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Innovation without change?
Commonwealth involvement in Aboriginal health policy
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CONTENTS

Executive Summary ........................................ 1

Introduction ............................................. 5

The origins of Commonwealth involvement ............... 6

The Whitlam Government ................................ 6

The Fraser Government .................................. 7
  The report of the House of Representatives Standing Committee on Aboriginal Affairs .......... 8

The Hawke Government .................................. 9
  The National Aboriginal Health Strategy Working Party .......... 9
  The Aboriginal Health Development Group .................. 10
  The National Aboriginal Health Strategy .................. 11
  Two blueprints ......................................... 12

The Keating Government ................................ 14
  Some national reports ................................ 14
  Some State reports ................................... 18
  Debate over funding ................................... 19

Conclusion .............................................. 23

Appendix 1
  Health expenditure by the Office of Aboriginal Affairs/Department of Aboriginal Affairs and the Aboriginal and Torres Strait Islander Commission .......... 25

Appendix 2
  National Aboriginal health strategy funding to ATSIC ........ 26

1993/94 List of PRS Publications
Executive Summary

There have been many inquiries into Aboriginal health problems over the last 25 years. Given, however, the frequency with which these committees' recommendations recur and given the current Aboriginal health status, it might be asked whether we have been witnessing 'innovation without change'. This paper will focus on the main policy developments.

Despite the 1967 referendum clearing the way for the Commonwealth to become involved in Aboriginal affairs, the Commonwealth did not become deeply involved in Aboriginal health issues until the Whitlam Government initiated a national campaign to raise Aboriginal health standards. The campaign involved data collection, the promotion of preventive medicine and community health (with particular attention to child health and chronic and infectious diseases), consultation with relevant authorities and tied grants to the States.

The Fraser Government followed through on two significant initiatives of the Whitlam Government, the National Trachoma and Eye Health Program and the Commonwealth funding of Aboriginal Medical Services (AMSs), which had started as unfunded community initiatives. In 1979 the House of Representatives Standing Committee on Aboriginal Affairs' report Aboriginal Health stressed the need for basic environmental improvements, self-determination, community development and much greater involvement of Aboriginal people at all levels of health-care service delivery. Many recommendations were not, however, endorsed by the Government and there was little follow through on those which were endorsed. The latter included that Aboriginal communities' water supplies and sanitation be improved, that various departments, authorities and communities define more clearly responsibility for public hygiene service and housing standards, that Aboriginal cultural beliefs and practices be taken into account when considering health care policy and practice, that non-Aboriginal health professionals be better educated in Aboriginal health problems and cultural ways, and that Aboriginal people be more involved at all stages in the planning and provision of health care services.

The Hawke Government initially simply continued the Aboriginal health policy and programs of the Fraser Government, but in 1987 a combined meeting of Commonwealth, State and Territory Health Ministers and Aboriginal Affairs Ministers appointed a National Aboriginal Health Strategy Working Party. The working party, comprising predominantly Aboriginal and Torres Strait Islander people, held wide consultations and in 1989 produced their final report, National Aboriginal Health Strategy. The report identified the need for clear delineation of Commonwealth/State responsibility. It also
called for a new administrative structure, more training for Aboriginal health care workers, a broad social response to health issues and specific strategies in areas such as alcohol abuse, women's health, infectious and chronic diseases, and violent anti-social behaviour.

An Aboriginal Health Development Group comprised predominantly of Government representatives and an Aboriginal Health Advisory Group comprising representatives from AMSs, both assessed the National Aboriginal Health Strategy Working Party's report. A combined ministerial meeting in June 1990 agreed to implement a NAHS (NAHS), featuring a new tripartite Council of Aboriginal Health, funding to tackle environmental health problems, to support more Aboriginal health services, to combat substance abuse in Aboriginal communities and to improve Aboriginal health research and data collection.

Despite some early achievements, many expectations raised by the ministerial agreement were not met. The Council of Aboriginal Health did not meet until April 1992, the Government commitment of $232m over five years was widely regarded as only fraction of that which was necessary and formal agreements with the States and Territories on matching funds were not completed until late in 1992.

In 1991 the recommendations of the Royal Commission into Aboriginal Deaths in Custody included a call for greater attention to environmental health issues, greater support for the principles of self-determination, greater support for the AMSs, greater Aboriginal involvement in the health care system and increased funding for the National Aboriginal Health Strategy. In this same year, to assist in the evaluation of the NAHS's effectiveness and to offer a framework for intergovernmental negotiations, an interim Aboriginal and Torres Strait Islander Health Goals and Targets document was produced. Like the Royal Commission's report, it stressed the need for attention to roads, communications, housing, water supplies, sewerage and waste disposal.

In March 1992, as part of its response to the Royal Commission into Aboriginal Deaths in Custody, the Commonwealth Government announced a $150m five-year funding package which included $71.6m for the establishment of Aboriginal-controlled drug and alcohol services. In June 1992 it announced a $250m five-year package with the focus more on land and employment.

Although Aboriginal communities' patience with the number of reports was wearing so thin by 1989 that the New South Wales Task Force on Aboriginal Health called its 1990 report The Last Report, between late 1992 and mid-1994 there were many more reports (a National Health Strategy paper, a review of the Council for Aboriginal Health, a report
on Aboriginal health worker training, a paper on the health needs of
tropical Australia, a National Rural Health Strategy, a report on
housing and Aboriginal health and a study on water and sanitation
provision in remote Aboriginal and Torres Strait Islander
communities). All stressed the need to tackle environmental health
issues more vigorously and to involve Aboriginal communities more in
service delivery. They also all urged Governments and authorities to
more clearly delineate their responsibilities. The House of
Representatives' Standing Committee on Aboriginal and Torres Strait
Islander Affairs suggested the Aboriginal and Torres Strait Islander
Commission (ATSIC) may be funding projects properly the
responsibility of other levels of government.

