



TRANSCRIPT OF PROCEEDINGS, E&OE

NATIONAL RURAL HEALTH ALLIANCE INC

PUBLIC SEMINAR: HEALTH AND WELLBEING IN REMOTE AUSTRALIA,

CANBERRA, 1 NOVEMBER 2005

MR HENRY COUNCILLOR: Good morning, everyone. I think Colleen has given me too much credit. I'm going to try and work this. I hope it will work. I do apologise for not giving you an introduction, but my name is Henry Councillor. I'm the Chief Executive Officer of the Kimberley Aboriginal Medical Service Council in Broome, which is a regional body for across the Kimberleys and it provides a number of corporate services. I'm a Jundulla [ph] man from the Jaru [ph] Tribe, basically the same ancestors where Colleen comes from, and I've worked in Aboriginal health, particularly in Aboriginal Medical Service - actually this is my 21st year working in Aboriginal health.

I started fairly young. It was an interest and a passion that I always admired and especially the development of young Aboriginal people in terms of training and becoming skilled and professionals in the field of health. My presentation today, because I wasn't actually - again, I apologise, I've never actually spoken to Gordon to actually find out what I was actually presenting. So I'm going to try and work through this and I'm going to talk about Aboriginal medical service and particularly Aboriginal medical service in the remote communities or in the remote areas of this country.

I'll just give you a little bit of graphing in terms of where Aboriginal Community and Community Controlled Health Services are. As you can see the largest component is the outer regional Australia and also in remote Australia and very remote Australia. And this is where we're trying to establish the Aboriginal medical services. And the concept for establishing the Aboriginal medical service in remote communities is so we can build the capacity of a workforce that actually can be sustainable in these communities where people actually live.



And that's the most important thing that we can find because we believe that we can get better productivity, better sustainability and, I suppose, a better ownership in terms of the problems that we are confronted with in our communities. And all the stuff that Colleen has talked about, of course, we do experience it quite differently, particularly when you're in the position that I am and when you confront these communities and you actually don't have the answers they're looking for. So you try and look for some form of solutions that we can actually try and work with so the communities in our country is able to participate and own those problems and try and look for the solution and build those capacities around it. And that's what we've found, which I believe is one of the most important areas that we, we as a collective, actually need to deal with.

And I suppose I could stand here and talk to you about all the ill health but I think I'm already talking to the converted and I think that too often we hear a lot of that and sometimes we have to hear it to remind us actually what our positions are and why we're in this game and where we need to head to, to actually make some huge difference. And it's not always relying on government and it's not always relying on doctors and nurses. It's also relying on individual participation.

I want to talk to you a little bit about the Kimberley Area Medical Service Model of Regionalisation. We've developed this model something like 20 years ago and it's a model that we're quite proud of because we believe we can get the best buck for the dollar we receive in developing this model and in developing the health service for remote communities in our region particularly.

Our region basically consists of something like 420,000 square kilometers. We cover a vast area of uninhabited land. We have about six health services which is Broome, Kununurra, Halls Creek and the - well the Jurrugk Health Service is on the Gibb River Road where there are four major communities and probably a hundred homeland movements, Beagle Bay and Bidyadanga which are the two fairly largest communities in our region.

Bidyadanga holds something like 860 people. They have a health service of three nurses and four health workers. And that's their health care delivery.

Remote Communities Health Services is in Gledhill, Duncan Highway Communities, Ringers Soak, Lambu [ph], Jarlmadangah, Dodnun Station, Pandanus Park, Beagle Bay, One Arm



Point, Lumbudina [ph], Luma [ph] Balgo, Wattaman [ph], Bidyadanga and all the Gibb River communities. And these are fairly large communities. A lot of them consist of between 500 to 800 people. So as you can see essential services like this is quite essential.

