, the National Aboriginal and Torres Strait Islander Health Promotion Network was established and an action plan was developed. Further membership from Torres Strait Island people is encouraged. Membership of Aboriginal Health Workers employed by community-controlled organisations is also encouraged but some administrators have blocked membership.

Network members and non-Indigenous staff from the National Centre for Health Promotion have worked in partnership to implement the action plan. They have coordinated the planning, implementation and evaluation of Aboriginal input into the mainstream Eighth National Health Promotion Conference held in Sydney in 1996, participated in a second satellite meeting of the Network at the Conference, and during 1995, wrote an article for publication in the *Australian Journal of Public Health*. The partnership became stronger during 1995/96 through participation in regular teleconferences. In addition, the Network has supported the National Centre for Health Promotion and the Koori Centre at the University of Sydney in a successful application for funds to establish a Graduate Diploma in Indigenous Health Promotion.

Some members of the Network have acted as the Advisory Committee for the Aboriginal and Torres Strait Islander section of this review. Their involvement shows their commitment to the project, and the preparedness of members to collaborate and to provide support for the project and the Project Officer. This is a model of an effective partnership. The health workers advised that it has been an important process that as many health workers as possible have had the opportunity to contribute to the review, and that the consultation was not confined to administrators and managers.

The Network and non-Indigenous staff of the National Centre for Health Promotion continue to work in partnership to improve the health of Aboriginal Australians. A national symposium held in December 1996 included a theme on Indigenous health, and considerable effort was made with

the Network to encourage and enable Aboriginal people and Torres Strait Island people to attend and to contribute to the discussion.

This particular partnership has succeeded because the Aboriginal and Torres Strait Islander health workers have specified the desired outcomes of working in partnership. The National Centre for Health Promotion has been clear about what it is able to offer in support of these, and together, it has been possible to make real progress toward achieving the agreed outcomes.

Both groups are involved in all decisions about the actions to be taken by the Network, and both benefit from the outcomes achieved.

6.6.3 Among the different levels of government with responsibility for Aboriginal health

The need for a more organised, coherent approach to providing services and programs to improve the health of the Aboriginal population has been widely recognised in all recent reports on Aboriginal health or related issues.¹³²⁻¹³⁴ All these authors have agreed that overcoming the structural barriers that have been erected in the name of Aboriginal health policy will be both difficult and necessary if progress is to be made. At the community level, too, there is widespread agreement that the development of effective, enduring partnerships is a necessary prerequisite for improving Aboriginal health.

6.6.4 Between the health sector and other sectors

It is widely acknowledged that many Aborigines have a poor living environment and that this is a major factor in their level of ill health.¹³⁵ The rates of death experienced by Aboriginal and Torres Strait Islander populations are a direct consequence of the social circumstances in which most Indigenous families are trapped, and the history informing that reality.¹³⁶

Low socioeconomic status in general and inequality in the distribution of income are significantly associated with health outcomes, social indicators and mortality trends.¹³⁷ (The 1994 NATSIS survey found that while one in 40 Australian adults was unemployed, the equivalent figure for Indigenous adults was one in every 14.)¹³⁸ The Royal Commission into Aboriginal Deaths in Custody detailed the physical and social conditions in which many Aboriginal people and Torres Strait people live and work.¹³⁹ In the context of Aboriginal health, the most important area in which intersectoral collaboration is needed is at the local community level building cooperation between land councils, community councils, education associations, housing associations and health organisations.¹⁴⁰ The solutions to the public health problem can be reached only by working with Aboriginal and Torres Strait Islander populations, and with a wide range of sectors-housing, employment, education, justice, for example.

6.7 Research, evaluation and dissemination of good practice

The review revealed continuing concern among Aboriginal people and Torres Strait Island people about research in their communities. Most of the people consulted referred to the fact that there is more than enough research that identifies problems. The need identified is for research that assists in solving problems identified by Aboriginal people and Torres Strait Island people.

The people consulted expressed the view that the development of ethical guidelines by the NHMRC and of Aboriginal Research Ethics Committees in the Northern Territory, South Australia, Victoria, and Western Australia, has been helpful but that further effort is needed to ensure that the guidelines and processes are adhered to. In Victoria, it has been recognised that it is important to encourage community confidence in the research process, and in that State, a set of procedures has been proposed for potential researchers to follow.

There is also a need to assist Aboriginal people and Torres Strait Island people to undertake their own research, and to develop methods to present data¹⁴¹⁻¹⁴³ so that individuals and communities can use the information themselves, for their own purposes.

The health personnel wanted assurance that all information be fed back to the community, the participants at workshops and involved in projects, or the people who contribute to consultations-not just to government workers.¹⁴⁴

The health personnel pointed to the need for assistance in writing up projects for publication, with particular emphasis on building knowledge of effective Indigenous health promotion practice and required practical assistance to establish effective, appropriate evaluation mechanisms for their programs.

The limited infrastructure support for Indigenous health promotion has meant that evaluation of individual interventions has been limited, with inappropriate technologies being one reason for this. However, evaluation can be expensive and time consuming-employing resources that are scarce in Aboriginal communities.

There is no nationally agreed framework or mechanism to allow evaluation of the levels of input to promoting Indigenous health; nor have standards been developed to enable measurement of the quality of interventions.

6.8 Workforce development

6.8.1 Access to training

Many people find that the time away from home and community causes personal, family and financial disruption and so it is often hard to adjust to study. Education programs that require people to travel for lengthy periods outside their communities are not a viable option.

6.8.2 Training issues in Indigenous health promotion

1. Limited numbers of staff, including administrators and managers, have been trained in health promotion which is a new concept to many.
2. The content and style of education for health personnel needs to be determined by the health personnel working in collaboration with the institutions or people providing the training.
3. Conflict management/resolution skills, 'people, groups and power', types of leadership, negotiation and communication skills, impact of the media, confidence building, mediation and organisation skills, counselling theory and practice and budgeting skills should be incorporated in courses.
4. The curriculum needs to include teaching on ways to respond to health policy, and on effective health care delivery. It also needs to assist people to use community development approaches in programs designed to address issues as diverse as nutrition or immunisation.
5. Health personnel recognised that it was valuable to learn computer skills, but it often seemed like a waste of time when, upon returning to the community, they did not have access to computers.
6. In addition to providing generic training in health promotion, the review identified a range of content-specific issues in which training is also required, relating health promotion principles to the prevention of domestic violence, the promotion of sexual health, the reduction of sexual abuse, and the development of an understanding of gender, and the discourse which surrounds expected roles in society.

6.8.3 Additional training for health service managers

1. The health personnel who were consulted recognised the need, not only for training specifically focused on health promotion, but also for training for skilled and experienced Indigenous health service managers and middle managers in managing the health promotion component of their service.

6.8.4 Training in cultural awareness

1. All health professional training courses need to include teaching to raise awareness and understanding of how colonisation affected the lives and the futures of Aboriginal Australians. Such courses in cultural awareness should be not only for non-Indigenous people but for Indigenous people as well.
2. Wherever possible cultural awareness training for non-Indigenous people should include working alongside Indigenous people at each other's workplace.

6.8.5 Course requirements

1. A curriculum that is accredited by a national body. The curriculum should include a separate, compulsory component contributed by each State/Territory that provides training that is specifically relevant and culturally appropriate to local communities.
2. Community-based or workplace-based practical assessment.
3. Recognition for prior study.

Part 7:

Conclusion

More than 1 000 Aboriginal and Torres Strait Island health personnel from both the community-controlled and government sectors around the country have contributed to this review. Although Indigenous cultures are very diverse, the consultation revealed considerable agreement about the broad issues that need to be addressed. The review also identified actions that are necessary if the health of Aboriginal people and Torres Strait Island people is to improve.

The Report highlights the extent to which the history of colonisation has affected and continues to affect the current health status of Aboriginal people and Torres Strait Island people in Australia. Although there have been some improvements in the health of Indigenous Australians in the last two decades their health continues to be much poorer than that of their non-Indigenous counterparts. Compared with improvements in the health of Indigenous populations in other nations, there is much yet to be achieved in Australia.

In the views of those people who were consulted in preparing this Report, four principles must underpin the development of the infrastructure support needed for Aboriginal and Torres Strait Islander health advancement in Australia. These are:

1. acknowledgement by non-Indigenous Australians that Aboriginal people and Torres Strait Island people have a right to their history, including the effects of colonisation on the health of Aboriginal people and Torres Strait Island people today;
2. the inclusion of Aboriginal and Torres Strait Island communities and individuals in all levels of decision making which affect their lives in general and their health in particular, through a community development approach;
3. the need for any initiatives to promote the health of Aboriginal people and Torres Strait Island people to be integrated with culturally-effective, high quality, accessible primary health services; and
4. the need for Indigenous and non-Indigenous Australians (and their organisations) to encourage the development of partnerships to improve Aboriginal and Torres Strait Islander health.

The review highlighted the extent to which the improvement of the infrastructure to support Aboriginal and Torres Strait Islander health advancement depends upon the development of more holistic, coherent and cohesive systems to plan and implement both effective primary health care services and planned health promotion programs. It is impossible, in the views of those people consulted during the review, to separate” these two issues. Nonetheless, this review has focused primarily on the need for infrastructure to promote health-in addition to the infrastructure for primary health care services.

The review identified many actions already being undertaken by Aboriginal and Torres Strait Island communities to improve their health. The positive outcomes of these and the processes by which they have been developed need to be recognised and encouraged. A companion volume is to be published of case studies that recognise and promote programs that highlight principles of effective health promotion practice in both Aboriginal communities and Torres Strait Island communities.

The review found that the positive actions (some of which are highlighted in the case studies) that have been taken by many Aboriginal and Torres Strait Islander communities would be more sustainable with the support of strong national, State/Territory and local infrastructures. In addition, the consultation highlighted the need for additional infrastructure support to increase the range and effectiveness of action to promote Aboriginal and Torres Strait Islander health. There is much to be gained from the forging of strong partnerships not only between Aboriginal health personnel, among Indigenous health organisations (government and community-

RESCINDED

controlled) and between these groups, the mainstream health sector, and other sectors. These partnerships must be between equals. The guidelines in Appendices one and two can assist in ensuring the development of such partnerships.

