Dr Jean Collie

I’d now like to hand over to Debra to give us her presentation and welcome Debra.

Ms Debra Hocking

Thank you Jean Collie. It’s certainly a great honour to be here today and I thank you for this opportunity to, for us to all learn together a way forward in how we can, deal with the issues that I’m going to be discussing today.

But I’d like to begin this session by acknowledging the traditional owners of the respective countries on which we meet together today. I acknowledge that they have occupied and cared for this land over countless generations and celebrate their continuing contribution to the life of the region. I pay respect to the elders of these communities, past, present and future, and acknowledge the memories of their ancestors.

So it would be really good to have an interactive session today. I’m looking forward to hearing from you, questions you may have, thoughts and ideas that we can share together.

What I want to do firstly, is discuss the definition of health, the one in the Aboriginal context as well as mainstream. I’m just going to do just a bit of a comparative look at that. We’ll also be doing, a case study so I hope you’re all sharp because we will have some questions. It’s a fairly straight forward case study, but it does incorporate new concepts of cultural safety. Also one thing I want to mention is because the field of Aboriginal health is so broad, I was limited today, to what I could present. Therefore I have attached resources for you to have a look at the statistics, because if I just did it on statistics alone, that’s all it would be. That is because it’s so wide and varied, so I’ve just streamlined it to the three points that I think are integral with inequality in indigenous health.

As I pointed out we are straight into the case study. Joanne is a non-Aboriginal female doctor who is kind and attentive to the patients, she jokes and is friendly and treats all patients the same and makes no distinctions between male or female, old or young patients, in the clinic. She’s heard that some of the men in the community would rather see a male doctor which confuses Joanne. She’s worked in clinics overseas in developing countries and found while people are very poor, they come freely to see her regardless of age or gender. In the clinic she observes that patients are shy and reticent and finds it difficult to elicit answers to her questions and she wants to be more culturally inclusive and respectful but is unsure how.

For this case study, I posed three questions and the first one is how does Joanne’s experience of healthcare influence her practice? How does her experience of healthcare influence her practice? Well I guess in the past, she’s treated everybody the same. Doesn’t distinguish between gender, male or female.
Now we know that working in Aboriginal communities, there is distinctions and it is men’s business; it is women’s business, and neither the two should meet. So in healthcare practice the genders are very well respected and treating everybody the same; it sort of worries me a little bit because everybody’s not the same. That doesn’t allow for diversity even within Aboriginal cultures. So treating people the same actually is almost stereotyping people so I think that we should not do and take everybody by their religion or their race separately rather than just think one size fits all. Because in mainstream we know that is actually what happens because it’s easier to mainstream and that’s the mainstream, it means everybody’s the same, well I’m telling you now, that’s not the case.

The second question is what cultural protocols around age and gender does Joanne need to consider and adopt in her clinic to ensure that all of the clients are culturally safe? Okay cultural protocols; that’s understanding the issues around age and gender and in a cultural way. Now Joanne may not have had any insight at all into cultural awareness or protocols so if that’s the case, my advice would be if there is an Aboriginal liaison officer attached to that clinic, if there is a cultural broker, if there is a local elder; that is, they are the people to go to seek out what are cultural protocols. You can’t guess them. You can’t bluff your way through it believe me, you have to really understand what cultural protocols are all about, because if they’re broken it can mean the ineffective treatment of somebody and that’s not what we want.

So how can she work with a male Aboriginal health worker to ensure the clinic is a receptive space for Aboriginal men? Well quite easily. I mean that’s their role, the male Aboriginal health worker is there to guide people, guide the staff, the clinician, through how to be culturally appropriate with Aboriginal men. Therefore once you learn, with cultural competency, the first thing is cultural awareness. You have to be aware of the culture. You can’t just jump in and be straight away culturally competent. It takes much more than that. By being culturally aware sometimes, what I tell my students is, to go back to your own culture, think about your own culture and what aspects of your culture affect your world view. Okay because unless we understand our own culture, it’s very difficult to further ourselves out to understand others.

The Aboriginal health workers are there for support, for guidance, and it’s just a matter of accessing a health worker to guide you through the processes. Now if there isn’t one available then I have given you some other alternatives, what you can do. But having said that I just want to just talk a little bit about the Aboriginal health worker’s role.

Now in looking at their job description there actually isn’t one that fits everything that they do. They work around the clock, there’s no 09:00 to 05:00 for them, and it’s a hard road for them. So I think that in talking about this collaboration, if we can say that at this early stage about working at it together, appreciating that people are burning
Why is there inequality in health for Aboriginal Australians? Okay so these are the things that I’ve explained that I’ve streamlined. There are more but I think this is a good starting point. First of all understanding the Aboriginal definition of health, and when I show you what that is, you’ll understand what I mean; also lack of access for remote communities, lack of culturally appropriate health facilities. Lack of understanding of compound trauma and also by not completely following the three principles of primary healthcare which is accessibility, affordability and appropriate.