In June 1993 the desire of the then Minister for Health, Senator
Richardson, for his department to become more involved in Aboriginal
health, sparked a debate over who at the federal level should have
responsibility for Aboriginal health and how much extra money should
be directed to improving it. The National Aboriginal Community
Controlled Health Organisation and the Australian Medical Association
(AMA) supported greater departmental involvement. ATSIC, while
remaining open to the proposals for structural change, expressed
concern at the possible 'disempowering' of Aboriginal people. Systems
of joint or divided control were discussed. Many problems, needs and
proposals for change were debated at the March 1994 summit on
Aboriginal Health sponsored by the AMA.

In its May 1994 Budget the Commonwealth Government announced a
$500m five-year Aboriginal health package (an additional $162m to the
Aboriginal Medical Services program and an additional $338m to the
Community Housing and Infrastructure Program). The package
received much public attention, firstly because the allocation appeared
to be less than that reportedly sought by both Senator Richardson and
the new Minister for Health, Dr Lawrence, secondly because many
people argued that only a small portion of the promised $500m could
properly be considered new funding, and thirdly because administrative
mechanisms remained unchanged. Calls for the budget allocation to
Aboriginal health to be re-examined are still being made.

Not all the news with respect to Aboriginal health status is bad and
the front on which the Commonwealth Government is addressing
Aboriginal health issues has broadened in recent years. However, if
Aboriginal health outcomes are to improve as fast as they could, the
cycle of action and inaction, commitment and frustration, structure and
restructure needs to be broken and more attention needs to be paid to
monitoring the implementation of recommendations, co-ordinating the
endeavours of different bodies, and acting on the many practical
suggestions made over the years.
Introduction

Over the last quarter of a century there have been many significant milestones in Commonwealth involvement in the area of Aboriginal health, numerous committees inquiring into the subject, and continual policy developments. The health status of Aboriginal people is, however, by almost any indicator, appalling when compared to that of the total population. The incidences of diabetes and diseases of the circulatory system among young and middle aged adults are more than 10 times higher. The incidence of tuberculosis is 15-20 times higher. Notification rates for sexually transmitted diseases are up to 60 times higher. Similarly incidences of ear, eye and renal disease are much higher. Rates of hospitalisation for nearly every cause and for every age-group are higher and lengths of stay are longer. Mortality rates (both general and infant) are about three times higher. Death by disease of the circulatory system are more than two and a half times higher, death by accident and injury (including self-afflicted) are three and a half times higher, death by diseases of the respiratory system are five times higher.¹

Given the frequency with which many themes and recommendations recur in the commissioned reports and given the current Aboriginal health status, it might be asked whether we have been witnessing 'innovation without change'.² Leaving discussion of particular Aboriginal health problems aside,³ this paper will focus on the main policy developments.

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² A phrase first used with respect Aboriginal health policy by Professor Colin Tatz. See page 6 of this paper.

The origins of Commonwealth involvement

In the 1950s and early 1960s the State Governments, together with the Churches, controlled all aspects of Aboriginal life. There was no concept of ‘Aboriginal health’ as a national issue, no appreciation of the root-causes of Aboriginal ill-health and, at a time of growing Aboriginal population, inadequate funding of Aboriginal welfare agencies.4

The 1967 referendum and the subsequent establishment of the Commonwealth Office of Aboriginal Affairs heightened the prospect of Aboriginal health becoming a Commonwealth concern. Commonwealth involvement and tangible achievements in the area of Aboriginal health remained, however, slight. The most significant development, the establishing of the first Aboriginal-controlled medical service in 1971, was a community initiative without any Commonwealth involvement.

At a seminar on Aboriginal health in May 1972 Politics Professor Colin Tatz subtitled his review of developments in the area since 1962 as "The paradox of innovation without change".5 He suggested that although almost all of the appalling ill-health was theoretically remediable, there was negligible progress because of the narrow focus on personal curative services at the expense of 'promotive' health services (employment, nutrition, education etc), 'preventive' health services (ante and post natal clinics, infant welfare clinics, immunisation services, creches, counselling clinic, school health services etc), 'rehabilitive' services and such non-medical and non-personal but quintessential services as housing, water supplies, and garbage disposal.

The Whitlam Government

The Whitlam Labor Government, elected in December 1972, changed the Commonwealth Office of Aboriginal Affairs into the Department of Aboriginal Affairs (DAA), made 'self-determination' official policy, doubled direct Commonwealth expenditure on Aboriginal assistance

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4 Briscoe, Gordon, 'Aboriginal health and political economy in Australia', in Janice Reid and Peggy Trompf (eds), The Health of Aboriginal Australia, Sydney, 1992: 393.

5 The original paper, 'Aboriginal health in the Northern Territory: The Paradox of Innovation Without Change' was commissioned by the national seminar on Aboriginal Health Services, sponsored by the Centre for Research into Aboriginal Affairs, Monash University, 15-17 May 1972. Colin Tatz, The Politics of Aboriginal Health, a supplement to Politics Vol.VII, No.2, November 1972, was a revised form of this paper.
programs and introduced Medibank (prior to which most mainstream health services were not affordable to most Aboriginal people).