The recommendations outlined in this report identify specific steps that need to be taken to build the capacity of the health sector to support the work of Aboriginal and Torres Strait Island health personnel working in partnerships (with their communities, with their peers, with other sectors and with the mainstream health system) to achieve improved Aboriginal and Torres Strait Islander health.

RESCINDED

Appendix 1:

Feedback on the first round of the consultation process

Consultation has, itself, often been used as a means of neutralising Aboriginal and Torres Strait Islander voices, as a means of ‘rubber stamping’ decisions made by bureaucrats with little or no understanding of the issues. Then, even if there was commitment to genuine consultation on the part of those conducting the consultation, there are many examples of non-Indigenous people lacking understanding of the process needed to ensure adequate consultation with Aboriginal communities.¹⁴⁵

Consultation is sometimes used to legitimise or ‘rubber stamp’ decisions that have usually already been determined, undermining any real attempts at collaborative decision making. This consultation for this review was undertaken with a commitment to consultation as a two-way sharing of information and knowledge.

There has been an attempt to develop a more participatory process, with time to allow Aboriginal people and Torres Strait Island people to contribute at different stages in its development. The protocol of each community was acknowledged and respected with Aboriginal health personnel highlighting their own specific geographic and demographic needs.

The consultation took place during one-to-one interviews, by tapping into conferences and organising other group workshops. People met, pondered, speculated and reflected. A check and balance system was built in. The consultant referred back to members of the National Aboriginal and Torres Strait Islander Health Promotion Network and an elected advisory committee during the many stages of the consultation.

All the people who contributed did so voluntarily. Only a few people refused to comment. Although more than 300 organisations were initially invited to comment, some organisations or their staff were unintentionally overlooked in the initial stages. However the publication of a Discussion Paper after the first round of consultation offered the opportunity for many more people to contribute their views on the findings.

People who were involved in the consultation were given every opportunity to learn about the project and its process. Each person was given the opportunity to share information during either a group discussion or during a one-to-one interview. Sometimes the consultation was short, while at other times the consultation took several hours or even half a day to complete. Much of the project evolved with feedback from the consultations guiding each stage.

Copies of the Discussion Paper were distributed beforehand, or at least sighted and discussed during the consultation where workshops were encouraged. Some consultations took place with the consultant present while other workshops were conducted without the consultant present. However, assistance was offered for all venues. Follow-up written or verbal feedback from colleagues absent on each particular day, was encouraged. There were many people who took the time to discuss this project at length, and most offered some rare insights into specific issues and offered some creative recommendations.

Occasionally names have not been included in Appendix two, when specific permission to do so was not given. However, all who met or talked with the consultant were given the choice to have their names and addresses added or not and where possible, work titles have been listed. This inclusion of names is meant for recognition of input, to guarantee specific personal feedback and to begin to develop a national register of skilled health personnel, aiming for the development of future role models. Copies of the final report will be sent to each person on the list.

Feedback on the consultation process

Many Aboriginal people and Torres Strait Island people had not been informed prior to the appointment of a Project Officer, of either the Discussion Paper or the consultation. The hardest task for the Project Officer was to convince other Aboriginal people and Torres Strait Island people that the report would not be 'just another report on Aboriginal health' but that it would focus on what can be done by the health sector to improve the infrastructure that directs and supports Aboriginal health promotion.

Feedback from Aboriginal people during the initial stages of consultation confirmed that the process for including an Aboriginal perspective in the Discussion Paper on infrastructure support for national health advancement was, initially, far from ideal. During the initial stages of consultation many Aboriginal health personnel expressed real scepticism that the review and report could be anything other than 'another report'. *Aboriginal Australians are getting sick and tired of hearing statistics about their health problems, and reading papers, journals and documents from non-indigenous people about how they see our health, and how they can fix our health problems. We are sick of hearing how waving the political wand will make all our health problems disappear. They can't fix our health for us and the wand doesn't work! Our people are dying from preventable diseases and yet there can never be any guarantee that consultation of this nature, will reap any real benefits which will improve the health of Indigenous Australians. We need people who can assist us to 'fix' our own community!*¹⁴⁶

When hearing of and seeing the initial Discussion Paper, most Indigenous Australians, particularly Aboriginal health professionals, felt that Aboriginal people, who should be regarded as specialists in their field, had been forgotten or overlooked. This being the case, Aboriginal people felt that asking for their input at this late stage, was merely an act of tokenism and that their health status had been trivialised. Aboriginal people and Torres Strait Island people have their own networks for disseminating information and the forwarding of all relevant reading material prior to a consultation is not only good manners but most essential. The fear was that once again Aboriginal people would read about their health and how to 'fix' it, in yet another mainstream health report.

In addition many people did not know about the role of the National Health and Medical Research Council, nor about the Aboriginal and Torres Strait Health Standing Committee, or the Health Advancement Standing Committee.

The late employment of the Project Officer meant that there was widespread suspicion about the intent of the project although, she, like other Aboriginal people and Torres Strait Island people, was willing to be involved in any project that not only had the potential to improve the health status of the Aboriginal community, but might also empower health personnel by eventually leading to improved support for their work to promote health. Most people who were consulted thought that it would be impossible to complete the report in the time-frame allowed, and that if the current barriers to improving health-racism, prejudice and ethnocentrism-were not spoken about, then these practices would not only continue to prevent better health gains, but the forming of any future partnerships with non-indigenous health care providers would prove impossible.

After meeting with the Health Advancement Standing Committee, steps were taken to make the second round of the consultation as close to 'best practice' as possible. The Health Advancement Standing Committee agreed to respect guidelines for the final stage of this project and in future consultations. There is optimism that non-Indigenous colleagues appreciate that a different kind of consultation is needed if respectful partnerships are to be built between Indigenous and non-Indigenous Australians.

Aboriginal people and Torres Strait Island people, Australia-wide, are very used to seeing their issues 'tagged on' to the end of other people's projects or reports, and are used to seeing their issues determined by non-indigenous people, or with a last minute hurried consultation, where community concerns are only half addressed or even overlooked completely. When projects are guided by short unrealistic time-frames they place the consultants in token positions but expect them to draw comment from other work colleagues. The risk is that usually the project ends up being totally insensitive to the cultural needs of the community and protocol is often forgotten.

Nevertheless, it is not just non-Indigenous people who are responsible for poor consultation practices. Heightened communication between health personnel and communities, between administrators and health personnel, across government departments and between government and community-controlled organisations and a need to encourage a more cohesive workforce is a beginning.

Many people have a lot to be gained from this and other such projects. There is hope of new training for Aboriginal and Torres Strait Islander health personnel and acknowledgment and support for the work already being achieved. People who have participated have done so because they cling to the hope that this report may well be the *beginning of a new era for the Aboriginal health personnel and play a major part in the design, development, implementation and evaluation of Indigenous health care.*¹⁴⁷ Moreover, health personnel have continually stated that they want to play a part in designing their own career paths by being involved in decision-making processes.

Contrary to the views of some, Aboriginal health personnel who are employed in both government departments and community-controlled organisations were very keen to hear about this project, would like to have had more time to study the Discussion Paper, and after gaining some knowledge about it, did contribute some very valuable first-hand feedback. Upon learning that most administrators were sent information prior to the consultation and that the reason for it not trickling down from management to Aboriginal health personnel was unclear, the response was that not being informed about the Discussion Paper was considered to be very patronising and in some cases, a form of colonialism from their own people.

In all, working through the consultation process for this report has been a collaborative and rewarding, but multi-layered, process.

Creating guidelines for future partnerships

Aboriginal people and Torres Strait Island people who were consulted in the course of developing this Report wanted to provide further advice to non-Indigenous employers on how to begin to work more effectively with Aboriginal people and Torres Strait Island people in the future. However, non-Indigenous practitioners should not just assume that the following guidelines are the ‘be all and end all’ of perfect consultation, remembering that each Aboriginal person and Torres Strait Island person and all Aboriginal and Torres Strait Island communities are different.

1. **Ensure that an Aboriginal person is employed who meets criteria established in consultation with the community with whom the person is to work**

Just employing an Aboriginal person *does not* guarantee that your project will run smoothly. The project can still meet with problems if the consultant needs to consult outside their own community. This can often mean that the consultant or even their family’s values (or their sense of community) is unknown by another community and comes under scrutiny by people they are meeting for the first time. Also, it can mean that the consultant’s work practices are unknown by other Aboriginal people. Likewise, an Aboriginal person who is very well known can still be considered unacceptable to either their own community or by other communities if projects the consultant was involved with in the past were unacceptable.

2. **Ensure that the Aboriginal consultant has credibility and qualifications appropriate to the community within which he/she is expected to work**

Degrees or other study certificates do not *always* mean that the person is right for the job. Aboriginal people have life skills that cannot be learned at any educational institution. Some values can even be lost after entering the white academic educational system.

3. **Ensure that the purpose of the consultation is clear to all parties and that there is genuine intention to respond to the results of the consultation**

As consultation is sometimes used to legitimise or ‘rubber stamp’ decisions that have usually already been made, undermining any real attempts at collaborative decision making. It is important that the purposes be very clearly agreed. If the consultant has never lived in the Aboriginal community being consulted, often there will

be much for a person to learn, regardless of whether they are Aboriginal or not. Often Aboriginal people who know *nothing* about community are inappropriately employed as project officers or consultants by non-indigenous people. They can do more damage than good, by ‘rubber stamping’ an idea that belongs to somebody else—often a non-indigenous employer. If the consultant is unaware of how they are being used, or what effect ‘rubber stamping’ has on their own or any other community, and if the employer doesn’t care, the damage they can both cause can be irreparable.