So we go to the definitions of health. Now the first one, is one which guides us through all our healthcare practices. “Aboriginal health means not just the physical wellbeing of an individual but the person’s social, emotional and cultural wellbeing of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It’s a whole of life view and includes the cyclical concept of life, death, life, which is rather inclusive, yeah? It includes most aspects of our lives.

We go to the World Health Organisation definition which states “Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. Now as you’ll see underneath this definition has not been amended since 1948. I’ve research definitions of health and I found, each state and territory have their own definition of health, but none that you can parallel with the Aboriginal health definition of what is the way we see health.

So until we start understanding that, health encompasses everything for Aboriginal people from work to social to physical to emotional; it covers everything. When you’re treating an Aboriginal person that have this view, world view of their health, and if there’s no understanding of that, it makes it very difficult. It draws up barriers because it’s more than just the biomedical side of health that we view and in mainstream, I’m afraid, that is mostly the one that is taken. So they’re the two definitions that I’ve used today.

Alright so with the points I gave you about inequality, we talk about access to health services as being one of the barriers and causing inequality. So accessible health services are those that are physically available, affordable, economic, accessibility, appropriate and accessible. Health services can be inaccessible if providers do not acknowledge and respect cultural factors, physical barriers and economic barriers or if the community is not aware of available services.
Now all those things play a big part in access to services because I know that some rural areas and even urban areas, primary healthcare clinics have got what they consider to be, a wonderful place for people to come and feel safe. But when I walk in I can, I can tell them straight away this is not inviting. It is not inviting, it’s clinical.

I’ve given them some ways of perhaps making it a little bit more inviting so that people will actually access services. I know it’s a lot more than that, but that’s a good starting point. So I suggested some health services, they put up some Aboriginal art or even, having the flag around somewhere, just something that people can identify with. This is so important because I’ve seen people walk in and walk straight back out and I know why.

Addressing cultural competence, accessibility and appropriateness through strategies such as, and not only have I given you the problems as I said, but also some solutions and this is, I hope to be solution focussed rather than just problematic. So the way that we can address cultural competence is develop new services around the holistic model itself and wellbeing, as in the definition of health, building therapeutic and clinical relationships based on trust and mutual respect.

Now trust and mutual respect is huge for Aboriginal people stemming right back to 1788 and the lack of trust in the Government because that trust was betrayed and it still is very much alive and well. How do you develop trust with somebody? Well to my way of thinking, it is to be honest with somebody; present yourself as yourself and not being judgmental. No matter what you hear, as a health professional. You may hear some things that actually might shock you, particularly in our community, issues around family violence, drug misuse and so on, and so for somebody to come forward and discuss that, there’s got to be a lot of trust, because it works both ways.

And also employing indigenous health professionals, health workers or cultural brokers to promote culturally safe service delivery. Now you might say well look we can’t employ anybody, you know we don’t have it in our budget, we don’t have this; we don’t have that. My answer to that is there are cultural brokering consultants out there that will actually come and they’re not on your payroll. They will have a consultancy fee, but they will give you some ideas on how to set up a culturally competent organisation/practice. So it’s not about costing you a lot of money, it can be done quite economically, but it is worthwhile considering it, if we’re to provide better access for Aboriginal people.

Adopting strategies that support cultural competency and safety at systemic organisational and individual levels including appropriate communication styles and working through community elders and kinship networks. So I’m not sure about organisational strategies, I can’t hazard a guess on what is out there and what isn’t, but if you go back to your strategic plan for your organisations or your businesses and see what’s in there; see if there’s any strategies in there that actually support, building these relationships with Aboriginal community. Because I actually went to a university’s strategic plan and sadly found nothing, there was nothing about Aboriginal employment, about
identification for Aboriginal students, so that was a big learning curve for the university and certainly we’ve worked on it now and we’ve certainly made a lot of good changes.

Also providing services in a non-traditional settings. That is that, it doesn’t always have to be a practice room; sometimes that’s very, very intimidating for people. And I know with my students I find a classroom, or lecture room rather, intimidating so if the weather’s nice outside I take them outside. I’m flexible with their learning needs and so what I’m saying is be flexible. If a person’s not comfortable with sitting in a practice room maybe have a nice tea room or something, some alternative that they would feel more comfortable in.

Now this all probably sounds a bit precious to you, you’re saying. Maybe thinking well, all these changes that we have to consider. Well here it is. We have the worst health statistics in the world for our first nation’s people. And Closing-the-Gap, we’ve got a long way to go. So let’s not get complacent about and have lethargy about things the same old, same old. We can make some changes. We can do that.

The next thing I want to talk to you about is trauma informed care and what it means because for Aboriginal people of Australia it is not a single traumatic experience that’s been undergone, it’s actually compound trauma stemming from colonisation. It’s things like being taken away as a child, losing your land, losing your identity, losing your culture, and how long I could go on, but all these losses and grief’s compound. And so what we’ve done now we have an evidence base that strongly suggests in that group, that the experience of trauma for Aboriginal people is indeed impacting so much on the physical health. So taking the lead from Canada, who actually went and researched this and saved Health Canada a lot of money, by changing the way they talk and by just having that extension a little bit further and it saved Canada Health billions of dollars. By looking into trauma informed care and understanding that, so I can’t emphasise enough again, and trauma not only impacts the physical health; but we look at issues like domestic violence, we look at drug misuse, and what we’re finding now is that people aren’t born into it. It stems from the traumatic experiences they’ve had as younger people and it’s unresolved. So that’s a lot of cause or factors in our social determinants of health.

