HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

CAIRNS

Friday, 8 May 1998

OFFICIAL HANSARD REPORT

CANBERRA

HOUSE OF REPRESENTATIVES
STANDING COMMITTEE AND FAMILY AND COMMUNITY AFFAIRS

Members

Mr Forrest (Chair)

Mr Quick (Deputy Chair)

Mr Cameron	Mrs De-Anne Kelly
Ms Ellis	Mr Lieberman
Mrs Elson	Ms Macklin
Mrs Elizabeth Grace	Mr Allan Morris
Mr Harry Jenkins	Dr Nelson
Mrs Johnston	Mrs West

Matters referred for inquiry into and report on:

(a) ways to achieve effective Commonwealth coordination of the provision of health and related programs to Aboriginal and Torres Strait Islander communities, with particular emphasis on the regulation, planning and delivery of such services;

(b) barriers to access to mainstream health services, to explore avenues to improve the capacity and quality of mainstream health service delivery to Aboriginal and Torres Strait Islander people and the development of linkages between Aboriginal and Torres Strait Islander and mainstream services;

(c) the need for improved education of medical practitioners, specialists, nurses and health workers, with respect to the health status of Aboriginal and Torres Strait Islander people and its implications for care;

(d) the extent to which social and cultural factors and location, influence health, especially maternal and child health, diet, alcohol and tobacco consumption;

(e) the extent to which Aboriginal and Torres Strait Islander health status is affected by educational and employment opportunities, access to transport services and proximity to other community supports, particularly in rural and remote communities; and

(f) the extent to which past structures for delivery of health care services have contributed to the poor health status of Aboriginal and Torres Strait Islander people.

WITNESSES

FLICK, Ms Barbara, Administrator, Apunipima Cape York Health Council, PO Box 2797, Cairns, Queensland 4870 493

GLADMAN, Mr Douglas James, 200 Toogood Road, Bayview Heights, Queensland 4868 526

HUNTER, Mr Puggy, Chairperson, National Aboriginal Community Controlled Health Organisation, PO Box 168, Deakin West, Australian Capital Territory 2600 493

KREGER, Ms Ann Janette, PO Box 7331, Cairns, Queensland 539

STAPLES, Ms Joan, Project Officer, Apunipima Cape York Health Council, PO Box 2797, Cairns, Queensland 4870 493

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Present

Mr Forrest (Chair)

Mrs De-anne Kelly
Dr Nelson
Mr Allan Morris

The committee met at 8.39 a.m.

Mr Forrest took the chair.

CHAIR—I am very pleased to open this eighth day of public hearings on the committee's inquiry into indigenous health, as referred by the Minister for Health and Family Services, the Hon. Dr Michael Wooldridge, with the support of the Minister for Aboriginal and Torres Strait Islander Affairs, Senator the Hon. John Herron, in June last year. The committee is looking at improved coordination, planning and delivery of indigenous health services against the background that past structures for the delivery of health services to indigenous populations has not resulted in significant improvement to health status of those communities and that there still exist barriers to access to mainstream services for Aboriginal and Torres Strait Islander people.

The hearing in Cairns today follows previous hearings in Canberra, Hobart, Adelaide, Perth, Brisbane, Townsville and Alice Springs and provides a further opportunity to explore issues with representatives of locally based organisations and individuals who have made submissions to the inquiry. Today's hearing also follows a series of visits to communities in the region over the previous four days. It is important the committee understands the particular characteristics and circumstances of Torres Strait and Far North Queensland communities as part of its investigation. I have to say, on behalf of all the members of the committee, that these inspections are vital in assisting our understanding of the difficulties faced by many of those communities. We were a little disappointed that our visit to Central Australia was not as eventful as we wanted. Five inches of rain hampered our access down there so we have to arrange another visit. The committee is also intending to visit even further remote rural areas of Western Australia and Arnhem Land as soon as we can make arrangements.

As I have indicated on previous occasions, as chairman I would like to stress that this committee is seeking to conduct this inquiry in a spirit of collaboration and cooperation with Aboriginal and Torres Strait Islander people. It is an unusual inquiry but there is a bipartisan resolve for a federal committee to break through what seem to be barriers to real progress on this very serious issue. From that point of view we are greatly assisted by having the assistance of Jim Kennedy, whose longstanding association with the department has been very useful. Also, Puggy Hunter, who is the chairman of NACCHO, the National Aboriginal Community Controlled Health Organisation, has been accompanying us on our trip to Torres Strait and also down the Cape. It has been very useful having Puggy's advice as we have undertaken our visits.

HUNTER, Mr Puggy, Chairperson, National Aboriginal Community Controlled Health Organisation, PO Box 168, Deakin West, Australian Capital Territory 2600

FLICK, Ms Barbara, Administrator, Apunipima Cape York Health Council, PO Box 2797, Cairns, Queensland 4870

STAPLES, Ms Joan, Project Officer, Apunipima Cape York Health Council, PO Box 2797, Cairns, Queensland 4870

CHAIR—Welcome. A submission was received from your health council as far back as October last year, Barbara, and there are a number of things ongoing so we would be very pleased to be brought up to speed and up to date on progress there. Whilst this committee does not swear its witnesses, the proceedings today are a formal committee process and contributions here are made in the same sense as they are made in the parliament, so the same respect is required as for the proceedings of the House of Representatives itself. That also provides for you the protection of parliament, so in your evidence you can be as fearlessly truthful as you feel you need to be.

