

Panel discussion—Q&A session

FACILITATOR: Folks, what we'll do for about 10 minutes is we'll just have a panel discussion here around the issues that each of the presenters has raised, and we've decided to have a specific focus around a case study of tackling smoking in indigenous communities and also workforce issues, such as the role of nurse practitioners and an inter-professional approach to these kinds of issues. I'll ask some questions, and I'll ask each of you to ask questions of each other as well.

I'll start with a quick run through. First of all, Judith, I was wondering if you could tell us—keeping in mind the audience are the people who are going to be scribbling down your advice, how do we influence government policy? How do we best use our time and be strategic about that?

MS ADAMS: Well, I'm really looking forward to the recommendations from the conference because, as I said, I'm very interested in grassroots feedback and I think that the recommendations from this conference, and I'm sure with Mike Daube and Tom here very keen on the smoking issues, that we will—there will be recommendations coming up. The biggest problem, of course, with government funding is getting recurrent funding because each government, of course, will only fund for the three years. And this is such a frustration, because you have the experts out in the field working really hard and there's nothing worse, and I think probably my colleagues will agree, is that you've got a very successful program going and you can't have it re-funded. And that, to me, is a great frustration as a policymaker.

So it's something that we really are looking at very hard and, often with our Senate inquiries, that would be the number 1 issue—is actually to have funding and be able to retain our staff and the expertise in the bush to be able to continue, because three years—these things just don't stop and we must—and usually you've had a breakthrough; you're starting to move forward; the community is educated; they're starting to think about what they're doing; and then, all of a sudden, bang, that's it.

FACILITATOR: So what are the elements of an organisation or a program that would attract recurrent government funding? What are some of the stand-out things?

MS ADAMS: I think, especially with the evaluation of the actual program, because, I mean, with funding—you can fund something but it must be evaluated to make sure that it's—that it can continue. And probably one that I'm fighting with at the moment, it's not smoking but bowel cancer—very, very important—and that funding, unfortunately, is being looked at in the next budget coming up, but it actually did—the program has sort of come to a bit of a grinding halt in December and it's just so important because people are really starting to grasp hold of that and it is going forward and it is making a difference. It's been evaluated, and we've just got to keep going. And I think that, when you hear from the others as far as the smoking, I know that there are some very big moves forward there.

And one thing being a midwife, it does worry me with a lot of the women and their body image. Now, this is not just for indigenous communities. It's for, you know, every young woman. They want to look like their colleagues and friends on TV and they think, well, smoking is the way to do it. And I think that's probably one of the biggest groups that somehow we must meet and try to convince that this is just not the way to go.

FACILITATOR: Tom, just pick ...

MR CALMA: Can I just come in ...

FACILITATOR: Yeah, please.

MR CALMA: ... on a couple of these things? Look, I can't stress enough how important it is to lobby and, you know—and particularly for this sector. You know, we currently have four independents who are from a rural background who are having some influence. You know, if only we could have three years' continual funding in Aboriginal medical services, you know, other than the six months and the rapid changes. The only way we were able to make a difference with the Close the Gap campaign was getting 140,000 people writing in to politicians across the nation, and they're both federal, and state and territory, politicians and local government politicians—the same letter, "Start to focus," and I think that's important. And if you have a look at the

moment, whilst we have a whole lot of inter-party bickering and point scoring, you don't see that in Aboriginal health at the moment, Aboriginal and Torres Strait Islander health, because we have this bipartisan agreement.

And, you know, issues like the national Close the Gap day, 24th March, over 700 events, community events, will be held to raise awareness. And politicians aren't blind to these things that are happening and, as a sector, I think we can really push the envelope for some consistent funding and to redirect the way some of the funding is going at the national level, because we are at a very important time in politics where we've got four independents from a rural background.

FACILITATOR: Thank you. Do any of the panellists have any questions or comments of each other? Just jump in if you do. Colleen, I wanted to ask you about how we translate some of these higher-level targets into what happens in the home. And you tell a very personal story about your family and your dad being the first teacher and principal in Australia and how he raised you guys. So how do we get these messages into the home?

MS HAYWARD: One of the things—and it's interesting that we needed research to actually demonstrate this, because I think it's something that most of us, if not all of us, in this room would know, and that is that, no matter what we're doing, it's always more effective if the people who are affected by it are involved in its design and implementation and evaluation. That bit is not rocket science. But, gee, we've really got to push to make it happen.