I won’t comment on the slide, but probably to say to support relationship building as a means of promoting, healing and recovery. So, it’s not about them and us, and it has been to a certain extent in this country, that yes we are two different races of people but we’re living in this continent together and there’s so many parallel groups working that don’t even know what the other group are doing. So what I’m suggesting is, support relationship building and it does make a big difference. And to collaborate I think will, is effective, there’s no two ways about it. We have Aboriginal community controlled health organisations and maybe think about collaborating, I know a lot of GP practices who collaborate with the Aboriginal community controlled health organisations, and there’s many other organisations that collaborations can occur.
Look the next part of the presentation, I want to do a critical reflection. And I thought about this in a clinical sense, how do I create an analogy that has a clinical sense but also can give an analogy to how people feel with grief and loss. So what I decided to do is to ask you to imagine this. If at any stage of your life through tragic incident you lost your main hand, whether it be right or left, but you lost your hand. It was severed and there was no chance that it could be restored. So a transplant was the option. And that hand has followed your neural responses from the word go. And I know when I say this in a presentation, people actually physically look at their hand and the reflection starts. So if there’s no chance of recovering the hand then the transplant is the option. What are the things that we consider with a transplant? We consider things like rejection, infection, adaptation, trauma, loss and acceptance. And if you’re going to have a transplant things that have to be considered are the colours and textures of trying to duplicate that hand as much as you can to the hand that you had. And as we know the body treats any new organ or tissue as an invader or as a germ and tries to destroy it so therefore we have to take strong drugs for the rest of your life to prevent rejection.

So what happens to the thinking and feeling process after the loss of the limb? What if the hand that you get does not match the one that you had? How would you adjust? And I’m going to leave it at that because that’s the analogy. That is the analogy of grief and loss that we experience every day of losing our right hand or left hand.

Alright so what I’ve said is that, currently in Australia we do have a state of lethargy where no-one really knows what to do and it’s sort of gone into, well hopefully things will right themselves. Well they won’t and we’re asking for help here. We’ve tried to do it ourselves, Government have not really helped us much. In the latest Closing-the-Gap Report we see a reduction in mortality which is fantastic, but that’s about it. So there’s many other things that need to be addressed. So let’s stop being disappointed at our lack of achievement on indigenous health and dare to dream about a positive future for all Australians. To do so is not a pipe dream for we know that overcoming indigenous inequality in health status is achievable. Thank you.

**Dr Jean Collie**

Thank you Debra for your presentation and the first debater for the affirmative is Dr Joanne Buckskin. So we’ll pass over to you Joanne if you would give us the affirmative side of our debate. Thank you.

**Dr Joanne Buckskin**

Thank you for that introduction and I too would like to acknowledge the countries from which we are all participating in our webinar from. We’re in Sydney, it’s a little bit overcast and cloudy and I’d just like to acknowledge country which is the home of mob.
Okay I haven’t done a debate for a little while so one of the approaches I’m going to take in regards to this debate the medical community can achieve equal health outcomes without social welfare and improvement.

So everyone just have a stop and think about what equal health actually means to you as an individual and what the outcomes of your health are and what resources you need to achieve your own health, health and wellbeing.

If we look at that from an indigenous perspective and we look at Aunty Deb’s framework of indigenous health, indigenous health in terms of Aboriginal people’s relatedness to their country, relatedness to their family, their relatedness to their social determinants which is their education, employment, income, and also we’re looking at health in terms of the access Aboriginal people have in a capitalist society.

Aboriginal people were put into and governed under a capitalist society which and my first argument therefore is that health is political, which means our Governments determined policy directives for the past 220 years around indigenous people’s health starting with invasion, protection, segregation, assimilation, determination, reconciliation, now Closing-the-Gap.

If we look at and understand health from a political standpoint then we need to ensure that the strategies implemented in social welfare need to be culturally competent, that Aboriginal people need to have access, equity, social welfare is a human right. We are internationally obligated to ensure all people regardless of race, socio, cultural and importantly participation, not only as indigenous doctors but in society; we need to have access to quality health including our country, our families, our clinics, and our allied health workers.

**Dr Jean Collie**

Thank you Joanne. Certainly what you’ve got listed there are very important aspects on the screen and I’ve, certainly from my point of view we’re trying very hard to implement some of the strategies that you’ve referred to.

So we’ll now pass onto our next debater who is Dr Meredith Arcus.

**Dr Meredith Arcus**

Thanks Jean Collie. So thanks Debra and Joanne for your excellent presentations and I’m here to present the negative of the debate topic and I think with Debra’s excellent holistic definition of health I’ve won the debate already. But I will go through with a, more of a medical practitioner view of the debate and talk about some of my experiences.