‘Rubber stamping’ has happened in the past, and like colonialism, it is part of the continuing process which has done nothing to empower a race where the disability of colonialism is not just history, but a part of one’s everyday life now and in the present”¹⁴⁸. If ‘rubber stamping’ occurs, non-indigenous people will *never* be able to work in *that, or any other community in the future*.

Two Indigenous people may build an instant social and/or personal rapport, but the fear of ‘rubber stamping’, combined with an entrenched mistrust of non-Indigenous employers, and of the entire environment within which the consultant is working, can often jeopardise the project.

4. Allow sufficient time

To consult adequately with Aboriginal communities requires time to ensure that community protocol is met. For individual Aboriginal people employed as consultants, a short time-frame that demands that they ignore such protocol means that the outcome will not meet the employer’s needs and the employee will lose self-esteem and confidence.

5. Acknowledge that the consultant is always responsible to her/his community as well as to the employer

Consultants are not just working to their employer’s agenda, even if that is where their wage comes from. They are working to the community’s agenda as well, and if the community’s expectations are not met, the project will fail. The consultants have to continue to live in and work with the community so their personal integrity and trustworthiness is always open to question when working with non-Indigenous employers.

6. Acknowledge the different senses of time of Aboriginal and non-Aboriginal people

Even if the consultant and the employer have mutual respect for each other, the working relationship is good, and the consultant has the skills to keep up with what appears to the employee to be ‘a non-indigenous bureaucratic and often academic timetable’, the community that the consultant is working with/for, probably won’t see the importance of meeting your demands in the time-frame you consider to be appropriate, and they will rightfully resent being hurried.

Having a different concept of time puts the consultant in a position where they are caught between two different cultures. It is often only when this happens that the consultant discovers that their goals, ethics and work practices are vastly different to those of their employer.

There is growing understanding for the need for reform in the way non-Indigenous people work with Aboriginal people, and the National Health and Medical Research Council’s approach of examining ways in which to assist Aboriginal health personnel to *improve the health of their own community* is encouraging.

In all, working through the consultation process for the report was a collaborative, rewarding, but multi-layered, process.

Appendix 2: Participation versus consultation

Be sure you can meet the needs of the community

An ongoing participation model rather than a consultative one is more likely to meet the needs of all involved. An Aboriginal consultant can advise how others can respect the protocol of a community by working with the community from the beginning of the project, and can act if necessary, as a facilitator to assist community in determining what their individual needs are.

Some of the steps in a participation model may be critical but remember even if each community has similar issues, each community is as diverse as another and each will have their own culture, language and protocol, often needing a different level of participation.^{149 150}

Principles of participation

1. *Get community involved from the very beginning.* Even *before* you advertise the position! In fact, before you write anything or do anything about 'fixing' a community, and before you approach anyone else (Indigenous or non-Indigenous), write to the administrators and/or directors in charge of the community organisations or departments where you want to work, asking if they are interested in the project and explain what the benefits to their community might be. Tell the administrator if you have worked with Aboriginal people before and if they have not heard of you or your work, they will ask other people if your work was appropriate and if the project you have in mind sounds feasible. *Don't 'name-drop'* to link you or your project to the community- *It will achieve nothing except to get you off to a bad start!* The community will decide if there will be a meeting and who will be present at the meeting. Tell the administrator if you are expecting to work with the health workers or that you expect to advertise a position. Ask if they have enough information to be able to invite the health workers to the meeting if you think they might be involved in any way.
2. Discuss the time-frame that you have in mind when you talk to the administrator, and with others who are at any future meetings. Do this *before* you advertise the position!
3. *Follow-up.* Next, post written follow-up information and fax the same information about your ideas or requests. Follow-up with another telephone call after a short period of time to the administrator. It is up to the administrator to decide if he will ask community leaders and elders and/or health workers for permission for you to be invited to speak about the aims and expected outcomes of your project. **If** *after all this you hear nothing, accept that the proposal is not acceptable at this point in time.* Make one last phone call stating that as you have heard nothing, is it right to assume that the project is not acceptable, and is there any way it can be changed to make it acceptable. If not, leave your contact number and forget about the project for now. The administrator or health workers may contact you at a later date.
4. Any meetings will usually take place around some type of meal, and you might be expected to meet some of the cost of either the meal or the venue. Expect this-Aboriginal people do business around a feed!
5. Meet community on their own 'turf' and don't expect to be a facilitator at that meeting. The meeting might not look like a 'meeting' to you at all. In fact you might be requested to attend more than one of these meetings, they might not start on time and there is no guarantee of how many people will attend. Don't be put off if only two or three people attend the first meeting. Money and resources are limited.
6. You might have to tell your story more than once. Be prepared to wait. You might think that nobody listened or was willing to talk, but people will definitely talk *after* you have gone. *The meeting will really be the community's opportunity to form an opinion about you!*

RESCINDED

7. Be prepared for babies, children and elderly people to be at meetings.
8. Take an Aboriginal person or Torres Strait Island person with you if they know about the project you are interested in and if they believe that it is beneficial to the community but *don't* just assume that they will get the project off the ground for you.
9. Let community set the limits.
10. Respect the elders and approach community members to help set up a meeting with them and other interested or key people. Thank them for their time-often they are volunteers! Thank them for allowing you to visit their community-even if it appears to you to be a very urban area and not in a remote or traditional community. It does not matter where the community is, the people will still have their own culture, identity and protocol. Culture and traditions are not all lost just because people appear to you to be *urbanised*.
11. Be prepared to spend some time! Lots of time-Aboriginal people and Torres Strait Island people are not clock watchers. They are not interested in keeping up with non-Indigenous bureaucratic timetables and they have a very different cultural concept of time.
12. Don't set the projects in short time-frames-they *will not work!* Let the community and the consultant propose the time-frame and work around that.
13. Have some members of the community involved in the interview process if hiring a project officer or consultant and ask for references from community members where the consultant has worked previously.
14. Make sure that *all* community members know where the consultant will be working, and that they know *all* the facts.
15. Advise community *who* is involved in the project.
16. Tell community what is to be gained and for whom? Don't lie to community members or tell half-truths. You will be found out!
17. Wherever possible, it should be community who identify the needs. A participation model can be used, but there needs to be an identified common goal between both parties and a mutual understanding of why any 'research' (which is often what the consultation appears to be), is being attempted and how the project is likely to benefit the community.
18. Be honest with the community, even if you feel that you need to say that you are attempting the project because you feel that you owe the community for some reason or if it is your moral obligation. *Honesty is the best policy!*
19. Don't just quote facts and statistics. Aboriginal people and Torres Strait Island people know how bad their health is (doesn't everybody!) and they find this practice very patronising. Tell them you have statistics, ask if anyone would like to see them and explain how bureaucracies and departments often demand statistics when funding is sought. Don't produce your statistics unless you ask permission first, and/or if people tell you that they want to see them. Take the trouble to explain the different types of statistics used and what they can identify and what that might mean for the community.
20. Don't be afraid to ask questions-Aboriginal people and Torres Strait Island people will tell you if your questions are taboo or inappropriate.
21. Better practice when working with an Aboriginal project officer (elected by some of the community) is to make sure they have the skills and support to coordinate not only the administration, report writing and minute taking, but more importantly, that they have a steering committee that works in participation from other community members and at times on a national basis.
22. Community *expects* and *must get* feedback.

RESCINDED

23. Keep updating community about the project so they don't think you have forgotten to pass on the feedback, as often the feedback will be a long time in coming! Make them aware of this from the beginning.
24. A steering committee can be a good starting point, but it must play a continuing role. It must have a committed facilitator and be made up of a group of people who are able to provide constructive feedback, *continually*.
25. Feedback *must be* to-the consultant, to the community and to all other group members. The group will expect to liaise with you continually, to make sure that the mandates are deliverable and will expect that you will assist them to make sure that they are all delivered. You might need to assist with minute taking
26. There *must* be an evaluation of the project and community *must* be involved in the design of, and in the gathering of all of the steps in the evaluation.

Appendix 3: People who contributed

Dion Adams
Health Education Officer
644 Chappie Lane
Broken Hill NSW 2880

Sylvia Adams
Health Education Officer
18 Wilson Street
Collarenebri NSW 2833

Annette Agnew
Aboriginal Hospital Liaison
Officer
Warrnambool and District Base
Hospital
Ryot St
Warrnambool VIC 3280

Louise Akinson
Mapoon Health Clinic
PO Box 574
Weipa QLD 4874

Eugene Alberts
Trainee Health Worker
Bidgerdie Health Service
Rockhampton QLD 4701

Betty Allam
Senior Health Edn Officer
Central Sydney Aboriginal Health
Service
Community Health/ Rachel Foster
Hospital
Redfem NSW 2016

Fay Allen
Southern Aboriginal Health
Service
Health Education Officer
90 Lakes Entrance Road
Oak Flats NSW 2529

Pat Anderson
Director
Danila Dilba Medical Service
PO Box 2125
Darwin NT 0801

Yvonne Anderson
Aboriginal Hospital Liaison
Officer
Goulburn Valley Base Hospital
Grahame St
Shepparton VIC 3630

Elsie Appo
Health Worker
Kalwun Health Service
PO BOX 19
Mermaid Beach QLD 4218

Gladys Appo
DAGS (Disability Action Group)
89 Rieck Street
Gin Gin QLD 4671

Tresna Appo
Member of the Housing Action
Group Committee
14 Ritchie Street
Bundaberg QLD 4670

Jan Arrowsmith
Health Education Officer
23 Railway Lane
Coonamble NSW 2829

Elio Auciello
Representing: Aboriginal
Education Unit
5 Harewood Ave
Enfield SA 5085

Karen Aucote
Chief Executive Officer
Mawamkarra Health Service
Aboriginal Corporation
PO Box 59
Roeboume QLD 67 18

Rachael Avard
Health Education Officer
144 Hawker Street
Quirindi NSW 2343

Selma Baird
Senior Health Worker
Yarrabah QLD 4871

Jenny Baker
Senior Lecturer Aboriginal and
Torres Strait Islander Health
Medical Education Unit
Flinders University of SA
Adelaide SA