Before proceeding further I would like to introduce committee members to you. Mr Allan Morris is the member for Newcastle, a New South Wales coastal seat; Dr Brendan Nelson, is the member for Bradfield, a northern Sydney suburban electorate; De-Anne Kelly is the member for Dawson, a rural electorate based on Mackay in Queensland, not far from here; and I am the member for Mallee, a large rural seat in north-west Victoria. Bjarne Nordin provides the secretariat to our committee; we could not conduct our activities without his organisational skills. Jim Kennedy, to whom I have already referred, is seconded to us. Mr Puggy Hunter will be present at the witness table throughout the hearing.

Barbara, it has been a while since October. Your submission made reference to a number of things. There was one that I was particularly interested in, in respect of training of health workers. But we would like to give you some time to make an opening statement and make reference to anything that you would like the committee to be made aware of. We have two hours today with you; we are quite keen to have that length of discussion with you because you have a wealth of experience to contribute. I just ask my colleagues: whilst Barbara is doing that, please restrain yourselves with questions and we will have a period of exchange with questions after she has finished. Are you happy and comfortable with all of that?

Ms Flick—Yes, thank you.

CHAIR—All right. We are in your hands.

Ms Flick—I want to acknowledge the traditional owners of Cairns before I begin talking. The delivery of health services to indigenous people in this country, for some reason or other, has become very complex. I think we all know that it has been

compounded by the government requirements that for a period of time did not do much for Aboriginal health at all, then passed the responsibility to ATSIC, where I believe we were marginalised in accessing proper health services, and Commonwealth and state responsibilities have always hampered the process of getting services on the ground. Remote community people are further disenfranchised by a national health system that pays through Medicare for fee for service for doctors when there are not a lot of doctors in the remote regions. I think that is one of the reasons why the information that we have is that less per capita is spent on the health of indigenous people in remote areas than on people who live in bigger towns. Those are some of the challenges that are before organisations such as Apunipima.

We are very much a baby organisation. We are only three years old. We fought hard to establish the organisation. We had some vague idea about what it should look like, and it is only after this first three-year process that we are clear in our own minds about which direction we want to take. We never wanted to deliver health services. We believe that the government has those responsibilities and should do it. We believe that the information, the data that we have reflects a long period of neglect in remote areas. It has been an ‘out of sight, out of mind’ mentality, in my view. I am still concerned that there is a lack of good baseline data.

I believe that there are three things you need to know if you want to deliver, or improve, outcomes in indigenous health—or the health of any community. One is that you have to have information about what you are dealing with. What do we know about the situation? What is the epidemiology, the pattern of morbidity and mortality? I do not believe we have that in Cape York even yet. There has always been talk about a data collection system. I believe there is not an understanding in the clinics of the reason to keep good data, so we do not have proper information, and I have made it clear that I really would not support any increased funding into the region until I was sure that we were targeting the diseases that we know about.

With that in mind, we were excited when Michael Wooldridge launched his national indigenous sexual health strategy because we thought that might be a way that we could start to compile data. So we put to him a proposal that we be funded to do mass community screening for communicable and non-communicable diseases. The federal and state governments have made a $2 million commitment to that program. We have started at one community and our staff are up in Thursday Island now negotiating with the Torres Strait community.

What do we know about the situation? We do not have enough information as yet. I have been talking to Dr Diana Lange in Brisbane who informs me that the government is committing funding to setting up some database. Dr Robyn McDermott is working at Pormpuraaw to trial some of this information collection. We then need to identify what services and resources we have. We have begun to develop a strategic plan with the Cape district. That strategic plan has not been completed at this stage but it should allow us to identify the services and resources that we have around the Cape. I think it should be

noted on the record that the state government has provided excellent clinics and accommodation for nurses in the Cape for the last three years.

Then we need to look at the gaps in services, to see what are the gaps and to identify them. One of the gaps has been identified for a long time: if you are working anywhere in Aboriginal health you will know that ENT specialists are a high consideration. The Commonwealth two weeks ago came to talk to us about what sorts of services should be provided, what services are in place for ENT and how a specialist might operate. There are things that the government should do. I believe that the government has a responsibility to deliver health services to everybody in this country at a very high level.

People who live in remote communities do not get the services that they require. If you look at the pattern of disease, you will know that we have high rates of mortality from cardiovascular disease; we have high rates of amputations—people with diabetes; we have rheumatic heart disease; we have lots of chronic diseases, for example, renal disease. In order to treat and manage chronic diseases I think you have to be in the community and not be locked behind the doors of the clinic. It has been a major concern for me that people are not aggressive enough in their intervention.

When the health council was set up I was concerned about the lack of a trained, skilled work force in the region. I did not think the health worker training that was being provided actually provided the skills required on the ground to do the job. So I wrote to the minister asking for a review of the program, which he refused. One of the reasons I wanted to review it was to confirm whether or not I was right in my assessment that it was not appropriate and, secondly, if it was not appropriate could we fix it up? I think at the time that was seen as a political motive by me and it did not happen, which is a great shame. Nevertheless, I proceeded to try and address the issue of health worker training.

I was in a community clinic one day when a young male health worker said to me, 'If a man comes in with an STD, the nurses tell me that I have to talk to him. I have not had any training, I do not know what to say.' I thought about that, and I thought about identifying some of the skills that health workers need in these communities and then trying to develop curriculum and, over a long period of time, putting together some sort of overall curriculum for health worker training.