I have worked for three years in medical administration in Alice Springs, Central Australia. The Alice Springs Hospital is unique in that over 80% of the patients are indigenous. It is a centre of excellence for indigenous health so I wanted to share my experiences in putting forward the strong case for the negative.
The medical community cannot achieve equal health outcomes without social welfare which includes improved employment opportunities. Now the Commission on Social Determinants of Health 2008 stated “Inequities in health, avoidable health inequities, arise because of the circumstances in which people grow, live, work and age and the systems put in place to deal with illness. The conditions in which people live and die are in turn shaped by political, social and economic forces” and I agree with Joanne that health is very political.

I also looked up the definition of social welfare. “Government provision of economic assistance to persons in need” or “Public social services for the assistance of disadvantaged groups”. Now I’m going to go through some of the COAG key indicators in the report from 2009, a little old but still very relevant, as we all know the population of Australia has, 2.5% is indigenous. The facts from the COAG report reported on the state of the social determinants of indigenous people.

Indigenous people interact with the criminal justice system at a higher rate than non-indigenous Australians. Imprisonment is 13 times higher than non-indigenous, juvenile detention is 28 times greater. We know there is a high incidence of domestic violence and indigenous communities have severe social strain. Alcohol and drugs are involved, overcrowding, child abuse and violence. Now the care and protection orders in the non-indigenous community is five out of 1,000, the care and protection orders for the indigenous community are 41 per 1,000. And the indigenous homicide death rate is seven times that of the non-indigenous population. I know Debra you didn’t go into the detail but I thought it was important to discuss that for those on the teleconference that may not know these statistics. Poverty, unemployment, low education and lack of social services were all identified in the COAG report.

There are other impacts on indigenous people including mental health issues, high suicide rates, so we know of the clusters of suicides in the Kimberley, substance misuse, imprisonment, family breakdown, social disadvantage and Debra has explained the dispossession and removal from family very, very well.

Now today’s debate I did wonder if that was going to be more about environmental health. In remote indigenous communities the issues there are safe drinking water, food safety, disease control and housing conditions. Overcrowding and sanitation is a big issue in Central Australia.

Now this results in diseases such as scabies, influenza, pneumonia, asthma and bacterial diseases. The most common cause of death of our patients in the ICU at Alice Springs Hospital is sepsis. So from a medical perspective we know that health cannot operate alone no matter how dedicated and devoted and culturally aware our staff are and there are many, many amazing altruistic doctors that work and healthcare staff that work in Central Australia. It is pure folly to think that these problems and issues can be solved by just one part of the system and COAG agrees with me.
because what I have done for my slide for the negative case is put up the six ambitious targets to address the disadvantaged in 2008.

And just to quickly go through them, Close-the-Gap in life expectancy by 2031, and as Debra said we have improved the gap in mortality rates for indigenous children under five, but the early childhood education, halving the gap in reading, writing and numeracy, and halving the gap for indigenous students in Year 12 or equivalent by 2020. We are struggling with that. And I thought it was important for this debate to say that COAG believes that halving the gap in enrolment outcomes, employment outcomes for indigenous and other Australians by 2018 was a key. Very, very challenging but certainly health cannot work by itself.

The targets that are set out in the National Indigenous Reform Agreement which commits the Commonwealth States and Territories to proceed to unprecedented levels of investment to Closing-the-Gap in indigenous disadvantage. Closing-the-Gap is a long term ambitious framework that builds on the foundation of respect and unity provided by the 2008 National Apology to Aboriginal and Torres Strait Islander People. It acknowledges that improving opportunities for indigenous Australians requires intensive and sustained effort from all levels of Government as well as the private, not-for-profit sectors, communities and individuals.

Now I just want to talk briefly about improving remote indigenous housing. There was a 10 year $5.5 billion national partnership agreement on remote indigenous housing, that was established to reform responsibilities between the Commonwealth and States and it was to address the overcrowding, homelessness or housing conditions and severe housing shortages in those communities.

Also there was investments made in schooling. The Aboriginal and Torres Strait Islander Education Action Plan was endorsed by COAG in May 2011. The Action Plan commits Governments to a unified approach Closing-the-Gap in education outcomes between indigenous and non-indigenous students. It brings together mainstream education reform, reforms under COAG’s National Education Agreement, with a range of actions specific to improving outcomes for indigenous students.

So to conclude my case I want to summarise again. The medical community cannot achieve equal health outcomes without social welfare and employment improvement. And I’m going to go a little bit off the script at the moment and talk about the medical community can’t contribute to any improvement if they’re not there and one of my hobby horses is a lack of doctors that actually work in rural and remote Australia. My particular hobby horse is having an Australian graduate working in ear, nose and throat surgery in Central Australia. We have amazing international medical graduate who come and work and take up the position in Alice Spring Hospital but for the many years, the last 10 years that I’ve been there no Australian graduate has worked there. So from my perspective I win the debate because the medical community can’t achieve it if they’re not there.
The assistance required by the indigenous community in my experience goes far beyond the resources and capability of the healthcare sector and certainly the medical community. To support the affirmative position is to ignore the experience of indigenous Australians and I agree with Debra, I think we should dare to dream.