Leanne Baker
Health Worker
Community Health
PO Box 446
Charleville QLD 4470

Patricia Barker
Health Worker
PO Box 301
Maryborough QLD 4650

Sharon Barry
Coordinator Women's Support
Group
Caloundra & Districts Aboriginal
and Torres Strait Islander Corp
PO Box 352
Caloundra QLD 4551
Debbie Beahan
Health Education Officers
188 Dandaloo Street
Narromine NSW 2821

Carolyn Beard
Health Worker
'Yulu-Burri-Ba'
Nth Stradbroke Island Aboriginal
and Islander Community Health
Service
Dunwich QLD 4183

Amber Beedie
APDO
CEIDA
PO Box 221
Newtown NSW 2042

Elaine Binge
Health Education Officer
109 Simpson Street
Boggabilla NSW 2409

RESCINDED

Promoting the Health of Australians-A review of the infrastructure support for national health advancement

Teena Binge
Health Education Officer
PO Box 419
Lismore NSW 2480

David Blucher
Health Promotion Officer
Aboriginal and Islander
Community Health
Ipswich QLD 4305

Eddie Bosuen
Napranum Malakoola Health
Centre
PO Box 52
Weipa QLD 4574

Lilian Bowden
Aboriginal Hospital Liaison
Officer
Robinvale and District Hospital
Latje Rd
Robinvale VIC 3549

Kaylene Bowen
C/- Post Office
Hopevale QLD 487 1

Wendy Brady
Coordinator
Koori Centre
University of Sydney
Sydney NSW 2006

Anne Briggs
Health Education Officer
1297 Bunnerong Road
Botany Bay NSW 2019

Alan Brown
Aboriginal Medical Service
186 Nicholson St
Fitzroy VIC 3065

Colleen Brown
5 George Street
Erowal Bay NSW 2540

Jane Brown
AHC
12 Simpson Street
Wellington NSW 2820

Margaret Brown
South West Regional Coordinator
Aboriginal and Torres Strait
Islander Health Unit
Community Medicine
PO Box 1030
Roma QLD 4455

Debbie Butcher
Health Education Officer
233 Wingewarra Street
Dubbo NSW 2830

Henriette Callope
Community Health Centre
Westcourt
Cairns QLD 4870

Donalleen Campbell
Aboriginal and Islander Health
Worker Journal
PO Box 502
Matraville NSW 2036

Patricia Canty-Bates
Snr Health Education Officer
PO Box 561
Bourke NSW 2840
Wayne Carroll
Health Education Officer
39 Yambil Street
Griffith NSW 2680

Sue Chellingsworth
Field Officer
Aboriginal Health
187 Phillips Street
Rockhampton QLD 4701

Angela Clarke
Aboriginal Hospital Liaison
Officer
Royal Children's Hospital
Flemington Rd
Melbourne VIC 3052

Matthew Clarke
Health Education Officer
Moruya CHC River Road
Moruya NSW 2537

Rhonda Clarke
284 Princes Hwy
Bomaderry NSW 2541

Lesley-Ann Clements
AHLO
PO Box 4096
Loganholme QLD 4129

Vanessa Clements
Health Worker
Aboriginal and Islander
Community Health Service
Ipswich QLD 4305

Ken Close
Health Education Officer
CHC Arthur Street
Grafton NSW 2460
Robert Cockatoo
Tropical Public Health Unit
PO Box 1103
Cairns QLD 4870

Karen Coe
Health Education Officer
24 Boughton Street
Tumut NSW 2720

Naomi Commandevr
Secretary - North Primary ASSPA
(Aboriginal School Support
Parents Assistance)
24 Donald Street
Bundaberg QLD 4670

Tracey Conlon
261 Noel Street
Nth Rockhampton QLD 4701

Kathy Cook
CNC Child Health
C/o - Thursday Island Hospital
PO Box 319
Thursday Island
Torres Strait QLD 4875

Karen Coolwell
Board Member
'Yulu-Burri-Ba'
Nth Stradbroke Island Aboriginal
and Islander Community Medical
Service
Dunwich QLD 4183

Chris Coomer
Aboriginal Health
Promotions Unit
Geraldton WA 6530

Steve Corporal
Welfare Officer
Aboriginal and Islander
Community Health Service
10 Hubert Street
Wooloongabba QLD 4102

Marie Cox
Kimberley Aboriginal Medical
Service Health Council
Health Promotion Unit
PO Box 1377
Broome WA 6725

RESCINDED

Anita Craig
Health Education Officer
12 Anderton Street
Coffs Harbour NSW 2450

Michelle Crouch
Health Education Officer
PO Box 159
Wagga Wagga NSW 2650

Janice Cutmore
Health Education Officer
72 Cambell Street
Inverell NSW 2360

Sylvia Davies
Community Health Centre
Westcourt
Cairns QLD 4870

Valarie Davies
Community Health Centre
Westcourt
Cairns QLD 4870

Mary Davis
Health Education Officer
7 Shipton Crescent
Mount Warrigal NSW 2528

Allison Dell
Office for Aboriginal and Torres
Strait Islander Health Services,
Commonwealth Dept of Health
and Family Services
GPO Box 9848
Canberra ACT 2601

Lillian Denning
16 Umbrella Street
Blackwater QLD 4717

Brian Dixon
Director
Aboriginal and Torres Strait
Islander Health Policy Branch
South Australian Health
Commission
PO Box 6 Rundle Mall
Adelaide SA 5000

Paul Dodd
Regional Coordinator
Aboriginal and Torres Strait
Islander Unit, South Coast
Regional Health Authority
Queens Street
Southport QLD 4215

Pricilla Doherty
Health Worker
Goondir Health Service
Dalby QLD 4405

Joyce Donovan
Health Education Officer
38 Stuart Road
Warrawong NSW 2502

Rob Donovan
Associate Professor
Graduate School of Management
University of Western Australia
1st Floor Myers Street
Nedlands WA 6009

Rhonda Dorman
Health Worker
Aboriginal Health
Ngua Gundi
189 Phillips Street
Rockhampton QLD 4701

Brian Dowd
Health Education Officer
80 Timor Street
Coonabarabran NSW 2357

Marion Dunlop
Assistant Secretary
Planning and Evaluation Branch,
Office for Aboriginal and Torres
Strait Islander Health Services
Commonwealth Dept of Health
and Family Services
GPO Box 9848
Canberra ACT 2601

Judith Dwyer
Chief Executive Officer
Flinders Medical Centre
Bedford Park SA 5042

Robyn Eaves
Health Promotion Officer
Sunshine Coast Regional Health
Authority
Maroochydore QLD 4558

Moyna Edwards
Health Worker
Aboriginal and Islander
Community Health Service
10 Hubert Street
Woolloongabba QLD 4102

Thelma Edwards
Aboriginal Hospital Liaison
Officer
Portland and District Hospital
Bentinck St
Portland VIC 3304

Ray Eldridge
Health Education Officer
River Street
Moruya NSW 2537

Vicki Emzin
Health Worker
South Coast Regional Health
Authority
Aboriginal and Torres Strait
Islander Health Unit
Queens Street
Southport QLD 4215

Judy Ferguson
Health Education Officer
10 Deborah Close
Coffs Harbour NSW 2450

Gwen Fisher
Gladstone Community Health
18 Bell Street
Gladstone QLD 4680

Ann Flood
Lecturer
Koori Centre
University of Sydney
Sydney NSW 2006

Sue Follent
Health Education Officer
Tweed Heads District Hospital
Florence Street
Tweed Heads NSW 2485

Bronwyn Fredericks
Lecturer
Faculty of Health Science
Central Queensland University
Rockhampton QLD 4702

Dianne Fuller
8 Werner Street
Nth Rockhampton QLD 4701

Anthony Galea
Diabetes Worker
'Yulu-Burri-Ba'
Nth Stradbroke Island Aboriginal
and Islander Community Health
Service
Dunwich QLD 4183

RESCINDED

Promoting the Health of Australians-A review of the infrastructure support for national health advancement

- Tong Galikii
Central Region Regional
Coordinator
Aboriginal and Torres Strait
Islander Health Unit
Central Region
PO Box 5945
Rockhampton QLD 4702
- Lorraine Garlin
Project Officer
Office for Aboriginal and Torres
Strait Islander Health Services,
Commonwealth Dept of Health
and Family Services
GPO Box 9848
Canberra ACT 2601
- Erica Girvan
187 Phillips Street
Nth Rockhampton QLD 4701
- Mavis Golds
NSW Health Dept
Nth Coast Public Health Unit
Kempsey NSW 2440
- Maxine Gosam
Mamu Medical Services
PO Box 247
Ravenshoe QLD 4872
- Gary Graham
Manager
Aboriginal and Torres Strait
Islander Health Unit
Dept of Public Health
Old Town Hall
63 Sydney Street
Mackay QLD 4740
- Krystina Green
Director, Health Issues
Office for Aboriginal and Torres
Strait Islander Health Services
Commonwealth Dept of Health
and Family Services
GPO Box 9848
Canberra ACT 2601
- Robert Griew
1st Assistant Secretary
Office for Aboriginal and Torres
Strait Islander Health Services,
Commonwealth Dept of Health
and Family Services
GPO Box 9848
Canberra ACT 2601
- Bev Grime
Aboriginal Health Council
of South Australia
PO Box 9, Rundle Mall
Adelaide SA 5000
- Glenis Grogan
Cape York Health
1st Floor, 19 Aplin St
Cairns 4870 QLD
- William Gulf
Aboriginal Health Services
Woorabinda QLD 4702
- Rita Gutchen
Wu Chopparen Medical Centre
PO Box 1268
Cairns QLD 4870
- Jill Guthrie
Assistant Director
Office for Aboriginal and Torres
Strait Islander Health Services
Commonwealth Dept of Health
and Family Services
GPO Box 9848
Canberra ACT 2601
- Keith Hall
Manager, Community Health
Aboriginal Health Branch
NSW Health
73 Miller Street
Nth Sydney NSW 2006
- Jemmes Handy
Aboriginal Hospital Liaison
Officer
Mildura Hospital
Mildura VIC 3500
- Betty Harris
Health Worker
South Coast Regional Health
Authority
Aboriginal and Torres Strait
Islander Health Unit
Queens Street
Southport QLD 4215
- Cliff Harris
Health Education Officer
PO Box 89
Lake Cargelligo NSW 2672
- Teresa Hazel
Diabetes Educator
C/- Thursday Island Hospital
PO Box 319
Thursday Island
Tort-es Strait QLD 4875
- Peter Hegarty
Senior Resource Officer
Office of Aboriginal and Torres
Strait Islander Affairs
Mt Isa QLD 4825
- Elsa Heiss
Health Education Officer
5 Cunningham Street
Matraville NSW 2036
- Janie Hilt
Assistant in Nursing
Jimbelonga Nursing Home
Eagleby QLD 4207
- Cheryl Hooper
Community Health Services
Dawson Road
Biloela QLD 4715
- Debra Hooper
The Boulevard
Theodore QLD 4719
- Richard Howell
South West Centre
for Public Health
475 Townsend Street
Albury NSW 2640
- Dawn Howlett
Health Education Officer
Benelkay Station
Via Walgett NSW 2832
- Tammy Hughes
Health Education Officer
Ivanhoe Health Service
Ivanhoe NSW 2878
- Ernest Hunter
Professor of Public Health
Dept of Social and Preventative
Medicine
Tropical Public Health Unit
The University of Queensland
PO Box 1103
Cairns QLD 4870