In March 1973 the Whitlam Government approved a Ten Year Plan for Aboriginal Health. The Commonwealth Department of Health was to have responsibility for a national campaign to raise the Aboriginal standard of health to that enjoyed by non-Aboriginal Australians (with particular attention to infant and child mortality and morbidity, infant and child nutrition, growth retardation, and chronic diseases and infectious diseases such as leprosy, trachoma, tuberculosis, gastroenteritis, and respiratory and ear infections). The strategy to accomplish the objectives involved data collection, a survey of current and planned programs, specification of health care resources available within Australia to Aboriginal people, promotion of preventive medicine and community health, and the development of a national campaign in consultation with all relevant Commonwealth and State authorities.

Although the 1967 referendum gave the Commonwealth a legitimate interest in Aboriginal Affairs, State Governments had always considered themselves responsible for all health matters. To encourage the State Governments to develop special Aboriginal health programs, the Whitlam Government made funds available by way of tied grants.

**The Fraser Government**

The Fraser Government, elected in 1976, although cutting Commonwealth spending on Aboriginal Affairs by 14 per cent in its first year, substituting 'self-management' for 'self-determination', and attempting to hand some responsibility back to the States, generally maintained the policies and programs of the Whitlam Government.

Two significant initiatives of the Whitlam Government which the Fraser Government followed through with were the National

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Trachoma and Eye Health Program and the Commonwealth funding of Aboriginal Medical Services (AMSs). The former was to have much short term success in dealing with one specific problem and might be characterised as vertical intervention. The latter offers a long term approach to general health problems and might be characterised as horizontal support.

The report of the House of Representatives Standing Committee on Aboriginal Affairs

In December 1976 the Government asked the House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA) to consider ways and means of improving Aboriginal health programs and status. The Committee's 1979 report *Aboriginal Health*, made 18 recommendations and 24 suggestions. It stressed the need for basic environmental improvements (e.g. safe water supplies), self-determination, community development and much greater involvement of Aboriginal people at all levels of health-care service delivery.

The Commonwealth Government response to the recommendations of 1979 report was released in 1981. Many recommendations were not endorsed (the Government feeling the goal behind the recommendation could be achieved within existing mechanisms) e.g. that a special technical advisory group be set up within the Department of Aboriginal Affairs, that priority be given to the housing needs of Aboriginals living in or moving into towns, that an inquiry be held into the implementation of the policy of self-determination as it affected community development, that savings to State funded health service from Commonwealth funded State Aboriginal preventive health programs be directed to further develop preventive programs, that the effectiveness of Aboriginal health care services and programs be independently evaluated, and that a Task Force be established to place the full range of health care alternatives before Aboriginal communities.

Those HRSCAA recommendations which the Government endorsed included the following: that Aboriginal communities' water supplies and sanitation be improved, that various departments, authorities and communities define more clearly responsibility for public hygiene service and housing standards, that Aboriginal cultural beliefs and practices be taken into account when considering health care policy and practice, that non-Aboriginal health professionals be better educated in Aboriginal health problems and cultural ways, and that Aboriginal people be more involved at all stages in the planning and

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provision of health care services. $50m was promised over five-years for an environmental health program. With many of the actions requiring co-operation from State Governments and with no monitoring of implementation, all these recommendations were still being put by committees 15 years later.

The Hawke Government

The Hawke Government, although reintroducing the principle of 'self-determination', generally continued the Aboriginal health policy and programs of the Fraser Government. Specific policy imperatives included supporting the development of and directly funding Aboriginal Medical Services (AMSs) as the main agents of health-care delivery, establishing a national system for collection of Aboriginal health statistics, supporting the training of Aboriginal health personnel and providing essential services to Aboriginal communities. Aboriginal health was not, however, accorded a high priority in the 1986 report of the Better Health Commission or the 1988 report of the Health Targets and Implementation (Health for All) Committee.

The National Aboriginal Health Strategy Working Party

In December 1987, after much lobbying from AMSs and in a climate influenced by the ideas, rhetoric and social health strategies of the World Health Organisation's 'Health for all by the year 2000' campaign, a combined meeting of Commonwealth, State and Territory Health Ministers and Aboriginal Affairs Ministers agreed to establish a ministerial forum on Aboriginal health and appointed a National Aboriginal Health Strategy Working Party (NAHSWP). The working party, comprising 19 members (14 of whom were Aboriginal or Torres Strait Islander), was chaired by Naomi Mayers, Administrator of the AMS in Redfern, Sydney.

While the NAHSWP held consultations with Aboriginal and Torres Strait Islander people throughout Australia and received numerous submissions from Aboriginal and non-Aboriginal organisations, agencies and individuals, structural and jurisdictional problems in the area of Aboriginal health were highlighted by two reports

9 Saggers, Sherry, and Gray, Dennis, 'Policy and practice in Aboriginal health', in Janice Reid and Peggy Trompf (eds), The Health of Aboriginal Australia, Sydney, 1992: 391.

published in 1988. The Australian Institute of Health's first biennial report found that funds were being distributed under the Commonwealth/State grant scheme on the basis of programs in existence when the scheme began, not on a population or relative needs basis (ATSIC subsequently reviewed these arrangements),\(^\text{11}\) while the Human Rights Commissioner Justice Einfeld, in his *Toomelah Report*, damned the failure of service-delivery agencies to clearly delineate their responsibilities and co-ordinate their actions.

The NAHSWP final report, *National Aboriginal Health Strategy*, was released in March 1989. It documented the current health status of Aborigines, discussed issues of Commonwealth/State responsibility, differing perceptions of health care, the education and training of Aboriginal health care workers, the need for social health strategies, and the need for specific strategies in areas such as alcohol abuse, women's health, infectious and chronic diseases, and violent anti-social behaviour. The report recommended the creation of an Office of Aboriginal Health to coordinate, monitor and evaluate Aboriginal health programs and to promote a cross-portfolio approach and the establishing of a National Aboriginal Health Council to act as a standing committee of both the Health Ministers and Aboriginal Affairs Ministers Councils.