This is not a good process, but it is a process it seems we have been forced into. We have worked with Dr David Bradfield, who is a director of the Sexual Health Unit here and the Rural Health Training Unit, and got some money from a RHSET grant to develop curriculum for sexual health. We hope to proceed after that to develop curriculum for health workers for antenatal care. But this is a tedious process and there are too many obstacles in the path of trying to get things right. If you do not have a skilled work force out there you are not going to see any improvements in the outcomes. You have a turnover rate of some 600 per cent for registered nurses. You have a primary health care manual that I think is in a bit of a mess and that not everybody uses. This is in contrast to

central Australia where they have a CARPA manual, which is a bible for health workers, nurses, doctors and newcomers, so there really needs to be a shake-up in the region.

Access to information, whatever information there is, is an issue for us. Apunipima is a stakeholder in health service delivery to Aboriginal people in Cape York. The history of our seeking access to information has been that we have been told that the information does not belong to us, it belongs to the community, and therefore we cannot have it. I have asked some community people about what information they have about the health of their community and they have not been able to answer that question. I think this information should be provided to stakeholders in Aboriginal health. It should be an open and transparent discussion about the situation because surely we cannot help to lobby for resources if we do not have access to that information. That is an ongoing matter.

There is lack of sufficient funding, in my view. There is an awful lot of work to be done. You only need to look at the trend. If we are seeing an increase in excess mortality in Cape York, then there is obviously an argument for more resources. You need to provide adequate staffing levels; I do not think that is being met, especially when we are talking about skilled staff. You need appropriate equipment and infrastructure. It was only last year that one community clinic was running a raffle to buy a tympanometer. You need money for repairs and maintenance. That seems to be a major problem even with Cairns Base Hospital, so that needs to be addressed.

The transport needs of people is a serious issue for us. An old grandmother with glaucoma, who was in Cairns Base Hospital from the Cape, had to be sent to Brisbane and was going to be sent down there on the plane by herself. How she was going to get herself out of the plane into a taxi and to the hospital is beyond me. There needs to be some inquiry or investigation about the patient transfer scheme to allow people to travel accompanied and to be returned to their communities.

I have mentioned the fact that there is a high staff turnover. There is insufficient orientation in the clinics, so people who come up from down south often do not know what kind of situation they are getting into. Apunipima has now established a working party with Cairns Base Hospital and we are working with them to develop orientation material. To me, it is not cross-cultural material. I am not interested in whether or not doctors particularly like Aboriginal people. I am interested in the fact that they know enough about this region and the people and their culture to be able to treat them in a proper way and to ensure that there is informed consent and that the people are taken care of.

There is lack of expertise, including clinical, public health and management skills, among people currently involved in the service delivery and that surely has to be a problem. Some of these issues are being addressed. We have worked with the Queensland government and the Health Insurance Commission to increase the number of doctors in the Cape in order to get more skilled staff into the region. I think that all nurses should undergo trauma management training before they come to these regions and be properly

oriented.

CHAIR—We have heard that, but we have not been convinced that it is delivering yet. I hope you can assure us that it is being delivered.

Ms Flick—That what is not delivering?

CHAIR—Real people out there. That initiative has only just started, hasn't it?

Ms Flick—I am not sure which one we are talking about.

CHAIR—The agreement with extra staffing.

Ms Flick—That is a Medicare agreement with the extra doctors on the Royal Flying Doctor Service.

CHAIR—Can you assure us that it is delivering what is needed?

Ms Staples—The nature of the system is such that it will increase over time. Because there is a component of Medicare money coming back, it is going into a fund which will gradually build up. At this stage my understanding is that the Royal Flying Doctor Service has put on extra staff. We do have further doctors in Kowanyama and increased day presence in a number of communities. That definitely is in place and is happening. It will improve over time as the money begins to flow in and that fund builds up.

Ms Flick—You have a two-page document, appendix 3, that outlines that remote medical benefits scheme project. The Cape York demographics differ from those of Queensland and that makes it difficult sometimes for us to access funding. The Queensland population is highest in the older age groups, whereas ours is highest in the younger age groups. More resources need to be allocated to these younger members of the community.

I talked about aggressive intervention. I was impressed on a recent trip that I took to New Zealand funded by the AMA and the APMA. After talking to people in the medical profession and in the community, I decided that there were two things that made a difference to the Maoris. One was that there had been a political commitment for many years and people had been involved in the system for many years. The Waitangi treaty was introduced or signed off in 1840. I talked to people who said their families had been involved in health service delivery as a community group since 1910. Their involvement has been much longer than ours—we started being involved in the early 1970s. I think that has made a great difference. The second thing is that they really are much more aggressive in their intervention.

I want to challenge this idea of community consultation. When I look at the data

before me about mortality in Cape York, it seems to me that I could be looking at data of some other underdeveloped country, for example, Rwanda. I think that if you went into Rwanda you would not start by having mass community meetings about what you should do. We are in a serious situation and services should be delivered. I think the process of community consultation has to be realistic. Cairns Base Hospital does not visit me in my home in Cairns and say to me, 'Do you think we should immunise all the children?' I expect that they will do that and that is part of good health services. I think a lot of people are intimidated and get tied up by this thing called 'community consultation', which I do not think is altogether clear or useful to the people on the ground.

There is no reason why, in a region such as ours with discrete communities, there should not be 100 per cent full immunisation of children to the age of two years. We asked around what the rate of immunisation was when the council was first set up. We were told, 'It will be close to 100 per cent.' So we commissioned a survey by a Tropical Public Health Unit which showed that the rate of full immunisation was much lower than that. In some communities they were doing very well in the 1990s, but in others it was quite low. At least we have a document now to report back to the community and say, 'You need to lift these immunisation rates.' By any standard, you need to immunise children, especially children who live in poverty, because what you do is effectively eliminate those infectious childhood diseases so at least the kids have some chance.