RESCINDED

Jane Hurley
Health Education Officer
127 Edward Street
Gunnedah NSW 2380

Liz Hurrell
Parks Community Health Service
Traflord Street
Angle Park SA 5010
Marion James
Wu Chopparen Medical Service
PO Box 1268
Cairns QLD 4870

Ron James
Manager
Koori Health Unit
Dept Human Services
2/555 Collins St
Melbourne VIC 3000

Pat (Russell) Jessop
Health Education Officer
51 Kingston Place
Tomakin NSW 2537

Sharon Johnson
Health Worker
Community Health Centre
Goondir Health Service
PO Box 1879
Dalby QLD 4350

Vicki Johnson
Health Education Worker
320 Knox Street
Broken Hill NSW 2880

William Johnson
ATSIC
Broken Hill NSW 2880

Mark Jones
Board Member
'Yulu-Burri-Ba'
Nth Stradbroke Island Aboriginal
and Islander Community Health
Service
Dunwich, QLD 4183

Jenni Judd
Acting Manager
Health Promotion Unit
Territory Health Services
PO BOX 40596
Casuarina NT 0811

Liz Kelly
Health Education Officer
Bourke CHC
3 Hume Place
Bourke NSW 2840

Bella Kennedy
Liaison Officer
Dimboola Hospital
Lloyd St
Dimboola VIC 3414

Vince Kennedy
Health Education Officer
89 Dewhurst Street
Walgett NSW 2832

John Kennell
Health/Liaison Worker
PO Box 1030
Roma QLD 4455

Dawn Kenny
Health Worker
Aboriginal Health
187 Phillips Street
Rockhampton QLD 4701

Geoff Kenny
Alcohol and Drug Project Officer,
South West Regional Health
Authority
174 Victoria Street
St George QLD 4487

Gwen Kimber
Assistant in Nursing
Georgina Davidson Aged Person's
Hostel
694 Wynnum Road
Morningside QLD 4170

Debra King
Health Education Officer
Darling Street
Menindee NSW 2879

Richard King
Katherine Government Centre
Department of Health and
Community Services
PMB 73
Katherine NT 085 1

Maureen Kirk
Cancer Support/ Liaison Officer
Royal Women's Hospital
Bowen Bridge Road
Herston QLD 4006

Kaz Knights
Clinical Nurse Consultant
Regional HIV/AIDS Coordinator
Sexual Health Program
Cairns District Health Services
Cairns QLD 4870

Stanley Knowles
Trainee Health Worker
Bidgerdie Health Service
Rockhampton QLD 4701

Tony Kolbe
Director
South West Centre
for Public Health
475 Townsend Street
Albury NSW 2640

Les Kropinyeri
Port Lincoln Aboriginal Health
Service
Port Lincoln SA 5606

Sandy Kyriazis
Acting Director of Nursing
Bamaga Hospital
Bamaga QLD 4876

May Laifoo
Generalist Health Worker
Sibuwani Ngurpai Meta
C/- Thursday Island Hospital
PO Box 319
Thursday Island
Torres Strait QLD 4875

Yancy Laifoo
Health Centre Manager
C/-Thursday Island Hospital
PO Box 319
Thursday Island
Torres Strait QLD 4875

Sue Laird
Kimberley Aboriginal Medical
Service Health Council
Health Promotion Unit
PO Box 1377
Broome WA 6725

Gerrard Lasserre
Health Worker
Community Health Centre
Inglewood QLD 4387

RESCINDED

Kenny Laughton
Aboriginal Medical Services
Alliance
PO Box 1604
Alice Springs NT 0871

Rosemary Laurie
Health Education Officer
PO Box 368
Grafton NSW 2460

Sharon Laurie
Health Education Officer
PO Box 523
Ballina NSW 2478

Andrea Law
48 Rodway Street
Zillmere QLD 4034
Traven Lea
PO Box 206
Aitkenvale QLD 48 12

Diai Luffman
Generalist Health Worker
Sibuwani Ngurpai Meta
C/- Thursday Island Hospital
PO Box 319
Thursday Island
Torres Strait QLD 4875

James Lyons
Health Worker
Aboriginal Health Service
Roeboume WA 67 18

Jennie Lyons
Director of Public Policy &
Planning Unit
Dept of Health and Family
Services
GPO Box 9848
Canberra ACT 2601

Patricia Madigan
165 Walsh Street
Mareeba QLD 4880

Dr Paul Magnus
National Heart Foundation
Cnr Denison and Geils Street
Deakin ACT 2601

Ray Mahoney
Student Needs Coordinator
Aboriginal and Islander
Health Worker Education
Program, Wide Bay Regional
Health Authority
PO Box 116
Torquay QLD 4655

Bernice Mango
Napranum Malakoola Health
Centre
PO Box 52
Weipa QLD 4874

Darren Manns
Trainee Health Worker
PO Box 1030
Roma QLD 4455

Ester-Rose Manson
Territory Health Service
PO Box 40596
Casuarina NT 08 11

Allen Mathieson
Health Worker
Back Beach
Yarrabah QLD 4871
Kim Matschoss
Trainee Health Worker
Bidgee
Rockhampton QLD 4701

Gail May
Health Education Officer
PO Box 297
Narranderra NSW 2700

Lorna McArthur
Health Worker
Aboriginal Health
187 Phillips Street
Rockhampton QLD 4701

Cathryn McConaghy
University of Queensland
Grad School Of Education
PO Box 1103
Cairns QLD 4870

Tassie McDonald
Generalist Health Worker
Sibuwani Ngurpai Meta
C/- Thursday Island Hospital
PO Box 319
Thursday Island
Torres Strait QLD 4875

Lyn McInnes
Aboriginal Hospital Liaison
Officer
Geelong Hospital
Ryrie St
Geelong VIC 3220

Linda McLaughlan
Health Promotion Officer
Cape York Sector
Regional Health Authority
C/- Weipa Hospital
PO Box 254
Weipa QLD 4874

Iris McLeod
AHC
56 Village Road
Jervis Bay NSW 2540

Betty McMahan
Administrator
Caloundra and District Aboriginal
and Torres Strait Islanders
Corporation
PO Box 352
Caloundra QLD 455 1

Margaret Mimi
5 Simon Street
Gayandah QLD 4625

Beryl Meiklejohn
Project Officer
Queensland University of
Technology
Locked Bag 2
Red Hill QLD 4059

Leanne Mick
Director
Primary Health Care
Peninsula and Torres Strait
Islander Health Authority
PO Box 5465
Cairns QLD 4870

Peter Miller
Executive Chairperson
Aboriginal Health Council
Box 499
Ceduna SA 5690