FACILITATOR: Thank you. And, Mike, you focused on advocacy as an important element in public health policy. So what makes smart and effective advocacy? We can all write down, you know, your tips for our organisations.

MR DAUBE: Well, look, I think we've already heard some of that from Tom. It's hard to go beyond Close the Gap as effective advocacy. We also see a whole lot of it in terms of advocacy that we're up against—commercial advocacy. I don't know how many of you are aware of traffic lights labelling—you know, a proposal for traffic lights labelling of food? That passes what we call in tobacco, the “scream test”. The louder the industries scream, the more you know it's a good thing. And in Europe the food industry spent over a billion Euros lobbying just against traffic lights labelling. So there's a lot of advocacy coming in from the other side.

But from a health perspective, what are the things that you need? First of all, you need solid evidence. If the evidence isn't solid and if you're talking about, you know, “may be evidence” and so on, people aren't going to listen to you. A politician like Judith won't be impressed if you say it's four but it's actually two and so on. So you need solid evidence. Then you need to keep finding new ways of presenting the evidence. I've lost count of the number of different ways we've talked about the dangers of smoking, you know. It's individual, it's tens of thousand of this, it's that, it's the other—all kind of new ways—and there are always new ways of presenting the evidence.

Then, if you're lobbying for something, advocating for something, you need a consensus on what you actually want. You need to set your targets, but you need to have a consensus because, again, if 40 different groups are coming to Judith lobbying her for something with 40 different sets of target things they want, then she'll sort of open the door and let them go. But if you have a consensus about what you want, then you can really be powerful. My next one—and don't worry, there aren't many to go—my next one is to have effective coalitions, and that's where Close the Gap has been fantastic—working together as coalitions. It doesn't mean that there's only one voice. You make sure there are lots of different voices but you work together as effective coalitions.

Then, if you're in advocacy, you've actually got to be professional about it. Years ago people used to get what they wanted pretty much walking into Ministers' offices and banging their shoes on the table. That doesn't happen any more. You have to be professional about your advocacy. Personalising it is important. There was a chap called Joe Stalin who said, “One death is a tragedy. A million deaths are a statistic.” If you personalise it, if you tell people how many of this are happening in their constituencies, what's happening to people they know, how it affects their own constituents, and so on, personalising is tremendously important.

And finally in advocacy, patience—you know, we're getting great results nationally on tobacco—huge results nationally. For the first 20-odd years I was involved in tobacco, people kept coming to me and saying, "You've failed. You've failed." Now they say, "What's the secret to success." So I sometimes put up a slide that says, "Overnight success comes slowly." If you're in advocacy you won't get what you want overnight. But, if you stick with it, if you've got good evidence, a consensus, coalition, you're professional about it, you personalise, particularly with politicians, and you're patient, then you can get good results.

FACILITATOR: And, Sandra, just touching on some of the inter-professional issues, and if you want to speak specifically around the nurse practitioner role in public health or health promotion or even delivering services to hard-to-access areas ...

MS DUNN: I think that nurse practitioners are one area, and they're certainly an area in which I'm heavily involved and feel are very important because they're a changing environment. They're an area where we've got a workforce evolution and revolution rather than a slow change. It's making waves. It's making print. It's an area where there's a degree of consternation and distress about what this actually means. But I also think it's critically important to recognise in the sorts of things that my colleagues have been talking about today, in public health issues, in chronic disease, that we are not talking about something that can be addressed by only one type of approach and one type of health care. I think that, particularly if you start looking at chronic disease, for example, you're talking about things that go all the way from prevention through to palliative care. They've got the acute care treatment. They've got the means for people to understand what the problems are. They've also got what happens with the community and how it is that we actually promote healthy messages.

These are the sorts of problems that are messy problems. They're things that need to be addressed in a variety of different ways. And, as health care professionals, one of the things that I think is critically important is that, as I've said, we recognise where the skills and knowledge from various groups come in, and we effectively work together in the kind of coalition that Mike has talked about, in order to address a wide variety of approaches, and to be able to say, "This is where my practice best fits, but here is where I can respect and acknowledge the sorts of practice that other health care professionals are able to provide." And to move on and say, "Good. You pick up the baton here."