We are presently commissioning a survey into the uptake of Pneumovax and Fluvax. We have not had an adult death from pneumonia for a couple of years since this has been introduced and that is a good thing. We are trying to do a survey of disabilities in Cape York to find out exactly how many people out there have disabilities, what age group they are in and whether they are accessing government services. A friend of our is hobbling around on an artificial limb that he has broken because he cannot afford $30,000 for a new one, and there is some talk about involving Rotary. I do not think we should be involving Rotary. I think we should be able to get services to people.

Administration is an issue in remote regions. There are many examples of poor administration. This applies to state and territory government departments as well as Aboriginal organisations. If you look at the educational skills and management skills of local people, you will find that they are very low and that there are always difficulties in recruiting people from outside the community. There should be better employment practices. Training and support is needed in that area.

Governments always want to run an argument with us about diseconomies of scale, saying that the communities are small, people travel a lot and it is expensive to deliver those services. I think this is an excuse for doing nothing. This will always be a major problem. This problem will not go away. People will always live in small communities, they will always be mobile, they will be dispersed, they will be travelling. People have obligations under their own law to do that. Some community controlled health services have been able to take a regional approach. You have probably seen the one at Nganampa in central Australia and the one in the Kimberley, where people are trying to cover a

broader region to ensure that that small mobile and dispersed population is taken care of.

There are always going to be issues of distance, communications and transport. That is something you will not get away from either. But this is a significant problem for ensuring access to health care. We have been talking to the broadcasting people and NIMA, the National Indigenous Media Association, to improve the BRACS network in Cape York in order to get more appropriate information into the communities. In our organisation itself we have just produced a three- to four-minute video on SIDS. It is a little video about some of the risk factors associated with SIDS and how you might avoid them. But we need that information to go into the communities and it is one way we can talk about doing that. During the wet season in Cape York the roads are closed—you can only go as far as Hopevale North—so travel is only by plane. The funding of the health council itself has a very high component of travel. We need to charter sometimes or fly commercially throughout the region.

There are government structural issues that I want to address. I sometimes fear—if I can be so bold to say—that there is a failure of leadership in government health departments. I think one of the things that you need to have is good strong leadership. It cannot be six people in a clinic or in a region running the show. You have got to have somebody saying, 'This is what we're going to do and this is how we're going to do it,' and you have to make sure that people are supervised and trained.

The program funding is much more flexible than it used to be. That is a good thing and I think it should be acknowledged. At Apunipima, we have developed national, state, regional and local networks to try to ensure that government policy is implemented. There is often a confusion of roles between agencies and confusing structures within agencies that make it difficult for things to happen.

In regard to housing, we are having a discussion—to be polite—with the department of local government and housing about the sewerage system at Coen at the moment. The *7.30 Report* came up last week and we tried to show how serious the problem was to try and force some political commitment from government to address it. Those enviroflow systems were put in without proper negotiation with the community and failed miserably. Children are still wading through sewage every wet season. Gastrointestinal diseases in those children skyrocket during the wet season because the sewage lies around. A lot of the children are evacuated to Cairns Base Hospital, but a lot now are being managed by the local staff who recognise that this is going to happen. The long-term development of the growth of the children concerns me.

This confusion of roles between agencies and government departments is ongoing. It is still a matter of pass the buck—nobody is responsible and there is too little money. The Royal Commission into Aboriginal Deaths in Custody talked about the importance of government departments working together to ensure the best outcome. It is still not happening. There is still defensive rather than constructive reactions on the part of governments when policies or practices are questioned. It makes it difficult to bring about

change: you either take it on the chin or you try to work it out on the scale of importance. If it is seen as less important than having a row, then you let it go for a while.

Sometimes it is difficult for government to support local decision making and that is still an issue for us. People decide that they want a particular thing to happen in the community but government might decide that it is not the right thing to do. A prime example of this, I suppose, is the work that we did at Pormpuraaw with the housing for health program. In your documentation you will have a report of that.

We commissioned the health habitat people from central Australia to come and look at one of the communities in the Cape and to give us and the community some advice about infrastructure, housing and waste systems. The prime finding of that report was that houses were not constructed properly in the first place. There has got to be some proper regulation of housing. The state government were very annoyed about us saying that, but we were clearly able to show that houses were not constructed properly initially. In regard to the lack of funding for repairs and maintenance, people get money for new houses but do not often get money to fix the existing houses. If you are home owners yourselves, you know that you have to maintain your own house otherwise it will fall down around your ears.

Apunipima thought that it was the best organisation to do this work because we looked at it from the health viewpoint. We did not want to get into a discussion about yurts or some other style of architecture. We wanted to ensure that people had hot and cold water in their houses, that they had some sort of electrical system that worked, that they could have a shower or bath, that the water would run away, that they could prepare a meal in a hygienic place, that the gas was safe—those sorts of things. We found instances of hot water systems put on the wrong side of the house so they do not get any sun and the people never have hot water. We have high rates of skin infections—for instance, infected scabies. It is important that we have hot and cold running water in these homes.

My biggest thing, the thing that I worry most about, is that we are not delivering comprehensive primary health care in the region. By that I mean that, if you are sick, you have people who are skilled enough to treat your illness using standard treatment protocols. There should be 24-hour emergency care. There is a process at the moment—and I do not know whether you have been told about it—whereby, if you are sick after hours, you ring the bell, the nurse answers and she calls security. The security comes and picks up the nurse and takes her to see you at the clinic. I worry about whether people are bleeding to death or having a coronary and whether that works. But that is the situation. It is supposed to be for the protection of the nurse, but I do not know what the evidence is on the nurse not being protected in the first place.