Peter Miller
PO Box 499
Ceduna SA 5690

RESCINDED

- Wes Miller
Wurli-Wurlinjang Health Service
PO Box 896
Katherine NT 0851
- Phillip Mills
District Manager
Thursday Island Hospital
PO Box 319
Thursday Island
Torres Strait QLD 4875
- Sharon Minnicon
Health Education Officer
162 Bettington Road
Carlingford NSW 2118
- Sue Minnicon
Sexual Health Worker
SWC Public Health Unit
Townsend Street
Albury NSW 2640
- Wendy Moore
Health Education Officer
42 Doyle Street
Brewarrina NSW 2839
- Helen Morgan
Aboriginal Hospital Liaison
Officer
Bairnsdale Hospital
Day St
Bairnsdale VIC 3875
- Jenny Muir
Aboriginal Hospital Liaison
Officer
Ballarat Base Hospital
1 Drummond St
North Ballarat VIC 3355
- Bob Mumbler
Health Education Officer
CHC
Polwood Street
West Kempsey NSW 2440
- Bill Murray
Health Education Officer
PO Box 86
Cowra NSW 2794
- Colleen Murray
3 Stan Mickelo Drive
Cherburg QLD 4605
- Valda Murray
Health Education Officer
CHC 131 Tamarind Street
Albury NSW 2640
- Pat Naden
Health Education Officer
9 Castlereagh Street
Gilgandra NSW 2827
- Barbara Napie
Support Worker
Aboriginal and Torres Strait
Islander Corp For Women
Cordeilia Street
South Brisbane QLD 4101
- Elsie Nawie
Sexual Health Worker
Northern Peninsula Area
Bamaga Community Health
Bamaga QLD 4876
- Martin Nean
Senior Health Education Officer
141 Piper Street
Tamworth NSW 2340
- Marilyne Nicholls/Peiris
Aboriginal Hospital Liaison
Officer Swan Hill District
Hospital
Splatt St
Swan Hill VIC 3585
- Patricia Nona
Area Coordinator
Northern Peninsula Area
Bamaga Community Health
Bamaga QLD 4876
- Angela Nye
Health Education Officer
41 Kingston Place
Tomakin NSW 2537
- Frank Oates
Health Education Officer
PO Box 246
Warren NSW 2824
- Steven Ober
Health Worker
Hervey Bay Community Health
PO Box 1073
Pialba QLD 4655
- Helen Parata
Cooktown Community Health
Service
Cooktown QLD 4871
- Sylvia Parsons
Aboriginal Hospital Liaison
Officer
Princess Hwy
La Trobe Regional Campus
Traralgon VIC
- Poi Pensio
PO Box 319
Thursday Island
Torres Strait QLD 4875
- Shirley Perkins
Clinical Nurse Consultant
Aboriginal Health
187-189 Phillips St
Nth Rockhampton QLD 4701
- Ailsa Perry
Board Member
'Yulu-Burri-Ba
Nth Stradbroke Island Aboriginal
and Islander Community Health
Service
Dunwich QLD 4183
- Amanda Philp
Health Education Officer
93 Hebbard Street
Broken Hill NSW 2880
- Bruce Picard
Aboriginal and Torres Strait
Islander Health Policy Unit
Charlotte St
Brisbane QLD 4000
- Felicity Pollard
Women's Health Officer
Women's Health Centre Inc
PO Box 3
Torquay QLD 4655
- Tracey Pratt
Western Australia Health
Health Promotion Unit
3rd Floor B.Block
189 Royal St
East Perth WA 6004
- Dot Proctor
West Gippsland Hospital
Landsborough Rd
Warragul VIC 3820

RESCINDED

Leona Quinell
Senior Health Education Officer
13 Hindmarsh Street
Inverell NSW 2360

Deborah Reid
Senior Policy Officer
Aboriginal Health Unit,
Tasmanian Dept of Health &
Community Services
GPO Box 125B
Hobart TAS 7001

Grace Richards
Mareeba Community Health
9 Lloyd Street
Mareeba QLD 4880

Faye Riley
Health Education Officer
PO Box 399
Wee Waa NSW 2388

Stuart Riley
Far West Ward
Aboriginal Health Service
PO Box 457
Broken Hill NSW 2880

John Robinson
Administrator
Danila Dilba Medical Service
PO BOX 2125
Darwin NT 0801

Rob Rolls
Clinical Nurse/Team Leader
Central Region Regional Health
Authority
Aboriginal and Torres Strait
Islander Health Unit
187 Phillips Street
Rockhampton QLD 4702

Geraldine Rolton
Health Education Worker
PO Box 2
Menindee NSW 2879

Lori Ryan
Wide Bay Aboriginal and Islander
Community Health Service
PO Box 2465
Bundaberg QLD 4670

Robyn Schrieber
Health Worker
Yarrabah QLD 4871

Nichole Sealey
Snr Diabetes Health Worker
Aboriginal Health
189 Phillips Street
Rockhampton QLD 4701

Trudi Sebasio
Health Promotion Officer
Brisbane South Regional Health
Authority
Cnr Kessels Rd & Magreggor Sts
Mt Gravatt QLD 4122

Goefrey Shannon
Deputy Director
Aboriginal Congress
ACAC

Sonia Shea
Health Education Officer
PO Box 159
Wagga Wagga NSW 2650

Juanita Sherwood
NSW Health Dept
Aboriginal Health Branch
Sydney NSW 2001

Dorothy Shipley
Health Education Officer
CHC
596 Hoxton Park Road
Hoxton Park NSW 2171

Lyn Shipway
Nth Stradbroke Island Aged Care
and Respite Centre
Nth Stradbroke Island
Dunwich QLD 4183

Vema Singleton
Coen Clinic
Coen QLD 4871

Eleanor Sloane
Health Education Officer
PO Box 23
Menindee NSW 2879

Annette Smith
Assistant in Nursing
Georgina Davidson Aged Person's
Hostel
694 Wynnum Road
Morningside QLD 4170

Darryl Smith
Public Health Unit
PO Box 119
Mackay QLD 4740

Lynda Smith
Aboriginal and Torres Strait
Islander Community Health
Services
73 Beach Road
Sarina QLD 4737

Marilyn Smith
Health Education Officer
59 Phillip Street
Goonellabah NSW 2480

Frank Spry
Aboriginal Issues Officer
Public Health Strategy Unit
Northern Territory Health Services
Casuarina QLD 0811

Jenny Springham
Student Needs Coordinator
Aboriginal and Torres Strait
Islander Community Health
Education and Training
Hubert Street
Wooloongabba QLD 4102

Patricia Srpak
PO Box 920
Brisbane QLD 4000

Kura Stephen
Generalist Health Worker
Sibuwani Ngurpai Meta
C/- Thursday Island Hospital
PO Box 319
Thursday Island
Torres Strait QLD 4875

Elliott Stewart
Health Education Officer
10 Hadley Street
Forster NSW 2428

Jacqui Stewart
Aboriginal Hospital Liaison
Officer
St Vincents Hospital
41 Victoria St
Fitzroy VIC 3065

Karen Stewart
Health Education Officer
30 William Street
Orange NSW 2800

Greg Strong
Health Education Officer
CHC Locked Bag no. 4
Armidale NSW 2350

RESCINDED

Catherine Swain
Aboriginal Health
2 Catt Crescent
Nth Rockhampton
QLD 4701

Lisa Thorpe
Community Health Programs
Manager
Victorian Aboriginal Health
Service Co-op Ltd
186 Nicholson St
Fitsroy VIC 3065

John Tomlinson
Course Coordinator
Bachelor of Social Science
Course, Queensland University of
Technology
Beams Road
Carseldine QLD 4034

Mark Thompson
Student Needs Coordinator
Aboriginal and Torres Strait
Islander Health Workers
Education Program
Rockhampton QLD 4072

Anne Tranby
Hospital Liaison Officer
Aboriginal and Islander
Community Health Service
10 Hubert Street
Wooloongabba QLD 4102

Norma Tranby
Wuchopperen Medical Service
PO Box 1268
Cairns QLD 4870

Denise Troon
Health Promotion Officer
Aboriginal Health Council of
South Australia
PO Box 9 Rundle Mall
Adelaide SA 5001

Aletia Twist
Tropical Public Health Unit
PO Box 1103
Cairns QLD 4870

Coral Walker
HACC
6 Tummon Street
Bundaberg QLD 4670

Scott Walker
Health Worker
20 Mt Louisa Drive
Townsville QLD 48 10

Clive Walley
Health Promotion Officer
Dept of Health
189 Royal Street
Perth WA 6004

Eunice Wanganeen
Northern Metropolitan Aboriginal
Council
9 John Street
Salisbury SA 5 108

Sonia Waters
Aboriginal Health Division
PO Box 65
Rundle Mall
Adelaide SA 5000

Shirley Watson
Coordinator
Burrabah Resource Centre
PO Box 644
Woodridge QLD 4 114

Vera Webber
Enrolled Nurse
C/- Eidsvold Hospital
Eidsvold QLD 4627

Vicki White
314 Salamanka St
Nth Rockhampton
QLD 4701

Anthony Williams
Drug and Alcohol Worker
Inala Community Health Centre
Wirraway Parade
Inala QLD 4077

Jane Williams
32 Kensington Street
Bundaberg QLD 4670

Tony Williams
Aboriginal and Torres Strait
Islander Regional Coordinator
Sunshine Coast Regional Health
Authority
Maroochydore QLD 4558

Lindsay Wilson
Neporendi
112 Beach Road
Christies Beach SA 5165

Barbara Wingard
Aboriginal Health Council
c/- Murray Mallee
Community Health Centre
PO Box 346
Murray Bridge SA 5253

Cheryl Wright
Health Promotion Director
National Heart Foundation of
Australia
South Australian Division
155 Hutt Street
Adelaide SA 5000

Raylene Wright
Indigenous Health Promotion
Project
University of Queensland
Brisbane QLD 4000

Olivene Youse
Public Health Unit
10 Burston Street
Nth Mackay QLD 4740

RESCINDED

Promoting the Health of Australians-A review of the infrastructure support for national health advancement