**Dr Jean Collie**

Thank you very much. Just to summarise so that it focuses us Debra spoke to us initially with a case study and she posed and responded to three questions. She discussed inequality and how it could be improved and said to us that things are really very important to make the environment within which we the indigenous community comfortable and she did highlight the importance of Aboriginal art in places where we use to welcome Aboriginal patients into our services.

She gave us some definitions of health. She gave us some solutions to the inequality in services. She discussed cultural competence, acceptability, and appropriateness. She suggested the employment of indigenous health professionals as brokers to advise us as how we can be much more sensitive to the needs of our indigenous community.

Then Debra moved on to an analogy of grief and loss and said to us how could we imagine losing a particularly important limb such as one of our hands and that was a very poignant thought provoking exercise for me to think about how I would actually do that.

In closing Debra gave us a very optimistic and positive view about the future and I thank her for that.

In terms of looking at our debate Joanne was looking at the affirmative side of the debate and gave us some advice on the importance of cultural awareness training, the policy directives being embedded in our services, reviewing the gaps in our services and a partnership appropriate and our Aboriginal employment strategy and funding and a patient centred approach that could all assist us to provide much more culturally appropriate services.

Dr Meredith Arcus shared with us some of her experiences in Alice Springs. She spoke to us about the COAG indicators, reminded us that 2.5% of the Australian population is indigenous but their rates of imprisonment, juvenile detention, domestic violence, overcrowding, homicide, mental health issues, suicide, substance abuse, are all considerably higher than the rest of the community.

She argued very strongly that health cannot work alone and discussed the six targets of 2008 and the importance of the implementation of the national housing strategies for indigenous people and also referred to the COAG Action Plan of 2011.
She did highlight the public health issues that brought people into the Alice Springs Hospital and informed us that sepsis was the major cause of hospitalisation. And finally she reminded us very strongly that it’s been our internationally trained graduates that have come to Australia who have actually been the mainstay of the support of the services to the indigenous communities and she made a plea for Australian medical graduates to also support the improvement in indigenous health services.

So I’m not going to adjudicate on the debate, I think we’ve had some very thought provoking points made in both sides of the debate and I think the final points to me is that it is a partnership, we all need to work together, and it’s a partnership within health and with other services that we need to be able to produce the best outcomes for Aboriginal and Torres Strait Islander people.

Question time

We have had one question and I’d ask Debra, Joanne or Meredith to perhaps respond to this. This question is "I’m interested in the effect of the intervention. How do we reconcile being non-discriminatory with paternalistic control of pensions and income even when the community seems to be saying it works? " . Debra would you like to lead off with that please?

Ms Debra Hocking

Sure. That is right to a certain extent, but what I think has to be recognised here is that when, we have to be very careful in saying this is what the community thinks, we cannot judge one voice by what the whole community thinks.

Now I’ve been to the Northern Territory and I’ve spoken to many different communities, there is varying opinions on the intervention. It’s not just one ideal or one response. Some people welcome it, other people feel very much prejudiced by it and it’s an injustice, so I think that we have to be a little bit careful about just sort of saying well the community sort of think it’s alright because, it’s too diverse; we can’t make that assumption.

Dr Jean Collie

Thanks Debra. Joanne do you wish to make any comments?

Dr Joanne Buckskin

I think one of the things with the intervention model that it was a one size fits all approach and when you look at some of the evidence and, that’s coming out, you’ve got to look at the individual impact of the intervention; what the longer term political interest were with that. What are the benefits for indigenous communities in terms of having
more access and more funding being brought into those communities? And I think too, and it’ll be interesting to hear from, me as an urban Aboriginal woman, should never really speak on behalf of remote indigenous women.

I can only also be diverse, rely on what reports are coming out, have a compassionate understanding and try and think of it from all the different sides. And it’s going to be interesting to hear from my debater.

Dr Jean Collie

Thank you Joanne. Meredith would you like to make a comment?

Dr Meredith Arcus

Look I think Debra, is absolutely right. I think that every community has to make that decision. I think that there’s been a lot of coverage of this in the media and I think that some communities are very positive about it and some communities aren’t. So it really is for the community to decide.

And there are a lot of cultural issues around money and I think again people need to understand the culture and understand what’s going on and we have a very I think non-indigenous attitude towards management of resources and I think, it is challenging. I think you really have to not just go in and have an opinion, you need to understand the culture to know those extra challenges about paternalism etcetera, etcetera.

Dr Jean Collie

Thank you Meredith. We’ll now go to one of the questions from the audience. “Some indigenous people are happy to volunteer to be present for a clinic. Maybe do an indigenous focus clinic with such a person available”. Interpreting this question it seems to me that the person is suggesting that we actually hold a virtual clinic with an indigenous person who’s actually prepared to come and give us feedback about interactions, the questions that we’re asking and things like that.