There needs to be 24-hour access to the advice of a doctor either on site or via telecommunications. That fairly well exists in the Cape. They can get onto the RFDS and talk to a doctor. I have mentioned before the matter of ongoing management of chronic

illness. Diabetics in the community need to be identified. Somebody needs to have a list of them. They need to be visited at least once a week. They need to be monitored and they need to be taught how to manage their own condition. If you are going to sit in a clinic waiting for somebody to come, they will come when it is too late.

In regard to the provision of essential drugs, we have a well person's check program operating at the moment. One of the things that we have committed to, one of the outcomes that we want, is the eradication of Donovanosis in three years. We need Azithromycin for the treatment of Donovanosis, but that should happen, and hopefully we will be able to measure whether or not we have been successful in the detection and eradication of Donovanosis.

In the area of population health and preventative care, as I said before, people need to be immunised. There needs to be good antenatal care. There needs to be a good protocol attached to that. Women should be seen hopefully as early in their pregnancy as possible. They should be seen four or five times during their pregnancy. If an ultrasound is indicated, they should be able to access it and they should have their tests for STDs and gestational diabetes et cetera. There should be a good antenatal care protocol and it should be implemented. If I am told that there is a good antenatal care protocol, I would like to look at it. I have asked for it for a long time now. Secondly, it needs to be implemented. There is not much point in just having a good protocol.

There needs to be appropriate screening and early intervention and this includes activities in the clinic such as growth monitoring, well women's checks and well men's checks and we are trying to develop a model for a well children's health program. We then need to negotiate with the state government to trial or pilot it with a small community. We want to look at what are the components of a well child's program and to make sure those children access it.

There obviously needs to be good STD management activities going on in the Cape. If you look at the notifiable diseases reports, you will find low rates of chlamydia, gonorrhoea and syphilis. I do not think that is a true reflection of the prevalence of those diseases. I think there is a lack of detection. A lot of those diseases are asymptomatic and we need to encourage people to be screened. There needs to be secondary prevention of complications of chronic diseases, so the environment is an issue there.

There need to be specialist and ancillary services provided. At the moment we have a physician and a paediatrician who fly around the Cape and do the best they can. We have been lobbying for an ENT specialist and it seems that that might happen, though I hope the consultant does not spend six months in community consultation. I have suggested that interested parties should get together, workshop the issue in one day, looking at the difficulties and how they might be overcome, and put together a program of how you can deliver that. I do not think it needs six months of talking to everybody in order to do that.

We need appropriate visiting specialists in the region, and allied health professionals including dental services, mental health services and environmental health services. There has been a rapid increase in attempted suicides, in the last three years even, and completed suicides. There are not very many mental health services in the region. That is a serious problem that needs to be addressed. People who have some mental diseases need their medication reviewed, they need proper management. Younger people who are exhibiting suicidal behaviour should be recognised and there should be a protocol about how they are to be treated. All of these services just are not there.

Medical evacuation services are in place. Access to hospital facilities happens. But still we find people sitting on the streets in Cairns in their pyjamas who have been discharged. We have visited people in hospital with pyjamas piled up on their bedside tables, when they have not been helped to have a bath. And there are ongoing problems with discharge summaries back to the communities. That is a major task. We have set up a working group with the hospital now and we have quite a good relationship with them, and we are really going to try and sort out this whole business about discharge summaries, because people are sent home but the summaries do not come back to the clinics for a long time. So local staff do not know what medication they are on, what the diagnosis is, what the ongoing management is.

Next is the cost of transport and accommodation to access specialist and ancillary care. There are high costs of transport. People in the region are employed under the community development employment program, CDEP. Their average income is about $140 a week. The costs of commercial transport are very high, so people choose sometimes not to come to Cairns for specialist treatment if they cannot afford the costs. They also do not want to leave their children behind.

CHAIR—When I read your submission, Barbara, I was really encouraged. I thought there were some things which were good, a credit here and there. The committee's sense of optimism about whether we are making any progress varies a lot, in terms of the last person we have spoken to. We have been encouraged in some communities and then we have found out about some problems. A lot of them are basic things. You have mentioned putting a solar hot water unit on the wrong side of the house. It is really quite frustrating. We sense all that. I know that members of the committee have got a lot of questions, because the things you are telling us we have heard. I wanted to give you plenty of time to give us an overview, but I do not want members not to have an opportunity for some good questions as well and draw more information out. If it is helpful, and you have got information there, you can simply table that and we will have it formally included in the transcript.

We are so frustrated about simple things that are not complicated yet they are, because they all interact and mesh together. You are telling us things that astound us; they occur but they should not occur, and we have to find out why they do and make some really strong recommendations to crack through on all of this. You have been involved in this whole issue for so long that it amazes us that you still stick with it and still fight.

Could you give us some idea, perhaps, how much more of that information you need to tell us, and then we will get to some questions.

Ms Flick—I do not need to tell you any more. Out of all of the things I have talked about, I believe that if the government introduced the core clinical services that are set out in this document and said to the clinics, 'This is what you have to do,' we could see some outcomes. The fact that those services are not being delivered really astounds me.

