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CONCLUDING QUESTION AND ANSWER SESSION:

Facilitator: Sue McAlpin

SUE McALPIN: Right. So could I ask Henry and Colleen and Peter and Roy to come up the front so that we can have some questions. And our roving mic.

QUESTION: Look, thank you very much for a fascinating series of presentations. I'd just like to make one observation, I guess, and ask Henry a question. My observation is that whatever sort of qualitative or quantitative measures you want to use, the remote environment is different, and I think what we saw were presentations of a number of different models, I guess, in remote areas that are different, responding to local environment so that that last one, you know, paramedics there don't work like paramedics in the city.

In terms of food programs, food security programs, they don't look like what you might expect in other locations and in terms of models of service delivery, they're different in remote areas as well. And I think one of the commonalties there is that we need specialists generalists in more remote areas. So you can't be a very narrow specialist.

You've really got to broaden the scope and I think that was very well described in terms of what the ambulance service is doing in Far North Queensland.

I also really want to agree with your observation, Henry, that we don't say enough, either in the rural health community or relating to indigenous health about the success stories, and I think there are a lot of success stories. And the flip side of that is if we continue to always look at the bad things that are going on, it perpetuates a negative stereotype, I think, particularly in the southern press and I think that does affect our politicians and makes it harder, I think, for us to make progress in where we work. The other side of that, I guess, is that we often see the very successful models like the CAMS model of regional health service delivery which I think has been a very successful model for many years and it's just grown and grown, and really, I congratulate you on that.

I guess my question to you is, you know, there are a lot of members of NACCHO and there are some regional organisation, but there are also a lot of really tiny health services and those health services are very vulnerable to workforce issues, to staff turnover, to the problems that happen in those small communities. And I guess you've built a model in Kimberley that helps to protect those small health services against some of those threats, but in places like the Northern Territory where I work, there are a lot of small community controlled health services that have trouble with recruitment and so forth.

I guess my question to you is, you've got a terrific model up there, what are the barriers and how could we overcome having - seeing that sort of model implemented in other areas across Australia when it comes to small remote community controlled health services?

HENRY COUNCILLOR: Look, I mean, that's a very interesting question. We were confronted with that question somewhat last year and one of the reasons was, the Cape York Peninsula Apunipma - I think I can say it right - group came up to the Kimberleys and they wanted to look at different models - models that they reckon they can accommodate exactly for what you're talking about, where they have these small clustered little health services within the Cape York and they visited the Northern Territory - Central Australia, they visited the Katherine West Trials in terms of how they've collected, and they came across to CAMS, but they also came down here to New South Wales.

And one of the things they've asked us is, so in having an organisation like CAMS, how do we actually get these people all together? I said, "Well, it's actually about ownership and the

thing is that you would have the same problem in Cape York Peninsula as what we have in the Kimberleys about recruitment and retention."

And what needs to happen is that if you can get all the health services to agree upon having and setting up, like a corporate body, for pool of resources, where most of your corporate services actually can come out of and therefore allowing your health services to actually concentrate on service delivery rather than worrying about what the fiduciary duty require for this health service, the money we need for next year, the recruitment because the doctor is leaving in two months. You can then hand that across to there and this person then becomes - you own it. You're a shareholder or a body that actually deals with all the other stuff. And what we've done is that we've developed a structure so we're giving it Cape York Peninsula.

New South Wales and the regional areas also developed a similar style of incorporated body. What we're hoping to do is that - or what we'd like to do is allow people to come to the Kimberleys to look at it and articulate it in their particular area. Sure, there's going to be indifferences in terms of, okay, well, how we do it, but I think the only way that we believe that we can own it is by the Aboriginal people running it. And that's the key point of it, because it's theirs, and what services they actually want to come out of it. And we've been pushing that on the basis that in the last few years also, the department, particularly the Commonwealth department is talking about regionalisation in remote areas because of lack of access to professional expertise, additional funding, and so on.