This is just a photograph of Beagle Bay. This community is isolated by spring and during the wet is very difficult to get to, it's very difficult to actually leave this community, even to go fishing. It's also surrounded by salt water marsh, therefore it's very difficult to get to the salt water to even do some fishing, or even leave the community to get fresh fruit and veggies. This is an aerial photograph, it's slightly larger now at the present moment. I used to live in this community and this is where my family was actually taken to through the Stolen Generation process. This is a Catholic community, it's Catholic strong, it's still basically has a huge, strong Catholic influence in terms of how things happen in this particular community.

KAMSC governance structure. KAMSC Council is made up of all these selected health services. These are the major health services around the Kimberleys which then develop what we call a shared resource and these shared resources, through the KAMSC Council is then provided to the communities and to other health services. In the shared resources, we look for feasibility and sustainability. We have a central accounting system, we provide medical supplies, HR, IT support, policies development, administration and local advocacy where we are able to advocate our needs and basically our successes.

In the other areas of specialised areas, Aboriginal health worker training, social and emotional well being regional centre, health promotion unit, a regional health promotion unit and also we have an IT infrastructure which is the Project PIRS, which is Patient Information Recall System.

And that system has actually been put in place so that when people also looking at - particularly individuals - particularly the elderly people when they come into a health service, they don't want to come back tomorrow and they don't want to come back on Wednesday and they don't want to come back on Friday, so the patient recall system is to look at a - it's a tool that we use to look at a managing health care system.

So when a patient comes in and he/she needs to have a diabetes check, needs a hypertension check, we can do this and it's a forward planning to a six months ratio. So that way, when people do - we capture people and bring them into the health service, we're able to give them



a full examination and actually then plan their health care. And we've found that quite successful because to get people to come regularly to see a doctor or to get a health check has been very, very difficult, particularly if you're living in some of these remote communities.

This is just a central accounting system. Just to give you an insight we have something like - well, there's 260 people now on payroll, we manage something like 70 grants from - basically from 10 different funding agencies. We have one accountant and six book keepers and we find the most effective and efficient way of doing things, in terms of maintaining our accountability and fiduciary duties against the government and the public funds we receive.

These are some of the board members. These are members from Kununurra, along the border area and these ones up here is mainly from the Beagle Bay and along the Gibb River Road. The PIRS system I was talking about - I'll kind of race through this because I know that I only have a small timeframe, so I do apologise if I'm talking too fast.

One of the things that we pride ourselves in is the Aboriginal health worker training. We started this in 1983 and it's basically Aboriginal primary health care "practitioners" we call them, which is a model of Aboriginal health workers. And we've probably trained over 260 Aboriginal health workers throughout the Kimberleys. Probably about 60 per cent of them actually employed, which is a great success to us and the health worker training is very strong. It is now becoming nationally renowned and it's the whole way of the development. The curriculum is changing into competency based Aboriginal health worker training packages and I think that's going to be introduced late next year, early 2007, depending on the acceptance, I suppose.

CUCRH. CUCRH is the Combined University Centre for Rural Health which is based out of Geraldton. We have a partnership with them and in that partnership we were able to secure a part time academic pharmacist. And the reason why we wanted to look at engaging a part time academic pharmacist was based upon the management and particularly the management of medicine with chronic illness. So a lot of people don't know about medicine, they can't read the labels. All they know is they take yellow tablets in the morning, red tablets at lunch time and green tablets at tea time. When those colours change it just blows it way out of proportion. And I think a lot of you have had that experience. And we've found that the easiest way to do is to develop a curriculum and a training program that would focus on looking at management of medicine but also the understanding of section 100 in terms of how



we can access this, particularly for remote area communities.

We have been accessing section 100 for a number of years now. Actually the Kimberley Area Medical Service and the AMSs in the Kimberleys have been accessing section 100 for well in excess of 10 years and this was basically a success of Professor Ian Wronski who my predecessor Kevin Cox had worked very hard to actually get this and was able to succeed this.

Social and Emotional Wellbeing Centre is also developing training and social support. One of these things is about looking at what Colleen was talking about, particularly traumatic areas about young mothers in terms of pregnancy and antenatal. A lot of these mothers stay home and - they actually stay home till it's almost time to deliver because they don't want to go to Derby or they don't want to go to Broome and spend a month before they actually deliver their babies because they don't know anybody there.