I think it is an issue about leadership. I have run an Aboriginal medical service in Darwin that saw up to 100 people a day. You have got to have strong leadership, you have got to have workers who are highly motivated and highly skilled, you need to take matters into your own hands. I come from the old teaching school of nursing training. It was not easy but we fought to get the curriculum into the organisation to train our own health workers. They are the best health workers in the country, but we trained them on site, we supervised them and we were seeing lots of people every day so they had time to develop their skills, and we had two doctors supporting them. That is what should be happening in these communities. The rates of chronic diseases that are not being managed—I do not know how many times it has to be said.

The importance of organisations like Apunipima, I think, is to be advocates for change and to try and influence change, but we do that in all sorts of ways. It is a highly volatile situation that we work in, because there is always conflict, there is always us pushing to make things better and there is always a reaction that people are quite happy with what they are doing. Because they do not know the data or the information about their own community, they do not see what we get excited about.

I go into community clinics and say, 'How many people do you see a week or a month? What do you see most of? What is your rate of child immunisation?' If the nurse says, 'Oh, fairly good. We see a bit of everything, probably all the kids,' it is not good enough for me. There has got to be a boss who says, 'We are aiming at 100 per cent and we are going to make it. I will want to know why if you have not made it.' You need that kind of leadership. You need to fix up some of these really simple things quickly. There is no reason why these things should not be happening. You could raise productivity by 30 per cent without doing too much at all. It does not require more money; it requires proper information and knowledge about what you are doing. We need to set in place goals and targets.

We have the AHMAC statement about performance indicators that NHAC, the National Health Advisory Committee that I sit on, is going to workshop next year. We are going to have a national forum on the implementation of those performance indicators. We have a framework agreement between the federal and state governments and ATSIC. We need to be sure that there is involvement in regional planning, which to me is the important part of that agreement.

Apunipima straddles all these things. We straddle from being involved in national committees to trying to change things with representation on the ground. Instead of having direct conflict with nurses and health workers anymore, we are trying to say to the government, 'Why haven't you reached your goals and targets? Tell us about your implementation process.' Then it is up to them to make sure that things happen down the line.

We should be concerned that not only are things not as good as they should be but, in fact, in Cape York there is a major deterioration at the same time as there has been an improvement in outcomes for non-indigenous Queenslanders. Ian Ring's data can show that clearly. They are actually doing better and we are doing much, much worse. There have to be reasons for that and I think that people have to start being honest and serious about why we are not seeing the outcomes. We operate in a hostile environment a lot of the time because we try and force better outcomes.

CHAIR—On the leadership question, one thing I have noticed is that if you have the right person there with a bit of go then progress will be made. But they need to be identified and encouraged to be that sort of leader—if it is the health coordinator in the community or whatever. Is that happening, or are there things in the whole training sector that still are not up to scratch to ensure that those people get encouragement to return to their community and drive some of this?

It has been noticeable from community to community. We have been encouraged to see there is some progress but it is very much dependent on the person that is there to inspire a bit of cooperation within the school and the council and ensure that there is some nutritional information going through the school and the children are being told about the importance of immunisation and all those things. Then you go to another community and the strength of that leadership is not there and there has not been progress. Are there things that we can do better on the training issue?

Ms Flick—People need information first. One of the things that we try to do—and we have only been doing it for three years so it has not been a long time—is to inform the community about the health of their own people. I sometimes fear that Aboriginal people are getting used to burying people young. We are starting to believe ourselves that this is normal, that young people die, either in violence or from chronic diseases. I think that is a dangerous situation. It is difficult to break out of that. People have knowledge of themselves and their community but you need information to be able to be an advocate or to be able to try and improve an outcome. You need to know what the situation is at the present time.

That is our work in this mass community screening exercise. We report individually back to everybody who is screened. They have a private consultation with their doctor. Even if they are well they are talked to and we have a community report back. That has only happened in one place; we have only done this at Bowen. But the community now has a report on the levels of diabetes, cardiovascular disease, liver

function, renal function, nutrition—we have done red cell foliate measurements. For the first time they all have some information. I do not know how you make leaders in a clinic; I really do not. I am bossy so I can be a leader. I do not know the answer to your answer but I think that the bosses higher up should be demanding much better outcomes.

CHAIR—About the collection of data, it surprises me that the information is not available. We have seen health workers faithfully filling out form after form. When you ask the question, 'Do you know what happens with this?' they say, 'Oh, well, we send it off somewhere.' What we have discovered is it takes some years before we finally see it at our level in a report somewhere. It surprises me that you still insist that we need a better database. I think we are collecting it; the problem is we are not quickly processing it and conveying it back in real terms so progress can be measured, not every three or four years behind but up to date. At least we would know we implemented a program in that community, we had these effects and we knew that answer within a few months. That is the kind of response we need so we can find out what are good models.

Ms Flick—I think that is a question for the health department; it is certainly one that I would ask them. I know that forms are filled in religiously and I know that they are sent down here and I know that they are all punched into a computer. It does not go anywhere. A doctor who worked for me at one stage I sent down to take a look at what data they had. It was there but you had to struggle to find it. There was no way that you could present that back to the community or to the nurse and say, 'This is what you're dealing with here.'

CHAIR—That is very disappointing. I know Dr Brendan Nelson has had a long association from his time as president of the AMA. Some of the communities we have been visiting he had been to before.

Dr NELSON—I have just got a few things I would like to ask you about. You made the comment about community consultation—you know, 'We do not want more community consultation'—and to illustrate that point you have been talking about an ENT surgeon: if you could get one you do not want them to spend six months in consultation. A lot of people place a lot of emphasis on consultation. You do not want people coming in and doing what they think is the right thing without talking to the Aboriginal people involved first. Could you clarify what you mean in terms of not wanting more consultation?