References

- 1 National Aboriginal Health Strategy Working Party. *National Aboriginal Health Strategy*. Canberra: Department of Aboriginal Affairs, 1989.
- 2 Jan S, Wiseman V. Equity in health care: some conceptual and practical issues. *Australian and New Zealand Journal Of Public Health* 1996;20(1):9–11.
- 3 Commonwealth Department of Health and Family Services. *Discussion paper on the National Public Health Partnership*. Canberra: Department of Health and Family Services, 1996.
- 4 South Australian Health Commission. Commonwealth/State Aboriginal Health Agreement for South Australia. Adelaide: South Australian Health Commission, 1996.
- 5 Commonwealth Department of Health and Family Services. Office of Aboriginal and Torres Strait Islander Health Services. *Comments on Draft Report on the Infrastructure support for Aboriginal and Torres Strait Islander Health Advancement*. Canberra: Office of Aboriginal and Torres Strait Islander Health Services, 1996.
- 6 McMasters A. Research from an Aboriginal health worker's point of view. *Australian Journal of Public Health* 1996;20(3):319–320.
- 7 Health Advancement Standing Committee. *Promoting the health of Australians: a review of infrastructure for national health advancement. Final Report and Recommendations*. Canberra: National Health and Medical Research Council, 1996.
- 8 Pholeros P, Rainow S, Torzillo P. *Housing for health: towards a healthy living environment for Aboriginal Australia*. Sydney: Healthabitat, 1993.
- 9 Queensland Health. *Aboriginal and Torres Strait Islander health policy* 1994. Brisbane: Queensland Health, 1994.
- 10 National Aboriginal Health Strategy Working Party, 1989 op. cit. p. 51
- 11 *ibid.*, p.x.
- 12 Maher C, Tilton E. *Health promotion or self-promotion? A Central Australian Aboriginal alcohol media strategy*. Alice Springs: Central Australian Aboriginal Congress, 1994, p. 12-22
- 13 Bartlett B, Legge D. *Beyond the maze: proposals for more effective administration of Aboriginal health programs*. NCEPH Working Paper No. 34. Alice Springs, Canberra: Central Australian Aboriginal Congress and National Centre for Epidemiology and Population Health, the Australian National University, 1994.
- 14 Catford J. Health promotion in the market place. *Health Promotion International* 1995;10(1):41-50.
- 15 Pholeros P, Rainow S, Torzillo P., 1993 op. cit.
- 16 Harris E, Wise M, Hawe P, Finlay P, Nutbeam D. *Working together: intersectoral action for health*. Canberra: Commonwealth Department of Human Services and Health Sydney: National Centre for Health Promotion, 1995.
- 17 Australian Institute of Health and Welfare, *Australia's health* 1996. Canberra: Australian Government Publishing Service, 1996. p.203-4.
- 18 Colin T, Garrow A. *Thinking, listening, looking, understanding and acting as you go along*. Alice Springs: Council of Remote Area Nurses of Australia Inc, 1996.
- 19 Nutbeam D. Health outcomes and health promotion – defining success in health promotion. *Health Promotion Journal Of Australia* 1996;6(2):58–60.
- 20 Maher C, Tilton E. 1994.op. cit. p. 50
- 21 Tsey K. Aboriginal health workers: agents of change? *Australian and New Zealand Journal of Public Health* 1996;20(3):227–229.
- 22 Bartlett B, Legge D., 1994 op. cit., p.14.
- 23 National Health and Medical Research Council. Workforce Issues Working Party. *A national training and employment strategy for Aboriginal and Torres Strait Islander health workers and professionals working in Aboriginal and Torres Strait Islander health. Draft Report*. Canberra: National Health and Medical Research Council, 1996.

- 24 National Health and Medical Research Council. *A national training and employment strategy for Aboriginal and Torres Strait Islander health workers and professionals working in Aboriginal and Torres Strait Islander health. Draft Report.* Canberra: National Health and Medical Research Council, 1996.
- 25 *ibid.*, p.19.
- 26 Australian Bureau of Statistics. *National Aboriginal and Torres Strait Islander Survey 1994: detailed findings.* Catalogue No. 4190.0. Canberra: Australian Bureau of Statistics, 1995.
- 27 National Aboriginal Health Strategy Working Party. *The National Aboriginal Health Strategy. An Evaluation Report.* Canberra: Department of Aboriginal Affairs, 1989.
- 28 Australian Institute of Health and Welfare. *Australia's health 1996.* Canberra: Australian Government Publishing Service, 1996. p.22.
- 29 Australian Institute of Health and Welfare. *Australia's health 1992.* Canberra: Australian Government Publishing Service, 1992. p.217.
- 30 Australian Institute of Health and Welfare, 1996. *op. cit.*, p.22.
- 31 Australian Institute of Health and Welfare, 1996. *op. cit.*, p.22.
- 32 Australian Institute of Health and Welfare, 1992. *op. cit.*, p.219.
- 33 Thomson N. A review of Aboriginal health status. In: Reid J, Trompf P (editors) *The health of Aboriginal Australia.* Harcourt Brace Jovanovich, 1991.
- 34 Peacham R. *Valuing the past investing in the future: Evaluation of the National HIV/AIDS Strategy 1993/94 to 1995/96.* AIDS/ Communicable Diseases Branch. Canberra: Commonwealth Department of Human Services and Health, 1995.
- 35 Swan P, Raphael B. *Ways forward. National Aboriginal and Torres Strait Islander Mental Health Policy.* National Consultancy Report. Canberra: National Mental Health Strategy, 1995.
- 36 National Aboriginal Health Strategy, 1989, *op. cit.*, p.8.
- 37 National Aboriginal Health Strategy Evaluation Committee. *The National Aboriginal Health Strategy: an evaluation report.* Canberra: Aboriginal and Torres Strait Islander Commission. p.6.
- 38 Australian Bureau of Statistics. *National Aboriginal and Torres Strait Islander Survey 1994: detailed findings.* Catalogue No. 4190.0. Canberra: Australian Bureau of Statistics.
- 39 Australian Institute of Health and Welfare, 1996. *op. cit.*, p.25.
- 40 Kunitz S. *Disease and social diversity: the European impact on the health of non-Europeans.* New York: Oxford University Press, 1994.
- 41 National Aboriginal Health Strategy Working Party, 1989, *op. cit.*
- 42 Aboriginal and Torres Strait Islander Health Policy Branch. Division of Policy and Planning, Queensland Health. *Aboriginal and Torres Strait Islander Health Policy (Queensland) 1994.*
- 43 Kaplan G, Pamuk E, Lynch J, Cohen R, Balfour J. Inequality in income and mortality in the United States: analysis of mortality and potential pathways. *British Medical Journal* 1996;312:999–1003.
- 44 Jopson, D. Black jobless rate still at 25%. *The Sydney Morning Herald.* 31 May 1996:5.
- 45 Hunter E. Denial, rationalisation and trivialisation of state intrusion into Aboriginal family life. *Family Matters* 1996;44:16–19.
- 46 Australian Institute of Health and Welfare, 1996. *op.cit.*, p.21–29.
- 47 Thomson N., 1991, *op. cit.*
- 48 Hunter E. *Aboriginal health and history: power and prejudice in remote Australia.* Cambridge: Cambridge University Press, 1993.
- 49 *Royal Commission into Aboriginal Deaths in Custody. Final Report.* Canberra: Australian Government Publishing Service, 1991.
- 50 National Aboriginal Health Strategy Working Party, 1989, *op. cit.*
- 51 Egan T. *The Aboriginals.* Greenhouse Publications, 1987.
- 52 Australian Bureau of Statistics. *Australia's Aboriginal and Torres Strait Islander population. 1991 Census.* Catalogue No. 2740.0.
- 53 Galinovic, M Culture Shock. *The Border Mail.* 4 May 1996.
- 54 Bartlett B, Legge D., 1994. *op. cit.*, p.8
- 55 *ibid.*, p.8.
- 56 Read P. *A Hundred Years War.* Sydney: Australian National University Press, 1988.

- 57 Hunter, 1993. op. cit., p.256.
- 58 Budden C & Woodley J. *A technicolorfantasy. concerned citizens for a proper perspective on land rights*. Darwin: The Uniting Church Printshop, 1983. p.11.
- 59 *ibid.*, p.19.
- 60 Centre for Aboriginal Economic Policy Research. *Indigenous participation in labour market and in training programs*. CAEPR Issue Brief 1. Canberra: The Australian National University, 1996.
- 61 Ariss R. Writing black: the construction of an Aboriginal discourse. In: Beckett, J.R. (editor). *Past and present: the construction of Aboriginality*. Canberra: Aboriginal Studies Press, 1988.
- 62 Donaldson T. Hearing the first Australians. In: Donaldson I, Donaldson T. (editors). *Seeing the first Australians*. Sydney: George Allen and Unwin, 1985.
- 63 Long J. Aboriginal settlements: a survey of institutional communities in eastern Australia. Canberra: Australian National University Press, 1970. Cited in: Franklin M, White I. The history and politics of Aboriginal health. In: Reid J, Trompf P. (editors). *The health of Aboriginal Australia*. Sydney: Harcourt, Brace, Jovanovich, 1991.
- 64 Franklin M, White I. The history and politics of Aboriginal health. In: Reid J, Trompf P. (editors). *The health of Aboriginal Australia*. Sydney: Harcourt, Brace, Jovanovich, 1991.
- 65 Egan T. *The Aborigines*. Greenhouse Publications, 1987.
- 66 Brady M. Drug and alcohol use among Aboriginal people. In: Reid J, Trompf P. (editors) *The health of Aboriginal Australia*. Sydney: Harcourt, Brace, Jovanovich, 1991.
- 67 *ibid.*, p.186.
- 68 *ibid.*, p.18.
- 69 Hunter E. Denial, rationalisation and trivialisation of state intrusion into Aboriginal family life. *Family Matters* 1996;44:16-19.
- 70 Lehmann, J (a).Remote, poor and paying \$6 for milk. (b). Mothers allowed homeland births. (c). Cape seeks new hospital. (d). Prince preaches about joy of living. (e.) Diseased dog cull to halt rampant scabies. *The Courier Mail*. 24 June 1996.
- 71 Torzillo P, Kerr C. Contemporary issues in Aboriginal public health. In: Reid J, Trompf P. (editors). *The health of Aboriginal Australia*. Sydney: Harcourt, Brace, Jovanovich, 1991.
- 72 Jopson, D. Black jobless rate still at 25%. *The Sydney Morning Herald*. 31 May 1996:5.
- 73 Reynolds H. The other side of the frontier. Victoria: Penguin Australia, 1982. Cited in: Reid J, Trompf P. (editors) *The health of Aboriginal Australia*. Sydney: Harcourt Brace Jovanovich, 1991. p.5.
- 74 Torzillo P, Kerr C. op. cit., p.327.
- 75 Mobbs R. In sickness and health: the sociocultural context of Aboriginal well-being, illness, and healing. In: Reid J, Trompf P (editors). *The health of Aboriginal Australia*. Sydney: Harcourt Brace Jovanovich, 1991.
- 76 National Aboriginal Health Strategy Working Party, 1989. op. cit. p.1.
- 77 National Aboriginal Health Strategy Working Party., 1989. op. cit. p.1.
- 78 Franklin M, White I. op. cit., p.5.
- 79 Hunter E. 1996. op. cit., p17.
- 80 Ellis R. Equality, self management and health. *Aboriginal and Islander Health Worker Journal* 1996; 20(2): 19-23.
- 81 Spark R, Donovan R, Howat P. Promoting health and preventing injury in remote Aboriginal communities: a case study. *Health Promotion Journal of Australia* 1991;1(2):10-16.
- 82 World Health Organization. *The Ottawa Charter for health promotion*. Ottawa: Canadian Public Health Association/World Health Organization, 1986.
- 83 Howell R. *Aboriginal health and unemployment*. Albury, NSW: South West Centre for Public Health. 1994.
- 84 Hunter. 1993. op. cit., p.286.
- 85 Franklin M, White I. op. cit., p.26-27.
- 86 Wright, J. The myth about Aboriginal 'handouts'. *The Courier Mail*. 24 February 1996.
- 87 Bartlett B, Legge D. op. cit., p.8.