Ms Debra Hocking

Yes, sure. Well I have another idea. Rather than to use one person to come in and do a focus clinic why don’t maybe a mainstream practice go to the Aboriginal community controlled health organisation, actually sit in on how a clinic is run for Aboriginal people.

Dr Jean Collie
That’s a very good suggestion Debra and I would certainly support that move because I think one of the things that seems to me is actually happening is that a lot of the way in which services are being provided in the Aboriginal medical services not only make the Aboriginal and Torres Strait Islander patients feel comfortable, they perhaps actually make us feel a lot more comfortable because I think they do focus much more on the needs of the clientele and so I think we’ve actually got a lot to learn in how we provide some of our services from the Aboriginal controlled medical services.

Dr Jean Collie

Meredith would you like to make a comment on that one?

Dr Meredith Arcus

Oh just to say that in Central Australia we were able to work to enable male and female doctors to change clinics so that the community would get the female doctor and the male doctor. I think that sometimes you have the ability to do that and other times you don’t. But it is very, very important so you really need to be in tune with what the community is asking for.

Dr Jean Collie

Thanks Meredith. We’ll now move onto the next question posed by one of the participants. And this participant has said “Social welfare is used for the right purposes or to fund ongoing bad habits and for employment improvement works for those in areas of work but most regional indigenous communities is this viable?”. Again I’m not sure whether I quite understand the question but would you like to make a comment Debra?

“Is social welfare used for the right purposes or to fund ongoing bad habits?” I think that’s the first part of the question. And “For employment improvement works for those in areas of work but most regional indigenous communities is this viable?” So I guess the first part of the question is welfare used to support bad habits?

Ms Debra Hocking

Look it’s interesting, that’s an interesting point because over a period of time we’ve had compensations being set up for stolen generations and for other injustices and the big question about giving people money is, is it the right thing to do, is it, further feeding their addictions, is it further feeding their social behaviours. We actually don’t know that. But does it discriminate to those who actually do the right thing and are very appreciative of social welfare. So I think it’s a two way thought; I think in some ways because, there are those who benefit.
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And Joanne said quite rightly it is a basic human right that we have social welfare in this country and so, but is it the wrong thing to do. Maybe. And I think there’s two sides to that story, I don’t think there’s a clear answer.

**Dr Jean Collie**

Thanks Debra.

Okay. Meredith, over to you?

**Dr Meredith Arcus**

I don’t think I can say it better than Debra.

**Registered participant**

Jean can I just say that that’s not just for indigenous people. That goes for anyone who’s on social welfare and that in all honesty I have more Caucasians who are abusing their social welfare in my service, than I do indigenous people.

And I think this stereotyping that indigenous people drink their money and use it for smokes has got to stop because the Caucasians use it for worse, just as bad things, if not worse. They use it for ice and for all sorts of crack and rubbish. So I suppose I wanted to point out that we didn’t; we didn’t want to be sort of racially stereotyping.

**Dr Jean Collie**

Thanks it is a very important point. The next question that’s been posed is “There seems to be little community discussion about traditional spirituality. Government has apologised but the churches running the abusive facilities haven’t. The forced conversion of indigenous people around the world seems to be a taboo topic.”.

**Ms Debra Hocking**

Okay. In response to that I’m a little confused as in the first part of the question there seems to be little community discussion about traditional spirituality, Government has apologised, I’m not sure what that actually, how the two tie in, but the churches running abusive facilities haven’t. Yes I’m not really sure where we’re going with that.

I mean okay if we take the first part of the question, seems to be little community discussion about traditional spirituality. Absolutely, and it’s still very much alive and well in our communities, we, it’s one of the inherent I guess traits that have been passed on that have not been colonised, but there is little discussion about it. And where does it come into healthcare practice, traditional spirituality? Is there a place for it? I do believe there is. In fact I’ve done
a lot of work with some Nungkari’s who are our traditional healers from the Central Deserts and we’ve had this open
discussion about the place in modern medicine for traditional spirituality or health, healing.

There is little discussion and I don’t know whether it’s the fact that it’s not wanted, I just think it’s very little
understood, I think that’s the whole point, why there’s not much discussion.

Dr Jean Collie

Thanks Debra. Do you wish to make any comment about the last part of the question?

Ms Debra Hocking

Government has apologised but the churches running the abusive facilities haven’t. The forced conversion of
indigenous people around the world seems to be a taboo topic. Okay well I agree with that. I think that, the
Government has apologised on behalf of the people of Australia if we’re talking in the terms of stolen generation, see
that’s the apology was being referred to, I guess it is. But the churches running the abusive facilities haven’t. And in
some ways that’s right and in some ways it’s not. Because some churches have actually apologised.

But I agree with the point the abusive, running the abusive facilities, that hasn’t stopped, there is still abuse
happening. And I know that, there’s a huge inquiry into this and so we’d like to think it was a thing of the past but
unfortunately, things are being uncovered now that have happened over the years and what my fear is, that it’s still
happening. So, I think I agree with that comment to a certain extent.