The Aboriginal Health Development Group

The NAHSWP's report was presented to another combined ministerial meeting in Burnie in March 1989. This meeting established the Aboriginal Health Development Group (AHDG) to assess the report and recommend priorities for implementation of a National Aboriginal Health Strategy. The AHDG comprised the chair of the working party and one representative from each of the Commonwealth Departments of Aboriginal Affairs and of Community Services and Health, the Australian Institute of Health, and from each State and Territory government. In response to the concern from Aboriginal communities that were not represented on the AHDG, the Commonwealth Minister for Aboriginal Affairs established an Aboriginal Health Advisory Group (AHAG) comprising representatives from AMSs. Some of the AHAG recommendations and comments were included in the Aboriginal Health Development Group's, *Report to Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health*, December 1989.\(^\text{12}\)

\(^{11}\) *Australia's health: the first biennial report of the Australian Institute of Health*, AGPS, Canberra, 1988: 120.

The National Aboriginal Health Strategy

The AHDG's report and the views of the AHAG were considered at a third combined ministerial meeting held in Brisbane in June 1990. At that meeting the ministers agreed to implement a National Aboriginal Health Strategy:

The strategy will feature the formation of a new Council of Aboriginal Health, a tripartite body to advise Governments on Aboriginal health policy and monitor the performance of the NAHS.

The NAHS also will tackle serious environmental health problems for Aborigines, such as poor housing, lack of decent water supplies, and inadequate sewerage and power services.

Other initiatives will include measures to formulate new, and upgrade existing, Aboriginal health services, combat substance abuse in Aboriginal communities and improve Aboriginal health research and the collection of information on Aboriginal health.\(^\text{13}\)

The new Council of Aboriginal Health (CAH) was to comprise representatives from Aboriginal Communities, the Commonwealth and the States and Territories, and there were to be complementary tripartite forums in each State and Territory.

The ministers endorsed the need for a specialised Office of Aboriginal Health within the recently established Aboriginal and Torres Strait Islander Commission (ATSIC). They also agreed that the National Campaign Against Drug Abuse should give priority to funding Aboriginal community-controlled education and prevention projects and that the National Health and Medical Research Council give priority to funding Aboriginal community-controlled health research projects.\(^\text{14}\)

Although 67 additional health projects (including establishing or improving many Aboriginal health services) were funded under the NAHS (through ATSIC) in 1990-91, an Office of Aboriginal Health was quickly established within ATSIC, a national housing and infrastructure needs survey was set in train and a draft document on health goals and targets was soon produced, many expectations raised by the ministerial agreement were not met. Firstly, funds were quickly

\(^{13}\) Joint statement by the Minister for Aboriginal Affairs, Robert Tickner, and the Minister for Community Services and Health, Brian Howe, 10 June 1990.

allocated for establishing the Council of Aboriginal Health but, due chiefly to differences of opinion over its membership, the Council did not meet till April 1992. Secondly, the Aboriginal Health Development Group estimated that implementing the housing and infrastructure component of the new National Aboriginal Health Strategy would alone require $2.5 billion over 10 years, but in December 1990 the Commonwealth Government announced it would put only $232 million over five years into the NAHS ($170m for housing and infrastructure). Thirdly, most of the above Commonwealth contribution was dependant upon the State and Territory Governments agreeing to making substantial new contributions on a broadly matching basis, but formal negotiations on agreements did not start till April 1991 and were not nearing completion until mid-1992.

The Government could have defended itself, at least on the second of the above points, by noting that if the promised $232m over five years was added to existing Commonwealth and anticipated State funding in the area and extrapolated to a ten year period, the total would have exceeded $2.5 billion.

Two blueprints

In 1991 two documents were published which between them offered an enormous amount of practical advice on how to address the state of Aboriginal health.

The first was the long awaited report of the Royal Commission into Aboriginal Deaths in Custody (RCADC). The Report's section on health began with a caution that

health development comes not simply from more and better health and sickness care services, but from improvements in the quality of life in general and

and

to be effective, community development and health development must be part of an integrated set of processes of social change.

It then went on to offer a comprehensive overview of Aboriginal health needs, of current Commonwealth and State strategies to address these

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Innovation without change? Commonwealth involvement in Aboriginal health policy

needs and of the adequacy of current programs.\textsuperscript{18} The Report's twenty-five recommendations (246-271) included a call for greater attention to environmental health issues, greater support for the principles of self-determination, greater support for the AMSs, greater Aboriginal involvement in the health care system and the urgent funding of the National Aboriginal Health Strategy. The Report also noted that the sum of money which the Commonwealth had recently committed to the NAHS was 'less than a fifth of that estimated as being needed by the Development Group... Even then, the actual level of Federal funding will depend to some degree on the States and Territories making 'substantial contributions'.\textsuperscript{19}

The second relevant report of 1991 was commissioned by the Commonwealth Department of Health, Housing and Community Services and entitled \textit{Aboriginal and Torres Strait Islander Health Goals and Targets} (interim). Like the Royal Commission's report, the document noted that:

\begin{quote}
The health impact of over two centuries of dispossession is not simple to erase. The sheer complexity of the interwoven determinants of indigenous people's ill-health confounds attempts to achieve comprehensive and sustainable improvements through narrowly focussed interventions. Issues of Aboriginal and Torres Strait Islander control of their own destiny and Aboriginal and Torres Strait Islander self-perception are fundamental. Also indispensable to public health strategies are roads, communications, housing, water supplies, sewerage and waste disposal. This in no way is intended to down play the decisive role of health services including health advocacy, health promotion, prevention, curative and rehabilitation services, just to put them in proper perspective.\textsuperscript{20}
\end{quote}

The document grouped the goals and targets in sections relating to 'major causes of illnesses', 'risk factors for illness', 'housing, water, sanitation, environmental and personal safety', 'education, employment and training' and resource allocation, access and appropriateness, intersectorial collaboration, decision making, health development support and research'. Within this structure the document identified 46 goals and many more targets. It was hoped that these goals and targets might assist in the evaluation of the NAHS's effectiveness and perhaps also offer a framework for intergovernmental negotiations.