One of the sayings that's stuck in my mind over a long period of time is from the UK. There was a gentleman who was talking about health care and talking about workforce change and he said, "If we think about health care as a pie and, as one group gets a bigger slice of the pie, then other groups get smaller slices of the pie. Then we end up fighting for the size of the slice of the pie." But health care is actually more like space. It's a lot of space and very few particles. And we can use a lot more particles out there in the universe in order to provide the kind of care that our populations need. I think that that's what we should be looking at with health care reform—acknowledging, respecting and recognising what each of us has to offer.

FACILITATOR: Thank you. Any discussion from the panel about what's been put up so far? Okay. Well, then I'm going to turn the tables a little bit and have you guys look out here and think that you've got around about 1000 activists virtually at your disposal. So if you could ask these guys to do one thing that will help you achieve your goal, what would that be? We'll start with Tom and Mike, maybe specifically around the smoking—tackling smoking in indigenous communities.

MR CALMA: I think, you know—and it's a challenge for all of us, and that is to understand some of what's happening outside your own realm of life and look at some of the movements that are happening across the nation, you know, and I'm a strong supporter of Close the Gap, and to understand what's trying to be achieved out of there, having a look at some of the material and some of the rationale behind the Close the Gap campaign so that every time you see a politician, every time you see something written in The Australian newspaper that's not right, write back to them and correct it, you know, and make sure that politicians are made aware of these issues. And, you know, I often have a go at The Australian because it's often not accurate, but, you know, it's also—other newspapers also need to lift their game.

Try and get people to start to celebrate and focus on the successes, because I think they're really important to help build up people's self esteem. But share the good things that are happening with politicians and make sure that they understand. Write in to—when you see an invite for a public submission on an issue, write in about it collectively as a very significant group. Start to think about how we can lobby together. And it's that

shared and common vision that, you know, we were able to achieve through Close the Gap, so it didn't matter which way a politician moved, they got the same answer.

MR DAUBE: Do you want me to ...

FACILITATOR: Yes, please.

MR DAUBE: ... follow up? I think—and if you heard just a little barb from Dr Calma there about The Australian, it's because he and I have sent them a response to something they wrote about smoking that was written there that was grossly inaccurate. Somebody wrote a piece saying that nothing had happened since 2008, and that's actually the period during which more has happened than at any time in this nation's history so ...

MR CALMA: But they've yet to publish it.

MR DAUBE: So what do I want you to do? I want you to stay with it. I want you to keep doing things, because what we tend to do—and I'm as guilty of this as anybody else—is I tend to think something's really important, I go off and do something, and then I'll go off and not forget about it, but I'll keep doing my day-to-day work, and I think it's really important to stay with it. I'd like you to think about what you can best do, what you can do, whether it's as an individual or through your organisations. There are some people who will be appropriate to be leading publicly or whatever else. There are some of you where if, for example, you work for governments and you went public on an issue like this it might not be a career-enhancing move.

But there are things that you can do. You can be active through your organisations. You can help to push those organisations. You can help to develop policy. You can get information around. You can find the people who will take action. So whatever you do, whether it's as an individual or through an organisation, whether it's up front firing the bullets or whether it's creating the bullets, or whether it's encouraging other people, I'd like you to think about what you can do and then to make contact with some of those other organisations and help to develop the coalitions—the strategies and the coalitions—so that action will happen.

FACILITATOR: Thanks, Mike. And, look, I'll change tacks slightly and, Colleen, ask you to ask the audience to chip in to help you with fixing the inequities in the Human Development Index. That's something you're very involved in.

MS HAYWARD: Yeah. For me, I guess—because it's always nice to take something a bit practical away. You know, the theory is great and then you get back to the daily grind. So I guess my comment is about personal professional practice and the need to really—you know, the old adage of walking a mile in the other person's shoes. I can remember, and a number of you in the audience will know, a good friend, Preston Thomas in the Western Desert. I remember years ago when we were working on a health agreement and he said, you know, for the people that he represented he didn't want to know that if there was something wrong with the left arm you went there and if it was the right arm you went some place else, and the left foot is some place else again. If that person was unwell in any regard, they just needed a clear pathway to get better, not the run-around between agencies.

So, for me, I think that the real message is about having a look at the holistic, as we deal with people who are real people. We need to make sure that they can take and live the principle of free prior consent, which means they've got to understand the information that we give them, which means we've got to make sure that information is presented in a way that allows them to understand, not just what's comfortable for us, but how do they understand and what are the message they are hearing. And, for Aboriginal people, not necessarily only them, there will be other family members who they will nominate who also need to know. So it really is, if it was you, how would you like that coming and what sort of assistance would you need, so that, in struggling with an issue, you really felt that people cared.