And Broome, you go to Broome today, it's like walking around the suburbs here in Canberra because it's, you know, it's so modernised, it's just got everything. It's a big bustling tourist town and therefore things are moving fast and people just can't meet with that. Sure, it's good for business but at the end of the day, people forget about the basic care sometimes in terms of individual's rights. And what our Social and Emotional Wellbeing Centre is actually doing is looking at strategies and developing ways of how we can try and overcome and make people a bit more comfortable in doing that.

We do look at innovation in Aboriginal health promotion. We have the Regional Resource Centre and what we do is we develop regional materials that can be customised for particular areas, particularly in terms of language and particularly in terms of gender and particularly in terms of whatever the situation may be and whatever the issues are.

I don't know whether many of you have actually seen one of our two major renowned productions which is "No Prejudice" and "Change of Heart". "No Prejudice" was focusing on HIV and AIDS. It has actually travelled not just in Australia but overseas. It is a great success and hopefully we're looking to talk to the department, if they're here, to see if we can restart that. Because I think that most of us have now put HIV and AIDS on a back burner which, if you look at the stats, I think it was last year or early this year, that HIV and AIDS are increasing in the Aboriginal population quite rapidly, behind closed doors.



“Playback Theatre” has also been one of the best ones we have. It’s moving stories, it’s about theatre for playback in terms of people sitting down and focusing of their environment. And we took it out to Balgo and we sat with the community at Balgo and we said this is what we call moving story, it’s a playback theatre, we will do a re enactment of anything you tell us, or any of the problems or any of the success or anything that we can show you, because a lot of people can’t see themselves and they don’t want to see themselves in terms of whatever.

A lot of it came out of through the domestic violence and a guy who stood up at the back and he says, “Look”, he says, “you know when I go to Halls Creek, I get drunk and when I get drunk I come home and I bash my wife and I kick my kids”. And so we play it back to him and we say, “We want you to stay and have a look at it and tell us do you think this is right”, and he started crying. And it was so amazing that it really affected the whole team. We had to have a debriefing because something so simple hit people so deep in the heart that people couldn’t actually see. That guy actually don’t drink any more. He is now the member of the Peoples Church, he is becoming a pastor, so I don’t know whether we put him on the right track or not but - but it got him away from domestic violence. But they are just some of the things.

And the reason why I’m doing this presentation to you is also to show you guys a little bit of the success in Aboriginal health, on the inside. Too often we do sit here and too often we do talk about the ill health, the downside of Aboriginal health and I think that now and then we need to lift ourselves and say, “Hang on, we are doing something out there. We are succeeding in areas”.

Maybe it’s small drips and teardrops, but they are actually making a difference and I think that to continue to make this difference we need people to hear these successes, particularly people in positions that actually make changes and actually stop saying, “Okay, well we’ve got to stop finding the downside of Aboriginal health, we should be starting to find the upside of Aboriginal health, to maintain the continuity of these programs so that more and more people can actually access these programs”.

Population health has also been one of our greatest data collection in terms of looking at some of our successes, particularly with the eye camera. Too often the specialists in the Kimberleys come once a year and by the time the specialist comes, all he’s doing is actually



screening, he's not actually treating. So when it's time for treatment you've got to wait until next year to actually get treated, or you get flown to Perth if there's an appointment.

What we've done, we invested in an eye camera, we now take the photograph of the retinas at the back of the eyes and we now send those films to the specialist in Perth, he then sends back and says, "I want to treat A, B, C, D, E and G". And when he gets there, what he's doing is actually treating people, he's not just screening people. We actually do the screening for him which we found was really good, it was also supported by Lions Eyes Institution and - in terms of the training and so on. We now have four Aboriginal health workers that are actually trained in the use of the eye camera so they can actually bring that stuff out to the bush and actually do it. So what we're trying to do is bring innovative health to the bush.