\textsuperscript{20} Ian Wronski and Gracelyn Smallwood, \textit{Aboriginal and Torres Strait Islander Health Goals and Targets} (interim), 1991: 4.
The Keating Government

In early 1992 the Commonwealth joined with State and Territory Governments in preparing and releasing a report of responses to the recommendations of the Royal Commission into Aboriginal Deaths in Custody. The Commonwealth followed through in late 1992 and early 1993 with an interim and then final 1992-93 annual report entitled Implementation of Commonwealth Government Responses to the Recommendations of the Royal Commission into Aboriginal Deaths in Custody. During this period two funding packages were announced. In March 1992 the Commonwealth Government announced a $150m 5-year funding package which included $71.6 million for the establishment of Aboriginal designed, controlled and staffed drug and alcohol services. In June 1992 it announced a $250m 5-year package with the focus more on land and employment. The first package was clearly directly related to Aboriginal health, the second only tangentially.

Some national reports

Between late 1992 and mid-1994 at least seven reports made sage recommendations with respect to many Aboriginal health issues.

The first was the first National Health Strategy Research Paper, Enough to make you sick: How income and environment affect health, released in September 1992. The paper included a chapter on Aboriginal health inequalities and developments aimed at improving Aboriginal health. The chapter ended with the conclusion that:

In order for Aboriginal health to be improved there is a clear need for Aboriginal involvement/participation and better coordination of service delivery at all levels... The speedy implementation of the recommendations of both the National Aboriginal Health Strategy and the Royal Commission is an urgent priority.

The second was the Review of the Council for Aboriginal Health, Developing a Partnership, March 1993. Among the review's 18 recommendations were that better data be compiled on State and Territory activity in the area of Aboriginal health, that the Council act as a peak body for the State and Territory tripartite forums and that the Commonwealth consider testing the concept of bilateral agreements to help make progress on the Council of Australian Government's December 1992 National Commitment to Improve Outcomes in the

21 See the official publication, Response by Governments to the Royal Commission into Aboriginal Deaths in Custody, Canberra, 1992.

Delivery of Programs and Services for Aboriginal Peoples and Torres Strait Islanders. All three of these recommendations should have been unnecessary as they had on earlier occasions been declared the intention of governments.

The third was a report on Aboriginal and Torres Strait Islander Health Worker Employment, Education and Training prepared for the Health Policy Section of ATSIC by Stephen Begg. The report reviewed some of the debate surrounding the appropriate role of Aboriginal Health Workers, assessed the implementation of NAHS and RCADC recommendations aimed at strengthening the role of Aboriginal health workers, suggested primary health care workers achieve the best result when their functions are defined by their communities and saw dangers in the Australian Health Ministers Advisory Council pursuit of a system of core competencies, core curriculum, national registration and award coverage for Aboriginal health workers.

The fourth was a paper prepared by an independent working group for consideration by the Prime Minister's Science and Engineering Council at its meeting on 29 November 1993. The paper, which was entitled Research and Technology in Tropical Australia and was released by the Office of the Chief Scientist, Department of the Prime Minister and Cabinet, made but one recommendation:

That additional resources be provided to the NH&MRC to build on the work of the National Aboriginal Health Strategy, with a view to advising governments on what is needed to bring the health care available to Aboriginal peoples to a level comparable to that of other Australians. The NH&MRC should examine and report to the Australian Health Minister's Council:

- with a detailed assessment of the health needs and the services required by Aboriginal and Torres Strait Islander people;
- on the professional standards of practice in relation to health infrastructure, health education, health services and health research for Aboriginal and Torres Strait Islander people; and
- on lines of responsibility, funding requirements and mechanisms.

This work must include collaboration with Aboriginal and Torres Strait Islander peoples to identify social, cultural, educational, professional, structural and financial changes that will enhance the:

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supply and quality of health infrastructure and services;

demand for, uptake of and compliance with available services;

availability and uptake of health information for Aboriginal and Torres Strait Islander consumers;

community education that is culturally appropriate and prepares Aboriginal and Torres Strait Islander peoples for professional training; and

training of health professionals and para-professionals.\textsuperscript{25}

Several of the report's observations appear timeless. For example that:

No single agency is finally responsible for improving the quality of Aboriginal and Torres Strait Islander health care. With divided responsibility, the planning and management of health care for Aboriginal and Torres Strait Islander peoples will remain inadequate. Mechanisms for coherent planning and for the consolidation of professional knowledge for training purposes are inadequate and there are few incentives for the sharing of information and for co-operation between agencies.\textsuperscript{26}

Similarly that:

Culturally appropriate community-based health services should complement, but cannot replace, the responsible mainstream health service providers. However, mainstream services must become more responsible to the communities they serve, and the balance of power must shift to Aboriginal and Torres Strait Islander peoples, with an explicit shift from consultation to negotiation.\textsuperscript{27}

The fifth report was the Australian Health Ministers' Conference \textit{National Rural Health Strategy}. The report noted that:

Throughout many areas of rural Australia there is a shortage and maldistribution of health care providers, above-average population to health care

\textsuperscript{25} Office of the Chief Scientist, Department of the Prime Minister and Cabinet, \textit{Research and Technology in Tropical Australia: Selected issues}, A paper prepared by an independent working group for consideration by the Prime Minister's Science and Engineering Council at its meeting 29 November 1993: 4.