FACILITATOR: Thank you. And I might just pick up—oh, sorry, Tom, did you want to ...

MR CALMA: Yeah. Look, I think there's been a bit of discussion on two terms that we've heard here—one is equity and one is equality—and I think there's a danger if we just look at equity all the time, because equity is about giving the same, making sure that, you know, the same number of doctors are out in the rural areas as in an urban area; and equality is different, and equality of opportunity. And I often describe this in two ways through this example.

You have two people. One is down a hole that's five metres. The other one is down the bottom of a hole that's 10 metres. Equal treatment is if you throw them both a five-metre rope. That's helping one. The other one's bugged. He still can't reach that rope. And so the equality of opportunity is to give them what they need and take it back to a needs-based and appropriate level of treatment. So it's not equity; it's equality.

MS DUNN: I have to agree with that. And I think that the main point there is to consider not only access but outcomes. So what is it that we're actually trying to achieve as teams? What is it that we actually want to do to make a difference and to provide people with the resources that they need in order to achieve those kinds of outcomes? I also think that, in following along a little bit from what Colleen was talking about, about smoothing the pathways, one of the things that we absolutely have to do is to come back to our own team, to our own group, what it is that we are offering people.

I think that too often we provide people what we are comfortable with offering; that we divide that up according to our professional silos; and that we say, "Here's what we have. It'll be helpful; trust me." And what we really need to be doing is to look at what people are coming to us for and what is it that they need, and to provide, within the team, that smooth pathway so it isn't that we're having people jumping over bridges and crossing chasms. It's that, instead, we as a team are smoothing that kind of a road, that we're recognising the capacities that we have and that, where there are gaps within that team—whether it's in a remote team, whether it's in a rural team, whether we're talking clinical or whether we're talking a lobbying group—that we're able to provide a pathway that's smooth and that achieves outcomes that we're looking for, not just inputs that we have available to us.

MS ADAMS: Just to continue on with that with the outcomes, I mean, for me as a politician, I regard the National Rural Health Alliance with its 31 national bodies as an enormous—what would we say—oh, I can't think of the word. Just the evidence, the opportunities you've got—what we want are solutions. And if you can come to us with a solution, "Look, this is the problem; this is how you can fix it; this is the grassroots way of doing it; this is how we're going to work together to actually achieve an outcome with this,"; with the funding, that will really work. And this is something the Alliance has been very, very good at, and the visits that you do to Parliament House are highly regarded and my colleagues really do listen. But it's actual solutions and how we do achieve those outcomes—because we can't work it out. You're the people on the ground. You're the ones that can provide us with that. And then I think we can all come to some sort of solution and be able to put the funding where it really will matter.

MR CALMA: If we follow the theme of tobacco consumption, I think this is where we're seeing a difference in the way that government is supporting and the opposition is supporting the way that we're going about tackling indigenous smoking. We're moving away from the national approach that's happened. And it's worked pretty well with the general population; we're now smoking less than 20 per cent—about 18 per cent across the general population. But it hasn't resonated with Aboriginal and Torres Strait Islander people who are still smoking. You know, from 50 to 70 per cent of the population are still smoking. And so what the government has been brave enough to do is to support a different way of going about it. And so, over the next three years, or four years actually, we'll be rolling out a workforce across 57 regions of Australia of putting six people in each of those regions, and they'll be tobacco action workers and healthy lifestyle workers. They won't be clinicians. They'll be community developers and community educators working with the community to identify what's needed to help people give up smoking and take on a better life journey, I guess.

And so it's being evaluated and I think—well, we will evaluate it; it's just kicking off. But I think that's a different approach to what's happening. And I think they're the sort of innovative ways that we need to look at doing our business. And, you know, with the national broadband, whether it's here or it's not, you know, it'll be—but it will be there, and we've got eHealth and we need to start to look at the new technologies to be able to provide both education and treatment for people in rural and remote areas.

MR DAUBE: Can I make a point that relates to that? As Tom said, if you look at smoking, overall it's declining quite dramatically in Australia and, of course, because Western Australia is perfect, declining faster in WA than in any other part of the country, and less than 4 per cent of our 12 to 17 year olds are now regular smokers and so on, so I think things are going well. But this is the area—the area of indigenous smoking is the key area where we need novel approaches.