Too often we try to get the people from the bush to come into town and that doesn't always work because the issues that Colleen had talked about this morning, that's transportation, that's accessibility, that's language barriers, that's all these things that we all know about. And I talked a little bit about section 100 which is basically to supply free medicine to remote Aboriginal communities which is working quite successfully. What we are trying to do in NACCHO is trying to get that and now look at implementing that in other state run clinics. We have got endorsement for that to happen but also look at how we can also implement that in rural health as well.

Now, one of the other areas that we've sort of been innovative in is kidney dialysis in a regional model. We now have a satellite unit in Broome which is staffed assist and also for self care patients, respite for people who are on holidays, mainly just a small component of it and we also have self care training working out of there, on-site support as well. What we're hoping to do, and this is a partnership with Royal Perth Hospital, the Broome Hospital, the Kimberley Aboriginal Medical Service Council and the Local Aboriginal Medical Service in Broome. What we want to do in a regional model is look at a hub and spoke system so that we can actually get more people back home through this system and it's about home dialysis and it's about how we can support that.

We're in the process of discussion with both the departments, the State and Commonwealth, in terms of how we can actually make this come to reality. And we're sure it can come to reality because it's been such a success having this unit set up outside of an Aboriginal Medical Service because people who use the machines are a majority of Aboriginal people.



We did an analysis last year. We have 47 people on dialysis machines at the present moment being dialysed. In 2008 we look to have 60 people actually on the dialysis machine with end state renal failure.

And, you know, also with the success of a number of agencies, that we've been able to get more people on the kidney transplant list to try and get people - the ultimate goal of having a kidney transplant. The other thing that we've also set up in the last couple of years was the Kimberley Area Medical Service Centre for Aboriginal Training and Education and Research and this is looking at an integrated education and training programs which will integrate GP registers, med students, medical undergraduates, Aboriginal health worker and other public health, allied health, like pharmacists and other areas.

What we're trying to do is to bring and develop a pool of resources in our region so that hopefully we can give them something so that they want to come back to the bush because most of the doctors and professional people we have in the bush aren't Australian people. You know, a lot of them are foreign doctors, a lot of them are new Australians.

But the sad thing about Australian doctors, they don't seem to want to come out to the bush and that's - I know there's been a number of strategies over the years to try and get that to happen but it hasn't happened successfully and I think that if there's anything that this forum can push, it's to look at how we can get more professional Australian doctors to the bush, because we believe that the Australian doctors should have more of an insight about Aboriginal people, the illness, the chronic illness and how to treat these sort of illness because, not being unfair to non-Australian doctors but a lot of them don't understand the cultural barriers that they face when they turn up there. And that's the saddest thing. And sometimes it takes a long time for them to understand that and sometimes a lot of them actually can't cope.

And it's not about us trying to stress people out and send them back to mental institutions but more in terms of trying to make them educated so that they understand what they're actually dealing with, because it's not just about the individual, it's about the community and the environment these people live in. It's not good me fixing somebody up and sending them back into the same environment, because that's - to somewhere like Kiwirrkurra in the desert where you get fresh fruit and veggies maybe once every fortnight, where, you know, water is



in drips and drabs, the environment is really, really dirty. So these sort of things need to be understood and sending them back with a dietary program that says, “Well, now, you need to have some bananas in the morning, apples in the afternoon” and what not, that actually doesn’t happen because it’s not there, it doesn’t exist.

And how we keep it all together. Well, we set up the Kimberley Aboriginal Health Planning Forum which was established in 1998. There’s also a link to the State Health Department and the Federal Health Department. We set up and signed a plan in 1990 and the forum continues to meet four to six times a year. What this means is that we bring all stakeholders to the table, including myself, particularly who can actually make decisions for our region and make the decisions and have a clear pathway on how we will tackle problems in the remote communities.