Ms Flick—I suppose I am talking about evidence based medicine. If I get sick and come to Cairns Base Hospital I expect a good outcome; I expect that I will be treated properly with the best medicine, with the best diagnostic tools possible. I do not want them to come to me and talk to me about which might be the better tools that they might use. We are talking about people who live in poverty, people who live in situations where there is often violence, where there is always worry about money and children. How can we expect their communities to sit down and draft out a strategic plan for the delivery of health services? I think that is an outrageous thing. I do not think any other section in the

community has to do that.

I think there should be best medicine, best practice in all of these clinics. There might be some things in which the community might want to have a say about how they are delivered: should we all come at once, or should you come to the house and do this, or those types of issues. This community consultation process I have run out of patience with over the years. I really think it is a waste of time and resources. I think a small group of people ought to be able to decide whether this is a best practice and it should be implemented.

Dr NELSON—If government agencies, including Aboriginal pseudo-government agencies, were to pursue that course would they not run the risk of being criticised for not being sufficiently sensitive to Aboriginal people?

Ms Flick—Absolutely. I think you are right, but I still disagree with it. I still say it has been used for a long time in a way that has not provided good outcomes. It has wasted a lot of time and energy.

Dr NELSON—A lot of us try to do everything we possibly we can to improve the health of Aboriginal people. You know better than anybody that it is really Third World stuff, a lot of it. We heard a man yesterday, the chief executive at Kowanyama, who said it was the welfare that was killing the people. We met with the justice committee, which is a group of ladies—older Aboriginal ladies—and a significant number of children in Kowanyama are malnourished, maltreated and neglected because the parents, usually the male parent, spends the money on alcohol and then the kids have nothing to eat.

Is it beyond the wit of Aboriginal people and governments to devise a system? I do not care if you are black or white, if you are maltreating your children, then there ought to be some penalty applied to that. Is it not possible to design a system where the money is redirected or managed in a way so those children's needs are met and for that to happen within a community? I had some disagreements with some well-motivated members of the previous federal government. One said to me, 'Well, they are all Australian citizens; everybody has to be treated the same way.'

I represent a metropolitan Sydney seat which is probably one of the most affluent in the country. You cannot tell me that the people living in my electorate are living in the same circumstances, with the same cultural backgrounds and expectations of people living in Kowanyama. It seems to me that a part of our best efforts that are well motivated are actually contributing to the problem. Have you given any thought to how we can deal with this? It also seems to me that we are trying to improve the health of people and to have a reasonable life expectancy, apart from anything else, when in fact they are living in places of desolation, poverty and destitution and there is no hope of any meaning in their lives, there is no hope of a job. You say to yourself why would you bother?

Ms Flick—There are two things that have to happen in order for people to have

good health. Firstly, the government has a responsibility to deliver health services to us as citizens. Secondly, we need to address the social factors of drinking alcohol and smoking cigarettes, and the need for good nutrition. I do not back away from that. I do not believe in the victim syndrome. I do not think we should be victims of our own making.

I do not see that the issue of destruction by alcohol through early death, or the destruction of culture and language, is just an issue about medicine. The question that we put to our people is whether we want to be here in 50 years time. That is the question. Forget about what the government or anybody else is doing. Do we want to be here, speaking language, singing songs and dancing corroborees that are thousands of years old, in 50 years time, or not? The decision really is up to us. The Alkali Lake community in Canada have done some interesting things, and we have been looking at that work. One of the things that they did was to introduce a system of food vouchers. There is one community in Cape York that does that already, and I am not prepared to name it.

I have been very concerned over a lot of what are, in my view, unsubstantiated claims about the importance of canteens in providing the community with funds to fix up the roads and other things. If there are local government issues involved in this, we are intending to commission a consultancy to look at the alcohol economy of the region, to be sure about the facts. Does it in fact subsidise local government funds, or does it not? We need to be clear about that.

All of the things about economic development are important factors: that we do have a job, that we do have self-esteem, that we do feel useful and that we can contribute. The health council does a lot of work in promoting the culture and language of the peoples of the region, and we see that as a health priority. We also see the move back to outstations or homelands to get away from that environment as a high health priority. We work with the Cape York Land Council and Balkanu Development Corporation and ATSIC Peninsula Regional Council in order for that to happen.

We get into trouble with everybody, I might say: our concern about the misuse of alcohol had really put us in conflict with community councils. The last strategy that we have developed, but that we have not started to work on yet, is much more interesting. It is about having a coalition of regional organisations against alcohol misuse. Together, the land council, the health council, Balkanu, ATSIC, the ACC will be united in their approach to substance misuse. I might say that there has been a lot of funding and effort put in to deal with the problems of people who live at the bottom of the scale, those who live in the parks and those sorts of places. We are keen to aim the strategy at the leadership, to challenge the leadership to set an example and to provide proper leadership in that respect.

Dr NELSON—I would like to ask you two more things, and then I know my colleagues will ask questions. You have run an Aboriginal community controlled health organisation now at Apunipima that basically oversees or facilitates the provision of services through a lot of government-run health services, through Queensland Health. Mr

Hunter, of course, represents the community controlled health organisations. In your submission you said that it does not really matter who controls these things, but rather that they are of good quality and meet the appropriate standards and presumably are sensitive to Aboriginal culture. Could you elaborate on that? As you know, there are others who have a very strong view that all the Aboriginal services ought to be community controlled. Is there a preferred model?

Ms Flick—No, I do not think there is a preferred model. I think that those AMSs that operate effectively should be resourced to operate effectively, and that state-run services that operate effectively should also be resourced. They both should be accountable, and both of their performances should be monitored and evaluated.