Now, I should have added to my list of things you do in advocacy that you praise. So when Michael Wooldridge was Health Minister back in, when was it Judith, 1670 or thereabouts ...

MS ADAMS: It seems a long time ago.

MR DAUBE: ... he set up the first national media campaign on tobacco and it was very effective and he merits great praise for that. Similarly, we have in Nicola Roxon—and I'm sure you will give her a hard time on various things, but she's done more on tobacco than any Health Minister—and I've been on tobacco for 40 years around the world, just under 40 years. She's actually done more on tobacco than any Health Minister I've ever come across around the world, let alone just in Australia, and she's the first who's done anything really significant on indigenous smoking. Setting up the campaign, putting a hundred and something million dollars into it ...

MR CALMA: 100.6.

MR DAUBE: \$100.6 million into it—and also having the courage to say to Tom, “This is your campaign; you run it,” and not interfering in it and allowing it to be innovative and so on. So I hope that, if you're talking about this, you will be supporting action on prevention—more than 2 per cent, please—supporting action on smoking—still more we need—price increases, various other things, but also praising the acts and actions that have been taken, particularly overall but in indigenous smoking, because I'm sure Judith will confirm, politicians get criticised a lot of the time, and if you praise them when they do good things, that's a real encouragement.

MR CALMA: Keep it up. And Snowdon also does a lot of work ...

MR ADAMS: Yeah, Snowdon. Yeah.

MR CALMA: ... in the rural and remote ...

FACILITATOR: And I think that's a really important thing for all of us to remember. It's that the people that we're trying to influence are just people like us, and influencing people is as simple and as difficult as communicating well, and I think we have to get that right at every level. Look, thank you all so much for that discussion. We'll, once again, change tack slightly. We've got about 10 minutes left in this session. I just wonder if ...

MR DAVIES: (Off microphone)

FACILITATOR: Oh, yes, that's what we're going to. That's great. Perfect segue. Who was that?

MS HAYWARD: Sandy.

FACILITATOR: Go for it.

ROVING MICROPHONE DISTRIBUTOR: Sorry.

FACILITATOR: And can the roving mics be out? If people have questions—please ...

MR DAVIES: Yes, Terry, I'm the first. You're talking about equality and equity. This conference already failed. I listened to the panel talking this morning. Aboriginal people are the most marginalised people in this country and the most marginalised people in health, and it's proven evidence here today of one of the most important health professionals in rural and remote Australia are Aboriginal health workers. Sandra, you didn't even mention them this morning. You gave us this great big list of health professionals and you left out the most important group of people in rural and remote Australia.

Now, my name is Sandy Davies and I'm the chairperson of the Geraldton Regional Aboriginal Medical Service and I've been in Aboriginal health for 30 years. We employ 12 Aboriginal health workers in our service. One of the programs that we run, we service all the remote towns and communities in my region and we have a massive big truck that doctors and health workers go out—and I'll use that as an example. And Terry, my CEO over there, will back me up. If we sent out doctors out to those remote communities on that truck on their 2000 round kilometre trip without the health workers they wouldn't get a foot in the door.

Aboriginal medical services, one of the most successful service deliveries in this country—if we didn't have Aboriginal health workers working at Aboriginal medical services and just all those health professionals you're talking about, Sandra, we would fail dismally. I look at the minutes and the agenda. There's nothing in this conference that gives credibility to Aboriginal health workers and, as an Aboriginal person, I'm absolutely offended by that. And are there any Aboriginal health workers in this building today? Put your hands up if there are any Aboriginal health workers here? Look at them. When you're giving out your super-hero awards tonight at the dinner, give it to those people because they are the experts in Aboriginal health in rural and remote Australia.

FACILITATOR: I'll let Sandra and then Tom respond but, Sandy, thanks for your passion. I think it's really, really important. And, for everybody, it's important that we deliver that with respect. I think there are a lot of good things happening in this place, but I think it's really great that you've brought this point up.

MS DUNN: I am embarrassed. You're absolutely right. And Aboriginal health workers are people without whom the best of the system could not function. I have to say that, in having been out into the remote areas and having worked with Aboriginal health workers here and in Canada, that I think the ability to communicate with the community, particularly in remote areas, is something that invariably other health care professional overestimate their capacity and the community is left oftentimes very, very confused. Without the links of the Aboriginal health workers—and if I could add in there interpreters as well, because that's another group that we use ineffectively, I think—that we really are not going to be able to make the kinds of changes that we need to, particularly in remote and very remote areas. I stand corrected and I stand embarrassed.