One of things we’re currently tackling at the moment is that the Kimberley Aboriginal Medical Service council will be taking on the clinical service in the Balgo Aboriginal communities. I think a lot of you actually know where Balgo is. It’s currently being serviced by the Mercy Health Care. And how we’re doing this, we’re actually bringing in a lot of other partners but we believe that we can’t do this problem on our own. It is a huge problem, it is a huge service needed to deal with it so we’re bringing in people like St John of God Health Care, we’re being in the Commonwealth and the State Health Department and working out some plans on how services can be run out there that can be delivered to the people in an appropriate way.

One of the things that we’ve looked at with NACCHO - and I’m going to do this bit about NACCHO - is that at the present moment you will find around the country a lot of people are using plastic Coke bottles as spacer device. And this is when people with asthma, particularly kids, and they cut the bottom off the bottle and they stick the Ventolin in the back and they press it and they’re sucking on that. And what we’re trying to say is that what should be happening is that some of this stuff, particularly spacer devices, should be either on section 100 so that they can be freely delivered or, you know, that the government needs to look at a strategy on how they are able to provide these sort of - particularly the spacer devices, particularly for kids with asthma.

Other things that we are looking at, particularly in NACCHO, is section 100, supply of medicine of course, it’s a huge success, particularly in remote area and we want to expand



that a lot further. There is an issue about the definition between “remote” and “rural” and we all know what that is and it’s just going to be there for a while. But also looking at special drugs. Particularly in the Kimberleys we’ve developed a special drug list which a lot of them aren’t on the PBS. And on section 100 they will want to bring particularly common drugs that are used for chronic illness, particularly with scabies, things that commonly people would see in remote Australia. And I think that’s something we really need to do and also the asthma spacer devices.

My chairperson that used to be my mentor, Dr Hunter, who many of you will already know, has passed on. One of the things that as my mentor and as my guide he has always looked at are key factors to improving health status of Aboriginal and Torres Strait Islander people and access to real culturally appropriate Aboriginal health promotion and a highly trained workforce. And he was pretty strong on that on the basis because it was very difficult for us to get workforce up in the northern hemisphere of this country unless they actually come from there or are willing to go there.

And this means that the workforce must be able to address the cultural and spiritual needs of Aboriginal and Torres Strait Islander people as well as addressing the specific health needs of Aboriginal and Torres Strait Islander people. And I always look at that because it also gives me a reminder of what I’m actually doing at times. You know, I stand as the NACCHO chair, I stand at a level where - this position gains a lot of respect, but then when you don’t see things actually happening on the ground it’s really, really difficult. They are things which we are able to tackle, particularly our personal problems and things like, you know, I might be the high and mighty but two years ago my wife had breast cancer and it was a difficult situation because I couldn’t do anything. What can I do? You know, other than try and make my family as comfortable as possible and go through the process. And, you know, thank God we’ve gone through that process.

But that’s just coming straight after my son had cancer. So, you know, it’s been a long, tedious road and these things that people think that, “Okay, well, he’s dressed in a suit and he’s standing there but he actually doesn’t know what he talks about”. But a lot of people actually don’t realise that we live these problems, a lot of our lives are lived around death. Every day somebody dies in our community and somebody is going to a funeral. Every time we get together as NACCHO, we find that there’s either been a tragic accident somewhere or somebody has passed on. And it’s just our lifestyle at the present moment that our people



aren't getting old, a lot of them are dying younger.

But you know, if you look on the other side of the fence, there are a small percentage of our Aboriginal population who are living longer. In June this year, we have an old elder that celebrated their 100th birthday and that was really great and it was really happy to enjoy that. But it actually didn't get the publicity it should have got in the media or in the public eye. There are people out there who are survivors.

And the message I want to give you today is about regionalising to remote community. How can we make our services more expandable and so they can be more accessible to people in the bush? And sometimes it's not about chucking a lot more money, it's about how we can do it more constructive and actually, like I say, get the best buck for the dollar we receive and how we do that is by sharing resources, is by building stronger partnerships. And it's about sometimes focusing on the positives rather than the negatives and I wish to thank you very much for your time.