\textsuperscript{26} Office of the Chief Scientist, Department of the Prime Minister and Cabinet, \textit{Research and Technology in Tropical Australia: Selected issues}, A paper prepared by an independent working group for consideration by the Prime Minister's Science and Engineering Council at its meeting 29 November 1993: 7.

\textsuperscript{27} Office of the Chief Scientist, Department of the Prime Minister and Cabinet, \textit{Research and Technology in Tropical Australia: Selected issues}, A paper prepared by an independent working group for consideration by the Prime Minister's Science and Engineering Council at its meeting 29 November 1993: 13.
provider ratios, high levels of health workforce turn over, and major problems of accessibility to services.28

The Strategy document identified ten 'guiding principles', formulated twelve 'key strategy goals' and presented thirteen 'proposals'. The report addressed many of the health care service delivery issues facing rural Aboriginal people, including the need for greater local participation in the system.

The sixth report was Housing for Health.29 The study found that in the small community of Pipalyatjara in central Australia Aborigines used the washing and cleaning facilities 'enthusiastically' when they were properly maintained - highlighting the need for attention to detail and continuing maintenance to ensure that basic hygiene facilities worked properly.

The most recent report of relevance to the subject of Aboriginal health was that table on 30 May 1994 by the Federal Race Discrimination Commissioner, Irene Moss, on the provision of water and sanitation in remote Aboriginal and Torres Strait Islander communities.30 Ten case studies illustrated how Governments often provide culturally or technically inappropriate infrastructure for the supply of fresh water and the disposal of waste water in remote Aboriginal communities. The Commissioner found a lack of community involvement in the choosing and providing of services. The Commissioner's first two recommendations were that Governments at all levels:

recognise the vital element of community control in the effective provision of services and reviews relevant legislation and structures to provide for the establishment of Aboriginal and Torres Strait Islander service provision authorities.

actively promote a broader community understanding of equity and equality based on recognition of differences between cultures. Evaluation should be on the basis of equitable outcomes, not similarity of inputs.31

30 Federal Race Discrimination Commissioner, Water. A report on the provision of water and sanitation to remote Aboriginal and Torres Strait Islander communities, Canberra, 1994.
Other recommendations included that the Federal Government prepare a national statement of Indigenous Peoples Rights (existing human rights instruments being inadequate mechanisms for ensuring the service provision rights of Aboriginal people), that the Aboriginal and Torres Strait Islander Social Justice Commissioner determine if changes are needed to Government programs and that the Race Discrimination Commissioner in one year's time commence a review of Government implementation of this report's recommendations. As commentator Paul Chamberlin suggested, these two final recommendations may be the most important as 'If they are carried out, they will ensure that this report does not die like all those which have preceded it.'

Whatever the issues focused on by successive reports, one problem is invariably identified. A brief statement of this problem headed the list of key findings in the House of Representatives' Standing Committee on Aboriginal and Torres Strait Islander Affairs' recent review of an Auditor-General's Project Report:

The respective responsibilities of Commonwealth, State/Territory and local Governments in the provision of community infrastructure to indigenous communities are unclear and ATSIC may be funding projects properly the responsibility of other levels of government.

Some State reports

Although an overview of State Government reports in the area of Aboriginal health is beyond the scope of this paper, it is worth noting that many of the recommendations in the Commonwealth reports mentioned above are also to be found in such State reports as those of the New South Wales Task Force on Aboriginal Health and the Western Australian Government's Task Force on Aboriginal Social Justice. Both these reports also drew attention to the propensity for commitments to remain untranslated into real improvements. The NSW Task Force noted that Aboriginal communities:

would not let us forget the history of comparative inaction on previous Aboriginal Health Review Reports


33 House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, Review of Auditor-General's Audit Report no.36, 1992-93: Aboriginal & Torres Strait Islander Commission: Community Infrastructure,... (and two other Audit Reports), May 1994: 2.

and some communities

placed on record their intention that this would be the last time they would attend consultations of this type, if action did not follow.  

The WA Task Force noted that:

Although one of the guiding principles [of the 'National Commitment' made to Aboriginal health at the Special Premier's Conference in October 1990] was that there should be 'increased clarity with respect to the roles and responsibilities of the various spheres of government through greater demarcation of policy, operation and financial responsibilities', those components of the document setting out the roles of the different levels of government provide little further clarity. Indeed, as do so many other documents in this area, they express a commitment to co-operation and to clarification of roles - but are capable of a wide range of interpretations.

Debate over funding

Making more public impact than any of the above reports, however, has been the recent debate over who at the federal level should have responsibility for Aboriginal health and how much extra money should be directed to improving Aboriginal health. In June 1993 the then Minister for Health, Senator Richardson, was widely reported as saying that Aboriginal health problems were getting worse, that he wanted his Department to be more involved in improving the situation, and that he would be talking with ATSIC. Although initially appearing only prepared to become involved in the area through ATSIC, the Senator's comments triggered a round of public calls for responsibility for Aboriginal health to be moved from ATSIC to the Commonwealth Health Department.

Among those to come out in support of greater Departmental involvement were the National Aboriginal Community Controlled Health Organisation (NACCHO), whose member AMSs rely almost entirely upon ATSIC for funding and hope for increased and longer-term funding from an office or division of Aboriginal health within the Department of Health, and the Australian Medical Association (AMA), whose president, Dr Brendan Nelson, felt that, although ATSIC was doing its best, there needed to be more health expertise in the area of Aboriginal health.