MR CALMA: Thanks. And thanks, Sandy. And, look, it's not up to me to defend the conference at all, but I did speak to Justin Mohamed, who's the chair of the NACCHO, the National Aboriginal Community Controlled Health service who was saying that they ran a master workshop yesterday and that was well patronised, and I think Justin is also and NACCHO are also on the governing committee that set the conference up.

FACILITATOR: Thank you. I'll just follow with one. I agree with you too, Sandy. I think that—in the work I do, I'm in paediatrics and we're doing a study in the Fitzroy Valley around foetal alcohol syndrome, so a fairly sensitive topic, and there's no way that the work could happen without the community navigators that we work with who are Aboriginal health workers so—agree, and, please, anyone in here who is an Aboriginal health worker, just take a bow because you guys really are the lynchpin or the most important cog in the whole machine. Lady in red.

AUDIENCE MEMBER: It's instead of my hat. I'm addressing this particularly to Tom but to all the other team. Yesterday we heard about the effectiveness of an integrated program in Timor-Leste and the SISCa program, and with the 57 teams that you're setting up for the tobacco, what is the potential for targeting obesity on top of that and targeting the other needs of the communities and developing the same integrated powerfulness that Timor-Leste has got?

MR CALMA: Yeah, I think, you know, it's a very important question again, and with that workforce I mentioned, there are tobacco action workers. There's three tobacco action workers and two healthy lifestyle workers. The two healthy lifestyle workers will focus on a number of areas that will contribute towards addressing some of the chronic diseases under the package. And there's a whole range of other programs that come out. The majority of these workforces will be hosted by Aboriginal Medical Services across the nation, but not all will be. Some will be involved with GP outlets or other areas. But it will be an integrated approach. It's not a clinical approach, and Aboriginal Medical Services have provided money, as is the GP network, to look at chronic disease management. And this workforce will be specifically tobacco. They will be doing a team approach and they'll be working across a region, across the existing Aboriginal Medical Service regions, and there's multiple different approaches.

But, you know, the key thing that we find with Aboriginal smoking is that it's very relationship related. It's about people who are not necessarily active in the sense that they don't have jobs, and so people congregate and they smoke, and so we're looking at alternatives. And already we've seen some of these teams embark on things like, you know, dance groups, whether it's round dancing or, you know, other dance to get older people actively involved, to nutrition programs, you know, and other activities. So just—just remember that it's only just started. The first people were employed in October last year. But, you know, already we're seeing some

very active participation. But I think the integrated approach is the way to go and try and get the maximum benefit from the inputs that we're getting.

FACILITATOR: Thanks, Tom. Okay, in the middle and then we'll sort of walk our way across. Okay.

MS MACHIN: Oh, thank you. Jess Machin from Country Arts WA. Thank you to the panel and thank you to the health conference for enabling us to program the arts and health stream, and it was great to hear the Walkabout Boys acknowledged. It took them two days to get to the conference. We nearly didn't have them because of the floods. We had to get a charter plane to actually get them here. They're going to be presenting this afternoon if you want to hear more about the role that arts plays in partnership with health, and that's part of my question back to the panel.

It was great to hear Tom, and it's fantastic to have Tom and Colleen on the panel—big heroes of mine personally—but an inspiration to what we're trying to do with the arts and its role in health and creating better lives, especially for young Aboriginal people. The Walkabout Boys were part of our youth leadership program three years ago. They were on the CDAT program, and the arts and music played an incredible role in enabling, in partnership with education with the Kimberley TAFE, for them to go on an amazing journey which saw them perform here and present later on. So I'm keen to hear what role you think the arts plays in the social determinants of health. And also an invitation for all of you—in September this year in WA we're having our own arts conference, which is entitled Open Your Eyes, on this theme that Colleen was talking about, inviting people to open their eyes to see how other—to walk in other people's shoes. But we're looking for—we are working in partnership with health and justice and education in creating a manifesto for 2029 on the sort of place that we would like regional WA to be, and we're handing the manifesto to state government. With all due respect, Judith, we're taking the lead of Close the Gap and creating our own vision, on which we hope the government will come with us.