So I think that it is a way forward - regionalization - but it needs to be done in a way that the community accepts it. And a lot of your people have heard about the COAG trial, the Council of Australian Governments, which has been running throughout the country. We are quite interested in the one in our particular region which is the Kajunka [ph] region and the Kajunka [ph] region is the Western Desert, Balgo, Chirracoran [ph], all those areas around there, and we believe it's not actually running as good as it's supposed to be running and it's about coordinating essential services in these areas to try and get, like, a one-stop-shop. But to have a one-stop-shop you also need to have ownership to that one-stop-shop, but at the present moment all departments have different regulations in how they operate.

They need to go beyond that, I think, and stop bumping into red tapes and using it as excuses, because that is the issue, and it's always been an issue. We've been able to go a bit beyond that in terms of ignoring red tape and says, well, hang on, this what we want. Either we come

on board or we can do it without you. And that's what I strongly emphasise about individual participation from each of the services. Some of the - and that's precisely point why we did that is because the services out there are individual services. They are individually incorporated, they have their own autonomy, they have their own governing structure, they also manage their own funds. However, they also access the corporate expertise from CAMS to actually do that.

I mean, it would be good if you could do that because then that way it doesn't become a one-stop-shop, but it becomes a pool of resources anybody can access. One thing we need to be quite clear and quite strong about is that the CAMS will only - it's core business will be health and primary health care. Sure it supports land, sure it supports law and culture, sure it supports changes in the environment, but its core business will be primary health care, and the reason I say that is because sometimes you can get the detoured from your main business into something else, particularly in regards to native title claims and so on. We've asked our communities that they keep that separate as that's a community issue, you know, and because of the number of different languages within our region, it needs to be maintained, and that's it.

There's the Kimberley Land Council has been set up for that, there's a Kimberley Law and Culture Centre been set up for that, there's an Economics Development Commission - a Kimberley body has been set up to look at economic developments, so that's all separate, but we're partners in all in one. So if they went to Kimberley Land Council and you wanted to talk about health and the land, they'll tell you, you go to CAMS. Or if you come to me and you want to talk about the Kajunka [ph] region, I'll tell you, you go to the Kimberley Land Council. And that's the only way we can do it, otherwise it's gets really messy, if you know what I mean.

But I mean, and that way, what we're able to do with that structure is actually support this model - this is where we have portability. Portability and transfer of entitlements and continuation of work. So if a doctor is working in Halls Creek and wants to move to Kununurra, all his entitlements moves across with him as well, because it's a corporate - collective body of membership, or he goes to Broome.

What we're actually trying to look at is to negotiate with the Commonwealth and state governments is to look at portability of transfer of doctor entitlements or other health staff

entitlements.

One of the problems we still have today is doctors will say, well, can I bring my entitlements across? And, you know, unless the state government pays it out to CAMS, no, they can't. But we're hoping to get around that and if you guys can help us get around that, it makes it a lot easier than to move people around. And one of the other things I failed to mention - I don't want to take too much - one of things we are looking at is looking at portability of transfer of skills in regards to Aboriginal health work across the northern hemisphere. We believe the same chronic illness we have in the Kimberleys is actually applied in Northern Queensland or the top end of the Northern Territory. So if we can get that, then you know, you create a better pool of resource. I hope I answered your question.

SUE McALPIN: Thank you. Other questions? Yes? Peter, I just want to ask, do you work in or have partnership with - I'm like Henry, I can't say it - Apunipma, the Cape York Health Council.

PETER CAHILL: Yes. Thanks for the question, yes. We collaborate with a lot of organisations to help us deliver our services and Apunipma is one of them. They actually sit on our service delivery framework reference body that I was talking about that we call our Queensland Emergency Medical or QEMS, they sit on that. We also partner with Department of Health and Ageing in the Torres Strait and we're a member of the Torres Strait Health Partnership Forum which is a body which consists of ourselves, state health, federal health and also the Torres Strait Regional Authority, and the TSRA are a federal government statutory authority that are the lead service or the lead provider in the Torres Strait.