By March 1994 the campaign for more action on Aboriginal health had gained considerable momentum. The AMA had sponsored a National Aboriginal Health Summit, appointed an Aboriginal health policy coordinator and called for extra funding for Aboriginal health in the 1994 Budget. Senator Richardson had publicly suggested that the Prime Minister and the Treasurer had agreed to the creation of a separate division of Aboriginal health within the Health Department and extra funding and that ATSIC would be able to redirect its existing health funds to address environmental health problems (e.g. sewerage and water infrastructure). 37

The Federal Minister for Aboriginal Affairs, Mr Tickner, rejected a proposal from Dr Nelson and Senator Richardson that the Medicare levy be raised to fund the new Aboriginal health commitment, saying it would send the wrong message to the Australian community about the real underlying causes of poor Aboriginal health and not address the failure of State and local governments to deliver adequate services to Aboriginal communities. 38

The then Shadow Minister for Aboriginal and Torres Strait Islander Affairs, Peter Nugent, although noting that some criticism of ATSIC indicated unfair expectations, suggested that 'some blending of mainstream and ATSIC special programs is probably necessary' considering the expertise in the mainstream but the necessity of ATSIC involvement. 39 He did, however, urge ATSIC to devolve more power to local communities and the mainstream to accept greater local participation in primary health care:

Rather than operating from the "top down" - talking about which programs might address which problem; talking about how much more money we should be spending to "fix" the problem; talking about the difficulty in getting qualified doctors and medical staff into the remoter areas; assigning remedies for this or that as we might shuffle a pack of cards... perhaps we might think for a moment from the ground up. 40

He also called for an end of the buck passing from ATSIC to the State and Territories, from there to the Federal Government and from there back to ATSIC in the name of 'self-determination'.


39 Peter Nugent, 'A Changing Role for the Medical Profession in Improving Aboriginal Health', Address to the AMA National Summit on Aboriginal Health on 10 March 1994.

40 Peter Nugent, 'A Changing Role for the Medical Profession in Improving Aboriginal Health', Address to the AMA National Summit on Aboriginal Health on 10 March 1994.
By April 1994 the new Federal Health Minister, Dr Lawrence, had announced that Aboriginal health would be one of her highest priorities and proposed tripling Commonwealth expenditure in the area. ATSIC, while remaining open to the proposals for structural change, expressed concern at the possible 'mainstreaming' of Aboriginal health, bypassing of the regional council network and 'disempowering' of Aboriginal people. Dr Nelson of the AMA suggested AMSs could be under the joint control of the Department of Health, ATSIC and NACCHO.

In May 1994 Budget the Government announced a $500 million five year health package. The package was said to 'more than double the 1990 commitment' and allocate:

- an additional $162 million to the Aboriginal Medical Services program over the period 1994-95 to 1998-99; and

- an additional $338 million to the Community Housing and Infrastructure Program over the period 1994-95 to 1998-99.

For several reasons, the package received much public attention.

Firstly, the sum appeared to be less than that reportedly sought by both Senator Richardson (more than $1 billion over four years) and Dr Lawrence ($800m over four years). In this respect, the debate over the new health package seemed to be an echo of that over the first National Aboriginal Health Strategy package - where actual funding was only a fraction of that publicly recommended by the Government's expert body reviewing the matter. Even before it was announced, Senator Margaret Reynolds, the Federal Government's Representative on the Council for Aboriginal Reconciliation, called on the Prime Minister to recognise 'the inadequacy of the Expenditure Review Process in assessing and responding to the dimension of the Aboriginal health crisis', to endorse the Richardson/Lawrence vision and to let the Budget night allocation be but 'Stage 1 of a National Action Plan'.

Secondly, the Australian Medical Association (AMA) and Democrat Senator Meg Lees came out arguing that possibly only $85m of the promised $500m could be considered new funding (additional funding of only $17m a year) as to continue existing National Aboriginal Health Strategy (NAHS) funding would require up to $413.9m over the

41 For example, the Sydney Morning Herald, 9 April 1994 and the Canberra Times, 13 April 1994.

next five years. Behind these analyses was an Access Economics study which the AMA had commissioned. Dr Lawrence insisted that as the existing NAHS commitment came to an end in the middle of next year, all money to continue the NAHS beyond that date was ‘new money’. AMA President Dr Nelson argued ‘You would only say it was new if you had assumed the Government was not going to put 1c into Aboriginal health’. The Access Economics paper argued that when the NAHS was first introduced in 1990-91 it essentially subsumed existing programs and to simply keep those pre-NAHS programs going would take up most of the Budget’s ‘new money’.

Thirdly, the new package was not to be delivered, as Senator Richardson and Dr Lawrence had proposed, through a special division in the Health Department, but, as all recent Aboriginal health programs have been, through ATSIC. Dr Lawrence announced, nevertheless, that an Aboriginal health unit would be set up within her department ‘to improve the coordination of services provided by the Commonwealth, States and Territories’.

The merits of the new allocation to Aboriginal health were still being debated a month after the budget. In early June 1994 both the leader of the Australian Democrats, Senator Cheryl Kernot, and the new Shadow Minister for Aboriginal and Torres Strait Islander Affairs, Mrs Chris Gallus, referred to the Government’s new package as a ‘con’. The Federal President of the Australian Medical Association, Dr Brendan Nelson, presented a petition to the Chair of the Labor Caucus, Mr Jim Snow, calling on the Federal Caucus ‘to re-examine the funding made available for Aboriginal health in the Federal Budget’.