MR CALMA: Just two things quickly. One is, you know, all the social determinants will be addressed and particularly, you know, the one slide—I had the blue one up there with all the different areas. I think it really does show the approach we need to do. I didn't say, but each of these 57 teams will be eligible to receive \$100,000—up to \$100,000 a year—to implement their locally-designed plan. So after they've spoken to the community and the community has identified what the priorities are, they can then come back to me and we can release up to \$100,000 a year. So it's taking it through not just, again, asking, "What do you want?" and then leaving it at that; it's giving them the goods to be able to deliver it.

And I think the other one, as you become more intimate with the Close the Gap campaign, you'll see the call is for a comprehensive national plan, and that takes in not only Department of Health, as I think somebody had said. It's more than just the Department of Health, but all the other agencies, and particularly, you know, FaHCSIA who has a fairly significant responsibility, and DEEWR and Arts and Heritage and so forth, all at the federal level, pulling together a comprehensive plan. And Warren Snowdon has been charged to champion that and to develop it up on behalf of government. And we're meeting on 23 March to progress that.

FACILITATOR: Colleen, did you have anything to say in response to that last question?

MS HAYWARD: The thing that occurred to me in terms of, I suppose, how different aspects, different portfolios, link together is I think, referring back to a comment that Mike made, in terms of thinking about different ways to get our messages across, and I think we need to do that not only, if you like, upstream, in terms of government and those with the funding—and I don't mean to be insulting when I say downstream, because downstream is actually much more fundamental. How do we get those messages across? And I think about some research that we did with the Cancer Council a couple of years ago. We were evaluating how effective a particular advertising campaign had been. It had been found to be very effective in terms of the non-Aboriginal population—in Western Australia this is rather than nationally—but much less impactful in terms of Aboriginal people and their aspirations to give up smoking. So we need other messages and we need other ways to represent those messages. And I think there's a great opportunity for the arts to play a role in that.

FACILITATOR: And, certainly, later on today we'll hear from Christine Jeffries-Stokes who's done a lot of work on the sugar bar project and bringing the arts into health messages. We'll just have time for two more question so, yes, please, the lady in pink, and then someone over here.

MR CALMA: And there's one more at the top on the left-hand side.

MS BROOKE: Good morning. My name's Nicole Brooke. I'm from the Whiddon Group. It's an aged care organisation in New South Wales and we specialise in rural and remote service predominantly. I draw from Judith's comment about ageing people in rural areas, but particularly the indigenous population, and Tom's slide about the graph to highlight that made it particularly evident to me. My concern is twofold. Firstly, what we as an industry or as a sector can do to support rural and remote health care in the older ageing population—the Productivity Commission inquiry, for which responses close very shortly on the care of older Australians—is a bit concerning. It tokenistically refers to a possibility of funding if you live in remote and rural communities, and another tokenistic funding if you're indigenous or of Aboriginal and Torres Strait Islander descent. That's quite concerning.

We have a number of aged care facilities that have elders living in them, quite a number of Aboriginal people in them, and we don't have the support, in terms of funding and resources, to adequately support them. Sometimes they don't necessarily tell us of their descent, and we find out—unfortunately, due to their passing, things come out. My concern to you and to ask for comment is where we can go to explore those issues. It's become almost impossible to pursue ethics, and given all the guidelines that come about with that, to interview ageing people that are of that background to where we can actually take our care and delivery. Ageing for indigenous people is new to us—and I say that very naively, I suppose—but it is becoming a big problem. We aren't an MPS, a multipurpose service, where they've got a lot of funding to provide this service. We have two and three people in our remote communities that reside with us.

The other I'd like to raise is about the indigenous—sorry, the ageing generally of our population and how we support those in remote communities. In our facility in Bourke, particularly, we can only fly in the Royal Flying Doctor Service—and I commend those people that might be here from there—once every three to six months to support our needs there, both from doctors and physios, and it's almost impossible to, I think service our clients well enough.

FACILITATOR: Thank you. I think we'll take that as one question and a couple of statements, and perhaps the question would have been around the first issue of interviewing indigenous people in the aged care setting.

MR CALMA: Yeah. Look, I think it's very important, even though we are dying younger—not many of us, 5 per cent, are in that older age group. A couple of things—Gerontology Australia, I think they're called, has got an indigenous advisory group and they're pretty active in addressing this. And last year, late last year, the first indigenous aged care conference was held in Adelaide and the workers got there. What's interesting is that they're the biggest actual workforce. There's over 3000 indigenous aged care workers, and we're talking about how they might form a peak body as well, to start to put a bit of pressure on. It's a high priority, I know, within the Department of Health, and I think it's just really starting to hit a few people that they need to do something about it. So I'd be looking at both the HACC program as well as Gerontology Australia to see that they can—what you can influence through them.

