The Role of ATSIC
in the National Aboriginal Health Strategy

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The Rural Health Strategy must link with the NAHS. It should develop from recognition of the roles and responsibilities of ATSIC Regional Councils and Aboriginal Health Services. Aboriginal and Torres Strait Islander people, through ATSIC Regional Councils, the Council of Aboriginal Health and the Tripartite Forums now have an opportunity to shape policy, planning and program delivery. Recognition must be accorded to the work of Aboriginal health workers and to the need for appropriate cultural awareness by health professionals.

Aboriginal and Torres Strait Islander people over the last two hundred years have experienced a lot of the problems that we heard about today and over the last few days of this conference. Whilst we don’t have all the solutions, because of our experience, we do have some of them.

Within the National Aboriginal Health Strategy (NAHS) we addressed the issue of rural and remote problems in the aboriginal health field. We have not yet agreed on the definitions of rural and remote. Even in Sydney because of some feelings towards aboriginal people in certain suburbs, although the health facilities are there, aboriginal people are still remote from using those health services. So you don’t have to be five hundred miles from the nearest telephone in order to be remote.

However, this conference is an occasion where we can work these problems through and learn to work with each other in ensuring that all of us have equity in health care and service delivery. It is essential to incorporate both aboriginal and non-aboriginal needs into the rural health strategy. We don’t want to see Aboriginal and Torres Strait Islander Commission (ATSIC) issues put into a special category and, as a result, excluded from a wider range of services and programs. We as aboriginal people are sick and tired of being quarantined from mainstream health needs.

As a member of the original working party for the NAHS and as an ATSIC Commissioner I am pleased to witness the positive response to the implementation of the NAHS, not just by the Federal Government, but also by communities, community people and State Government representatives. We thought that it was going to be quite some time before we could even start talking about health issues. We had to talk out about our differences about who had the better service for aboriginal people, whether it was State governments or community control people. That didn’t take all that long and we got down to business. From that day, right through to Federal Cabinet’s announcement of the extra money to implement the recommendations of the NAHS, everybody has played a major role in advancing it. We
now have some areas of local government providing some aboriginal health services. The NAHS goes some way towards providing opportunities for Aboriginal people to participate in developing and implementing programs. But Government support, education program support and your support are all vital to achieve real changes.

ATSIC itself represents a major breakthrough in participation by Aboriginal and Torres Strait Islander people. For the first time, we have direct input to the design and implementation of Commonwealth policies and programs affecting our families and communities. As you may know, on the 5th March 1990 the Department of Aboriginal Affairs (DAA) and the Aboriginal Development Commission (ADC) merged to become the ATSIC.

ATSIC took over the roles of DAA and the ADC but with one important difference - Aboriginal and Torres Strait Islander people took charge. The aim of the Commission is to achieve justice and equity, where Aborigines and Torres Strait Islanders have sufficient economic and social status to enjoy fundamental civil, social and economic rights as Australian citizens. There are 60 Regional Councils throughout Australia with between 10 and 20 members, depending on population.

These Regional Councillors will be responsible for programs and policy within their own regions:

- to formulate, and revise from time to time, a regional plan for improving the economic, social and cultural life of Aboriginal and Torres Strait Islander residents of the region;

- to assist, advise and co-operate with the Commission, other Commonwealth bodies and state, territory and local government bodies in the implementation of the regional plan;

- to make proposals for Commission expenditure in relation to the region; and advise ATSIC Commissioners on the needs and wishes of the Aboriginal and Torres Strait Islander people of their region.

Regional Councils are the foundation upon which ATSIC is built. Through Regional Councils Aboriginal and Torres Strait Islander people will be able to have a direct input into matters affecting them. They will also provide a unique opportunity to ensure co-ordination of services at the regional level.