For a graph of expenditure by ATSIC and its predecessors on Aboriginal health up to 1992-93 see Appendix 1. For a table of funds allocated to ATSIC under the NAHS since 1990/91 see Appendix 2.

44 For example Dr Carmen Lawrence, News Release, 11 May 1994.
47 For example The Canberra Times, 11 May 1994.
49 Appropriation Bill (No.2) 1994-95, Second Reading Speech, 7 June 1994, House of Representatives Hansard, 1580ff.
Conclusion

Despite the good intentions of all concerned over the last quarter of a century, how much has changed at the policy level? Committee after committee has been covering similar ground (e.g. how to raise the health-status of Aboriginals to that of non-Aboriginals). Report after report has been making similar recommendations (e.g. that governments, departments and agencies more clearly delineate their responsibilities, that environmental health problems receive more attention, that community-based programs be supported, that Aboriginal participation in health decision-making and service delivery be increased, and that health-care worker training and support be improved). Successive administrative changes have lead to similar debates (e.g. over the membership mix of a new body or the 'self-determination' implications of a new arrangement).

Neil Thomson, a leading commentators on Aboriginal health status, found himself still quoting the 1979 HRSCAA report in 1992:

Unless governments, and the Australian people, are prepared to commit themselves fully to achieving social and health justice for Aborigines, the standard of Aboriginal health will remain at levels that 'would not be tolerated if it existed in the population as a whole'.

Professor Tatz, author of the 1972 paper 'Paradox of Innovation without Change', commented at the AMA's 1993 National Conference that he was 'shocked to learn that so many practitioners and administrators in the field still consider the paradox relevant today'. He lamented the lack of a holistic vision:

We still persist, for the most part, in seeing Aboriginal and Islander ill-health as the presence or absence of disease: we very rarely use the WHO definition of social, physical and mental well-being... We don't have an integrated social and biomedical model for the provision of services or the alleviation of situations that give rise to the need for services.

Not all the news on Aboriginal health status is bad (for example, attention in recent decades to infant and maternal health services

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52 The same point was made by Peter Nugent, the previous Shadow Minister for Aboriginal and Torres Strait Islander Affairs, in an address to the AMA National Summit on Aboriginal Health on 10 March 1994; indeed, Mr Nugent also quoted Professor Tatz.
would seem to be paying dividends with a decline in Aboriginal infant and maternal mortality and some progress has been made towards achieving the desired 'holistic vision'. The front on which the Commonwealth Government is addressing Aboriginal health issues has broadened in recent years to include making funds available for an increasing number of Aboriginal community controlled health services, for projects dealing with substance abuse, sexually transmitted diseases, mental health and women's health, for work on housing, water, sewerage, electricity, communications and roads, and for better data collection. More recently still the Government has announced an intention to make more funds available for land acquisition and for Aboriginal and Torres Strait Islander aged care.

It is to be hoped that the health impact of this decade's strategies and initiatives will soon become apparent. Hope alone, however, will not make this happen. The cycle of report and inaction, commitment and frustration, structure and restructure needs to be broken and more attention needs to be paid to monitoring the implementation of recommendations, co-ordinating the endeavours of different bodies, and picking up on the many practical suggestions made over the years. As the Canberra Times editorial on 13 April 1994 soberly observed, whether a new structure and extra funding would improve Aboriginal health:

depends much more on the details than on broad statements of purpose. There have been many such statements before, but too many falters in their delivery.


HEALTH EXPENDITURE BY THE OFFICE OF ABORIGINAL AFFAIRS / DEPARTMENT OF ABORIGINAL AFFAIRS,
ABORIGINAL AND TORRES STRAIT ISLANDER COMMISSION*

* As recorded in successive Annual Reports.
   Excludes expenditure on housing and infrastructure but includes expenditure on substance abuse programs.
Appendix 2

National Aboriginal Health Strategy Funding to ATSIC

Under the original NAHS funding decision, $217.95m of the total $232m was allocated to ATSIC. $147.07m of this $217.95m was allocated by ATSIC during the period 1990/91 to 1993/94 as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Health</th>
<th>Housing and Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990/91</td>
<td>$6.57m</td>
<td>$2m</td>
</tr>
<tr>
<td>1991/92</td>
<td>$9.09m</td>
<td>$18m</td>
</tr>
<tr>
<td>1992/93</td>
<td>$9.98m</td>
<td>$33m</td>
</tr>
<tr>
<td>1993/94</td>
<td>$10.43m</td>
<td>$58m</td>
</tr>
<tr>
<td>1994/95</td>
<td>$10.88m</td>
<td>$60m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$46.95m</strong></td>
<td><strong>$171m</strong></td>
</tr>
</tbody>
</table>

The 1994 Budget allocates $499.4m (adjusted for inflation) over the period 1994/95 to 1998/99. This allocation overlaps during 1994/95 with the fifth year of the original NAHS.

<table>
<thead>
<tr>
<th>Year</th>
<th>Health</th>
<th>Environmental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994/95</td>
<td>$25.1m</td>
<td>$15.00m</td>
</tr>
<tr>
<td>1995/96</td>
<td>$36.99m</td>
<td>$77.063m</td>
</tr>
<tr>
<td>1996/97</td>
<td>$38.1m</td>
<td>$79.374m</td>
</tr>
<tr>
<td>1997/98</td>
<td>$39.243m</td>
<td>$81.756m</td>
</tr>
<tr>
<td>1998/99</td>
<td>$22.456m</td>
<td>$84.208m</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$162.00m</strong></td>
<td><strong>$337.4m</strong></td>
</tr>
</tbody>
</table>