FACILITATOR: Thank you. And we'll just have one more question, and quite a focused, brief question if that's okay. And we have moved across the room—so somebody up here.

MS MILES: Hello. My name's Rosalie Miles and I work with the country health services in WA. My question, I guess, was about increasing the numbers of Aboriginal people working in health across the board. I'm very passionate about that and that's what my job is. But I wanted to pick up on Sandy's point about Aboriginal health workers and how we can increase the way they are used in multidisciplinary care, I guess.

They have a—they traditionally have a fairly confined role, certainly in the state public health system in WA. There's a real opportunity with the national registration and accreditation of Aboriginal health workers that's coming into effect next year. I wanted to get some ideas from the panel about how, I guess—and this picks up on the advocacy, I guess, and lobbying—how the role of Aboriginal health workers can be enhanced and particularly around sort of clinical areas.

MS DUNN: One of the things that I haven't mentioned and that I think is critically important is that, when we're considering our teams, we actually talk about our clients, our patients, our consumer, our communities and their families, as part of the team that's providing health care in the rural and remote settings. I think that

one of the things—one of the areas that Aboriginal health workers and community workers actually provide a key role is in the links between the communities, the clients, their families and the health care provider sector, particularly non-indigenous people. I think that you're right that the national regulation has a huge potential. I think that has a great deal of opportunity to make people more aware of just exactly what kind of a role and what kind of a key link that that role really is.

But, again, it's a lot like all of our other health care professional roles. It's critically important that, within our teams, we actually recognise what the capacity is and that we work to stretch the envelope; that we're not trying to put boundaries around people and enforce those rigidly but rather to say, "This is where we start. Within our particular team, without our particular area, where is it that we can expand on the skills and the knowledge of this group in order to better provide the kind of comprehensive care that our clients require?"

MR DABUE: After you. No. No, you first.

MS HAYWARD: I was going to say I think a lot of it is also about respect, acknowledgement and recognition, which I know are all terms that we want to use when we're talking about workforce and workforce development. Part of why Aboriginal health workers are so effective within Aboriginal Medical Services is that Aboriginal Medical Services provide a culturally-secure workplace. The medical service, I've got to say, is quite hierarchical in terms of how people deal with each other. It's not actually very collegiate. I've got to say, from an education perspective—and can I just say it ain't just you—in universities, most university staff are covered by one of at least two awards—one for academic staff and one for others. I'm not too sure how academic staff would actually do their jobs without "the others". I'm not too sure why we don't just have a staff award, but that's just me.

I think, if people are in a mainstream service provider and they are overlooked or ignored or given menial tasks, or their experience, including their life experience, is overlooked rather than being respected and regarded, you know, maybe people don't stay there very long. There's a lot that we can do to make the work environment and context a better place for everyone, and it really gets back to that interpersonal relationship again.

FACILITATOR: Thanks, Mike.

MR DAUBE: Just a quick comment. Yeah, it's just occurred to me with a sense of shock and horror that this the building where the Commonwealth heads of government are going to be meeting, isn't it, and they're actually going to be sitting up on this podium. So watch where you put your chewing gum because there are going to be prime ministers and so on all over the place.

Okay. I wrote a note down in answer to your question which said, "Media, media, media," because, if you want to know what influences politicians by and large, it's media, media, media. They read about something—if they're given a hard time about something, if there's constant comment about it, then they're influenced by the media. They'll pick up their newspapers on line at 5 o'clock in the morning. When I was running a Health Department, I would be getting phone calls at 10 or 11 o'clock at night even, saying, "Have you seen what's on the front page or on page 3 of tomorrow's paper?" So my very blunt question [sic] to you about how to achieve more resources in that area is media; to make sure that your calls are there in the media, and also that there are positive stories in the media about the work that you're doing because—and Sandy has made the point that there is so much superb work being done. It's not getting the attention it merits. So I think I would be looking at trying to get coverage of the two kinds; first, more coverage about the good things that are being done and, second, media coverage on a pretty constant basis about the need for more resources, because it's media to which politicians respond.

FACILITATOR: Thank you.