The 20 ATSIC Commissioners will be responsible for developing national policies for all Aboriginal and Torres Strait Islander people and allocating money according to national priorities. They will carve up the annual ATSIC budget. So, things have changed in the administration of Aboriginal Affairs at Commonwealth level. Your NRHS must take account of this new structure and link with Regional Councils in the design and delivery of programs. There are other factors which must also be considered in the Rural Health Strategy, if it is to be effective for Aboriginal and Torres Strait Islander people.

The role of Aboriginal health services is vital in delivering health care to Aboriginal and Torres Strait Islander people, and it must not be overlooked. There are currently 69 community controlled aboriginal health services which provide a large range of primary care services.

The role of Aboriginal health workers is pivotal to change. These people are fundamental to culturally appropriate service delivery. They are also the means by which we can ensure the survival of many Aboriginal people until overall conditions improve. For, in many parts of Australia, survival is what we are talking about; not quality of life, but life itself.
Quite simply to be an aboriginal in rural Australia today is to be exposed to unacceptable dangers to personal health and welfare. For most aboriginals this means poverty and lack of mobility and an environment rich in community but poor in nutrition, with susceptibility to disease and vulnerability to disasters. This destruction must stop. We are all obliged to halt it and, in the process, learn from a spiritual culture steeped in communal caring and respect. While we all work at survival we must also ensure that changes to the policies and programs of service delivery will bridge the gulf of apathy and ignorance.

To this end there are two critical processes. Firstly, cultural appropriateness. Every aspect of medical intervention is culturally loaded, weighed down by the values of non-Aboriginal societies. These cultural factors tend to be forgotten in the rush to provide health care. The consequences of cultural ignorance are profound. An example of this is contained in Chapter 5 of the NAHS Working Party Report, and I quote:

“When using mainstream health services, Aboriginal women feel particularly vulnerable as non-Aboriginal health professionals display a great disregard for Aboriginal culture and law. Health policy should ensure that the rights of Aboriginal women to maintain their dignity, and have services provided by health carers who are both sensitive and knowledgeable about Aboriginal women’s health needs, and have respect for their concerns.”

It is essential that policy makers and program administrators are aware of the impact of Aboriginal law on the usage of services in non-homogeneous communities, at the most basic level. It is taboo for some women to talk about women’s health issues and to be physically examined by male doctors and health workers. Therefore mainstream obstetric, gynaecological, and general medical services and health care providers must be sensitive to the needs and cultural mores of Aboriginal women.

The NRHS provides an opportunity to address this issue. Both undergraduate and postgraduate education programs for medical health professionals must include training in appropriate cultural awareness.

The second process which will assist in bridging the gaps caused by cultural difference is the means by which decisions are made. Forget about consultation. This process encourages lip service and offers easy escape from dealing with the real difficulties involved. What must happen now is negotiation.

The recently released House of Representatives Standing Committee Report on Aboriginal Affairs, ‘Our Future Our Selves’, stressed the importance of negotiation with communities about the services they will receive. Understanding and implementing this process will require a major change in attitudes and actions for most people who deal with Aboriginal communities. It is a change which will reap rewards, for both service providers and recipients. It is about taking responsibility, and about ownership, for all involved.

The NAHS is a step towards this. The Council for Aboriginal Health will be the key advisory body to Ministers for Aboriginal Affairs and Health through the Aboriginal Affairs Advisory Council and the Australian Health Ministers Advisory Council. These Tripartite Forums will complement the activities of the Council for Aboriginal Health and give specific attention to intersectoral collaboration. The NRHS must develop extensive links with the NAHS through these peak representative bodies and through negotiation processes.

In summary, the NRHS can initiate change by:
recognising the role of aboriginal health services
acknowledging the contribution of aboriginal health workers
recognising the role of ATSIC Regional Councils
endorsing the necessity for appropriate cultural awareness in professional development and education
endorsing the process of negotiation prior to program implementation.

Your contribution to these changes is a first step towards genuine equity for Aboriginal and Torres Strait Islander people.