The forced conversion of indigenous people around the world seems to be a taboo topic. I actually agree with that
because I think that, in all my conversations and presentations that I do, you talk about the C word; that awful C
word, and you can see people shuddering in their seats. It’s like do we have to go back through this again; haven’t we
done this? But no we haven’t because the impacts of the big C word are still happening. So, I mean it does become a	
taboo topic because it’s guilt invoking, people feel guilt, and it’s not about that and I’m very quick to say that it’s not
about blame but it is about shared responsibility, that’s the whole thing about, what happened in our conversion.

I do agree with that participant to a certain extent because it’s still very hard to have that open frank conversation
without people feeling guilty or just saying I don’t really want to talk about this; why do we need to? I hope that
answers the question.

Dr Jean Collie

Thank you. We’ll now move onto the next question is “Do you think we will ever see any ‘indigenous hospitals’ in
Australia in the same way we have the Aboriginal medical services for the primary healthcare level?”. That’s an
interesting question. We certainly did have indigenous wards in the majority of our rural hospitals and I’m not sure whether that was a particularly good idea.

Registered participant

I was actually asking that question and I was just asking it more from the perspective in which we have seen the Aboriginal medical controlled health services particularly at the primary healthcare level taking what I believe is quite a considerable amount of leadership in shaping some of the actual health services within Australia certainly since the 1970s when Redfern started up. And I was just wondering, I have my own opinion and I’m not sure that it’s, we will ever see it happen and I’m not sure in this ongoing economic pressured climate, but I just wondered whether or not a secondary level health service such as a hospital, be it a public or private hospital, could actually help take some form of leadership in directing the way that existing health services, existing hospitals, might actually need to do some adjustments in their own cultural practices?

I had experienced of being involved with seeing Darwin and we had a lot of indigenous people who very much struggled with the vertical height of a five storied hospital building so it’s really basic practical things that we often overlook when we’re, looking at hospitals from an indigenous perspective. That’s really where I was coming from with that particular question.

Dr Jean Collie

Thanks for expanding on that, we appreciate that. I agree with you. I was amazed when I first saw the Royal Darwin Hospital after seeing the old Darwin Hospital after the cyclone and the distress of the Aboriginal patients in being in an air conditioned hospital, most of them were out in the grounds where they felt much more comfortable. I might pass that over to Meredith given that she’s just recently been to Alice Springs and to get her thoughts on whether we can actually make hospitals friendlier to the Aboriginal community.

Dr Meredith Arcus

My experience in Alice Springs Hospital is it’s a fantastic place. The majority of patients are indigenous and all of the staff there are really comfortable as are the indigenous people who come in and are treated there. So I think, the number of patients that are indigenous actually turn everything on its head. So they’re not the minority they’re the majority. People who go to work there work there because they’re committed to indigenous health so it’s just a wonderful place to work.
From my perspective the problems we have outside WA and the Northern Territory and Northern Queensland where there are less percentages, 2.5% average population of indigenous people, then it is really difficult to make. They’re the minority and like all minority groups it’s very difficult.

I just think that you can use the experience in Central Australia as an exemplar for how we should be working with indigenous people and making them feel welcome. Alice Springs Hospital is their hospital and I think that, I think that they’re very comfortable there. Is that helpful?

Dr Jean Collie

Thanks Meredith. That would be, I would share your views after being there for some time as well. Debra would you like to make a comment?

Ms Debra Hocking

Sure. Look I agree with what’s been said, I certainly do, but I just want to alert you to the factors of, hospitalisations around the country for Aboriginal people. Now we do know that Alice Springs is a really good role model I think for what can be done in our country because it’s widely known that the reason for apprehension of Aboriginal people to go to hospital is because, maybe the last person they took there died and if that happened they’re not going there, because they’re going there to die. And that’s the view of a lot of Aboriginal people. And that’s a trust thing; it was what I was talking about before.

And so, it’s one thing, to have the best hospital, whizz bang hospital, and no-one comes to it and then you’ve got to think why. Why is that? There’s everything there that they need. Why is it they’re not coming, and I think we’ve got to deal firstly with the cultural aspects of hospitalisations and the reason why people resist actually being hospitalised because even with our statistics we know, I mean Meredith was reading off some of the statistics that we already have. What frightens me is what we don’t know because people will not access services for various reasons and so, I think if we could role model something off Alice Springs, I think that would be fantastic, but there’s not the population to support that; that’s the only fear that I have.

Dr Jean Collie

Thank you Debra. Does Joanne wish to make any comments?

I must talk about a small anecdote in terms of the importance of smoking ceremonies. Now that all of our hospitals have smoke alarms it makes it actually very difficult for us to actually comply in terms of cleansing with smoking ceremonies which I think is actually very sad because I think that does help the Aboriginal community feel more
comfortable in coming into our organisations. I must admit when we were at Alice Springs we actually did get around one of the smoking ceremonies. I’m not sure whether it passed the workplace health and safety regulations or not, but I think it was extraordinarily important that we actually undertook that.