So yes, we collaborate with quite a number of organisations to do what we do. The other one that we've just recently started with is, we have a fully funded paramedical academic position in the Mount Isa Centre for Rural and Remote Health - that's part of JCU out at Mount Isa - and that position is set up to provide and to do some research to establish for our organisation a postgraduate qualification in rural and remote paramedical practice.

So we're also partnering with tertiary institutions as well. So yes, we could never, ever do it on our own. The issues are too complex and too insurmountable, and we heavily rely on other agencies to help do what we do.

SUE McALPIN: Okay. Anyone else? Henry, I just want to know, do Kimberley patients go down to Perth to have their eye operations?

HENRY COUNCILLOR: Yes. Eye patients still continue to go to Perth because that's actually where the teaching hospitals are. What we're wanting to do is sort of set up what we call a specialist intervention program, and that is to look at a buy-in process. So one of the things we want to negotiate with the Commonwealth and state governing is a buy-in process. At the moment the Commonwealth and states sets the programs so that these are the number of specialist visits will be to remote communities, and they actually plan that for us and is paid for that. What we're saying is, why don't we have some participation with the communities or community health services where there's a buy-in process so that when the specialists do come up that they don't stay for three days, yet they're paid for five because they claim one day as travel day?

We want to have them the whole five days because, you know, a prime example is the dental particularly goes to Halls Creek and he has a list of patients and he says, okay, well, Joe Brown or Bill or Joe will be at 2 o'clock, you know, Bill will be at 3 o'clock. And these people live at Balgo, 378 kilometres south of Falls Creek who don't actually have a car - we're waiting to get hold of a community car or some form of transport to get in town to get to the 2 o'clock appointment. He gets there at 4 o'clock and then he says, no, we can't see you. And that's the issue that's actually happening. So then they're stuck in town for a week, so if we can buy - we are going to try and buy in specialists into the communities and bring them in there and set them up.

You know, we talked about this with the state health department, particularly in Halls Creek, there's a brand new hospital that's been built which is now - accommodate for specialists visits which is looking at how we can now design that in partnership to try and have specialists stay longer. Specialists are really an issue, particularly in the - and that's just in Halls Creek. They all love to come to Broome, of course, and they'll stay the extra days in Broome, but getting them any further than that is really hard.

SUE McALPIN: Thanks, Henry. Yes? Henry, can I just ask on that basis, is there some

possibility of Halls Creek and Fitzroy Crossing being brought into your network?

HENRY COUNCILLOR: Halls Creek and Fitzroy is our network. Of course Fitzroy currently is set up completely different to what most of the other health services are because they mainly focus on what they call cultural, promotional and environmental health focus in a partnership with the state hospital, whereas that hospital provides the doctor consultation services and so on. But, sure there's been some issues. Fitzroy and Halls - particularly Halls Creek - is already in there. Fitzroy is coming on board. Apparently Fitzroy don't use a lot of our corporate services because they have their own structure, and as far as we're concerned, that's well done to them, really. If they are able to maintain that, then that's great. But yes, they are coming into the role. So they've come to us. We haven't stopped them from using our services. We don't deny that to anybody, so if they wish to use it, it's there for their use because we've developed it for Aboriginal usage.

SUE McALPIN: Any other questions? Well, if you're too shy to ask a question in this audience, I suggest you approach any of the speakers that you've heard today over lunch. Lunch will be held in the rotunda just over there, and that means everybody, including the council who are coming back for a meeting, they're to go across there and get their lunch. But I'd like to thank everybody for a wonderful morning's presentations, all of the speakers in the last session and this morning's speakers, John and Andrew and Senator Joyce. So I wonder if you could all join with me in thanking everybody.