- 88 Lea T. *Advocating for the health of an Aboriginal community in North Queensland. Paper presented at the Eighth National Health Promotion Conference.* Sydney 1996.
- 89 Kunitz S, Brady M. Health care policy for Aboriginal Australians: the relevance of the American Indian experience. *Australian Journal of Public Health* 1995;19(6):549-558.
- 90 *ibid.*, p.553.
- 91 Bartlett B, Legge D. *op. cit.*, p.9-10.
- 92 Kunitz S, Brady M. *op. cit.*, p.553.
- 93 Kunitz S, Brady M. *op. cit.*, p.555.
- 94 Kilham R. *Federal government funding for Indigenous health.* Canberra: Access Economics, 1996.
- 95 *ibid.*, p.3.
- 96 Kunitz S, Brady M. *op.cit.*, p.553.
- 97 Sibthorpe B. All our people are dying: diet and stress in an urban Aboriginal community. [thesis]. Canberra: Australian National University, 1988. Cited in: Kunitz S, Brady M. Health care policy for Aboriginal Australians: the relevance of the American Indian experience. *Australian Journal of Public Health* 1995;19(6): 549-558.
- 98 Myers F. Pintupi country, Pintupi self: sentiment, place and politics among Western Desert Aborigines. Canberra: AIAS. Cited in: Trompf P, Reid J. (editors) *The health of Aboriginal Australia.* Sydney: Harcourt, Brace, Jovanovich, 1991.
- 99 Bartlett B, Legge D. *op. cit.*, p.12.
- 100 Budden C, Woodley J. *op. cit.*, p.12.
- 101 Australian Institute of Health and Welfare, 1996. *op. cit.*, p. 26.
- 102 Kunitz S, Brady M. *op. cit.*, p.557.
- 103 Griew R. A strong commitment to improve Aboriginal and Torres Strait Islander health. *Aboriginal and Islander Health Worker Journal* 1996 20(2):53-55.
- 104 South Australian Health Commission. *Commonwealth State Aboriginal Health Agreement for South Australia.* Adelaide: South Australian Health Commission, 1996.
- 105 National Health Strategy. *Enough to Make You Sick. How income and environment affect your health. Research Paper No. 1.* Melbourne: National Health Strategy, 1992.
- 106 National Aboriginal Health Strategy Working Party, 1989. *op. cit.*
- 107 National Aboriginal Health Strategy. *The National Aboriginal Health Strategy*, 1989. *op. cit.*
- 108 National Aboriginal Health Strategy Evaluation Committee. *The National Aboriginal Health Strategy: an evaluation.* Canberra: Aboriginal and Torres Strait Islander Commission, 1994.
- 109 Last J. *A dictionary of epidemiology.* Oxford: Oxford University Press, 1993.
- 110 Green L, Kreuter M. Health promotion as a public health strategy for the 1990s. *Annual Review of Public Health* 1990;11:319-34.
- 111 Abelin T. Approaches to health promotion and disease prevention. In: Abelin T, Brzezinski Z, Carstairs V (editors). *Measurement in health promotion and protection.* Copenhagen: World Health Organization, Regional Office for Europe, 1987.
- 112 Torzillo P, Kerr C. *op.cit.*, p.352.
- 113 Abelin T. *op. cit.*, p.33.
- 114 Spark R, Donovan R, Howat P, , 1991. *op. cit.* p.12.
- 115 Crawford F. Jalinardi ways: whitefellas working in Aboriginal communities. Perth: Curtin University of Technology, 1989. Cited in: Spark R, Donovan R, Howat P. *ibid.*, p. 11.
- 116 Green L, Kreuter M, 1990. *op. cit.* p.322
- 117 Pholeros P, Rainow S, Torzillo P *op.cit.*, p.vii-ix.
- 118 Wales M. *Old Mapoon -planning for a healthy community.* Paper given at the Public Health Association Conference, Cairns, 1995.
- 119 Maher C, Tilton E, 1994. *op. cit.* p.38-47
- 120 Ellis R. Models of excellence in Indigenous community health. Part Four. Tennant Creek. *Aboriginal and Islander Health Worker Journal* 1996; 20(5):6-15.

RESCINDED

- 121 *ibid.*, p. 6.
- 122 Holman C, Donovan R, Corti B. *Report of the evaluation of the Western Australian Health Promotion Foundation*. Western Australia: Department of Public Health and Graduate School of Management, University of Western Australia, 1994.
- 123 Campbell D, Ellis R. Models of excellence in Indigenous community health. Kimberley Aboriginal Medical Service. *Aboriginal and Islander Health Worker Journal* 1995;19(6):5-9.
- 124 Queensland Health. *Aboriginal and Torres Strait Islander Health Policy* Brisbane: Queensland Health, 1994.
- 125 Siggers S, Gray D. Policy and practice in Aboriginal health. In: Reid J, Trompf P. (editors). *The health of Aboriginal Australia*. Sydney: Harcourt, Brace, Jovanovich, 1991.
- 126 Bartlett B, Legge D. *op. cit.*, p.12.
- 127 Torzillo P, Kerr C. *op. cit.*, p.337-339.
- 128 Hart R, Ring I, Runciman C. Public hospital activity, expenditure and staffing levels of indigenous and non-indigenous settlements in remote Queensland. *Australian Journal of Public Health* 1993;17(4):325-330.
- 129 Health Advancement Standing Committee. *Promoting the health of Australians: a review of infrastructure for national health advancement. Final Report and Recommendations*. Canberra: National Health and Medical Research Council, 1997.
- 130 McMahon B. *Letter to Peter Beattie, Minister Commonwealth Department of Health*. 12 Jan, 1996
- 131 Dodson P. Reconciliation at the crossroads: let's go forward. *Walking Together*, 1996;15:2.
- 132 Kunitz S, Brady M. *op. cit.* p.549-558.
- 133 National Aboriginal Health Strategy Evaluation Committee, 1994. *op. cit.* p.2
- 134 Bartlett B, Legge D. *op. cit.* p.1-21.
- 135 Torzillo P, Kerr C. *op. cit.* p.326380.
- 136 Hunter E. 1996. *op. cit.*, p. 16-19.
- 137 Kaplan G, Pamuk E, Lynch J, Cohen R, Balfour J. 1996. *op. cit.*, p.999.
- 138 Centre for Aboriginal *Economic Policy Research. Indigenous participation in the labour market and in training programs*. CAEPR Issue Brief 1. Canberra: Australian National University, 1996.
- 139 Royal *Commission into Aboriginal Deaths in Custody. National Report. Overview and Recommendations*, Commissioner Elliott Johnstone QC. Canberra: Australian Government Publishing Service, 1991.
- 140 Bartlett B, Legge D. *op. cit.*, p. 11.
- 141 Weeramanthri T, Plummer C. Land, body and spirit – talking about adult mortality in an Aboriginal community. *Australian Journal of Public Health* 1994;18(2):197-200.
- 1421McMasters A. Research from an Aboriginal health worker's point of view. *Australian Journal of Public Health* 1996;20(3):319-320.
- 143 Houston S, Legge D. Aboriginal health research and the National Aboriginal Health Strategy. *Australian Journal of Public Health* 1992;16(2):114-115.
- 144 Donovan R, Spark R. Towards guidelines for survey research in remote Aboriginal communities. *Australian Journal of Public Health* 1996. In press.
- 145 Siggers S, Gray D. *op. cit.*, p.413.
- 146 Kenny G *Regional perspective on issues associated with alcohol and drugs and Aboriginal and Torres Strait Islander People. Paper for Alcohol and Drug Conference-South West Queensland*, 1996: pl.
- 147 *ibid.*, p.1.
- 148 Bartlett, B & Legge, D. *op. cit.*, p.8.
- 149 Golds, M. Taking programs to the communities-a recognised model. *Aboriginal and Islander Health Worker Journal* 1994;8(6).
- 150 Spark R, Donovan R, Howat P, 1991. *op. cit.* p.12.

The National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) is a statutory authority within the portfolio of the Commonwealth Minister for Human Services and Health, established by the *National Health and Medical Research Council Act 1992*. The NHMRC advises the Australian community and Commonwealth, State and Territory Governments on standards of individual and public health, and supports research to improve those standards.

The NHMRC advises the Commonwealth Government on the funding of medical and public health research and training in Australia and supports many of the medical advances made by Australians.

The Council comprises nominees of Commonwealth, State and Territory health authorities, professional and scientific colleges and associations, unions, universities, business, consumer groups, welfare organisations, conservation groups and the Aboriginal and Torres Strait Islander Commission.

The Council considers and makes decisions on reports prepared by committees and working parties following wide consultation on the issue under consideration.

A regular publishing program ensures that Council's recommendations are widely available to governments, the community, scientific, industrial and educational groups.

The Council publishes extensively in the following areas:

- Child health • Clinical practice • Communicable diseases • Dentistry • Drugs and poisons • Drug and substance abuse • Environmental health • Health ethics • Infection control • Mental health • Nutrition • Public health
- Women's health.

A List of Current Publications is available from:

The Publications Officer
NHMRC
GPO Box 9848
Canberra ACT 2601

Phone:(02) 6289 7646 (24 hour answering machine)

Fax: (02) 6289 8776

Internet: <http://www.health.gov.au/nhmrc>