So we’ve got one more question and it’s “I understand we have limited supply of Aboriginal health workers’ workforce currently across Australia. What about the amount of work and funding focussed in this area? Would a focus in IMG as future workforce be more useful?” I’m not quite sure what that last part of the question means but perhaps if we could talk about the Aboriginal health workforce Debra?

Ms Debra Hocking

Well look it’s been a long hard road to get accreditation here in this country and as I said before, you look at the PD of an Aboriginal health worker that is nothing like what they’ve got to do because there’s so many things outside of that PD, that they have to do or that the communities expect them to do. I’d like to see certainly more Aboriginal doctors coming to our medical schools, getting people trained up, because even the Aboriginal health workers now are saying to us, things are getting bigger than us; we’re not trained to deal with all this, and that’s what concerns me.

You’re putting people in unsafe situations and so I think where the workforce does have to be further skilled, but there’s also got to be this commitment and funding from the Federal Government because at the moment what we’re seeing, and this is the sad reality, is that communities are being shut down, funding is being taken from the legal services, and it’s just not helping us at all. In fact it’s put us further into crisis I would have to say. So it would be great, to up-skill more people, but there’s got to be the resources and capacity and commitment to do it.

Dr Jean Collie

Thank you Debra. I think one of the things is the burnout amongst the Aboriginal health worker workforce and I’m always reminded that they not only work for their employer, which is usually the public hospital, they actually are on 24 hours a day, seven days a week, for the community and supporting the community. And this can be a fairly difficult situation for them to be in because there’s expectations on both sides and they have to be able to meet both expectations of their employer as well as the community and so it’s not an easy job and I take my hat off to all of them.

If we can go to the next question: “The indigenous picture of health is one which mainstream Australia should learn from. We would all be better for it.” I guess that’s a statement but I certainly share those views. Debra would you like to make a comment?

Ms Debra Hocking
I agree with you. I think it’s a wonderful, sound definition that we have and it’s encompassing everything that we, everything that we do and as I showed you that mainstream view from the WHO, the definition of health, wow it’s just one line, but yeah I think our philosophies are great. And I think Australians can learn a lot from our philosophies and even our inherent cultural characteristics that have remained.

There’s a lot to learn from both sides and let me explain it to you one way. If you could imagine two circles that had linked together in the middle and one circle is the Aboriginal world view, how far mainstream has come into Aboriginal world view. The circle goes in just a quarter of the way. If you turn it around and you look at, you have the mainstream view, and then how far they’ve come into our world. The Aboriginal have come three quarters into mainstream world, mainstream have come a quarter into us. So there’s still some long ways to go, still lots of learning and sharing and things like that and I hope I, I probably didn’t give that justice, but I hope it sort of gives an understanding as to just how far we have come and how far we need to go.

Dr Jean Collie

Thanks Debra. Meredith would you like to offer a comment in relationship to that last question, last comment?

Dr Meredith Arcus

Look just to talk about the international medical graduates and recognise the work they do in rural and remote Australia and I think that we work them very hard and I think it’s very, very challenging coming to a new country, new health system, and working, there’s incredible expertise you need to work in indigenous health and even very competent specialists have come into Alice from the coast, around Australia, and they take quite a lot of time to actually understand the chronic diseases and health issues of our clients and the culture.

I think that we need to recognise what the international medical graduates are doing but we also need to encourage our home grown doctors and clinical staff to actually come and take on those challenges and learn the skills that are required to provide indigenous people with what they deserve.

Dr Jean Collie

Thanks Meredith

Registered Participant

Can I just comment? I’m just wondering if the international graduates find it less, less difficult to adjust to that environment because they’re coming to a new place with an open mind and they’re prepared to. They don’t have preconceptions of what indigenous people are and they don’t have all the sort of, like that we’ve all been sort of
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hearing for our whole lives. So maybe their lack, their openness and their lack of preconceptions actually makes them, and that’s why they function so well in the workforce there. It’s just a thought.

**Dr Meredith Arcus**

I think that it’s challenging for any practitioner from any country and even our home-grown.

**Ms Debra Hocking**

Look in the classes that I teach at university, I talk to my students about cultural competence and what I find is interesting because a lot of our international students actually appreciate what I’m saying and can connect with it, more so than perhaps, Australians themselves because of their own cultural backgrounds. And it doesn’t take so much work because they already have an understanding of their own cultural values and things like that. I find that, with that sound understanding that should be built on because, okay it’s not Aboriginal but it’s certainly cultural and I just find it refreshing sometimes to hear from our international students and the way they feel about it. So I just wanted to share that with you.

**Dr Jean Collie**

Thanks Debra. I think that’s an interesting insight and something that we should all think about. I note that Emily has given us a few thoughts for the day. She says give a man a fish and he eats for a day, show him how to fish and he eats every day. Ask an indigenous person and he can tell you where the fish is and what the best way to catch it is.

So I think we’re just about out of time and I’d just like to take a few moments to thank our presenters Debra Hocking and Joanne Buckskin and Meredith Arcus.