Dr NELSON—Accountable to whom? To the communities that they serve? To governments?

Ms Flick—You are accountable in two ways. You are always accountable to the community that you serve, and you are accountable to where the money comes from. That is our money and it is for our people. I do not see that as government money; I see that as getting resources to do the work that we need to do. But I do not back away from the fact that both of them should be held accountable. It has to be transparent and there have to be set goals and targets for the health of the people. There should be plans and strategies about how to achieve that, and they should be transparent. The outcomes should also be available to everybody.

There are lots of things that we have done that have failed. That does not bother me all that much. What bothers me is that I need to know why they failed. I would be concerned if government stopped taking risks with any groups. I really and truly believe in best evidence based medicine. I really do. That is why I do not care if Martians deliver the services, but I want to be sure that there are good standard treatment protocols, that people know what they are doing and that there is proper leadership, a skilled work force and resources. Then I want to see the outcomes.

Dr NELSON—Lastly, one of the things that always seems to get people going is money. In general practice, for example, we had a better practice payments program—which is probably a misnomer, in my view—that is about to evolve into a practice incentives program. GPs, particularly in groups, who set and then achieve certain benchmarks will receive incentive payments. Should some thought be given to the Commonwealth providing a bonus pool of money for Aboriginal medical services—whether they are community controlled or, say, government provided—that can be accessed where appropriate goals for a community are achieved?

Some communities will have much better smoking rates than others, or better pap smear screening or immunisation rates and so on. If appropriate goals were set and confirmed for each community, then, on the achievement of those, they could access a pool of extra money, as a bonus. The point has been made to us that, if you have terrible

things going on in your community, you can get more money than if you are actually doing the right thing and going fairly well. There does not seem to be much incentive for doing an outstanding job. That is probably a bit of a distorted way of thinking. Do you think some sort of program like that would be appropriate? For example, if the smoking rate in a community is 75 per cent and you can get that down to 65 per cent, you then can get some more money. Or it might be increased immunisation, pap smear screening, or STD surveillance and treatment.

Ms Flick—Let me answer your question this way. There is a mentality in the department that they are watched and that they cannot favour any organisation. If you are doing work and you are doing it well, and are putting up good arguments and having good outcomes and being funded to try new things, you can be criticised by other organisations, who say, 'Why are you giving that organisation all this money? This is a silly thing to do.' If you are doing the work, you need to be resourced to do it. If you are not doing the work, then there seems to be not much point.

But there is a mentality of jealousy that goes on about who gets what money—and that seriously needs to be dealt with. It makes it difficult sometimes, even for ourselves, when the government expresses fear that, if they support any more of our initiatives, they will be in trouble from other groups. This needs to be seriously addressed. It is about doing the work, having the outcomes and getting on with it. If you want to get on with it and do it, you have to stop this silly jealousy that does pervade the environment of Aboriginal health.

Dr NELSON—What if the Commonwealth provides $110 million or thereabouts for community controlled health organisations? What if the Commonwealth said there would be an additional $25 million or $30 million available every year for communities who successfully achieve goals and targets that would be regionally set and determined? How would you react to that? Would that be a positive thing?

Ms Flick—I think that happens now. If the department sees that you are getting on with the business and you come back and want to try something new or want to do something more, then it happens. The idea of having a bonus system put in place could be discussed. I would like to think about it a bit more.

Dr NELSON—Whether you are at the bottom, the very worst health status of any Aboriginal community in the country, or whether you are at the top, if you set and achieved your goals, substantiated by a regional Aboriginal and health authority, then you could access more money. That would seem like a reasonable way to go, to me.

Ms Flick—I still think it should be based on needs: what do you need? What are you able to deliver? We are not able to deliver everything, you know. Apunipima is not some magic solution to everything. We have the confidence of the department to take risks and tackle some really hard issues. We operate in a hostile environment most of the time. It is not openly hostile. We are very young—just three years old—just new babies

on the block. We have climbed very quickly in those three years to develop credibility and to have some real input into the region, but I would like to think a bit more about the bonus system. I would hope that, if there were needs in the community, somehow or other the government would resource the work in that area.

Mrs DE-ANNE KELLY—Thank you for your presentation. I am going to ask a very ignorant question. How do you fit into the overall structure, and to whom are you responsible in terms of reporting? From whom do you get your funding? I could not quite work out whether you are federally or state funded and whether you work with the state health department and so on.

Ms Flick—We are none of those things and all of them. Who are we? In 1994, people in Cape York became increasingly concerned about the numbers of their own people who were sick and dying. They held a health summit. The Cape York Land Council and the ATSIC Regional Council funded a big meeting for people to come together and talk about it. As a result of that meeting, people decided to set up their own organisation.

They did not want to run the health services, because that is an enormous task in itself. They wanted an organisation that could lobby the government to provide good services, find the gaps in services, and put pressure on people to address the issues that we have talked about—health worker training, et cetera—in order to see a better outcome. The people then got incorporated under the Aboriginal Incorporations Act, which is a piece of federal legislation. They were funded initially by ATSIC, with a very small amount of money to set it up, and they recruited me. My first job then was to develop a strategic plan and to lobby the federal government. I did that and went off to see Carmen Lawrence and was in tears. The first attempt was not good. But we battled on from there.

Most of our funding is from the federal government. Our overall budget now, after three years, is $1.5 million, which is a lot of money. We do receive some funds from the state government. We have a much better relationship with the state government now. I sit on the Cape District Health Committee. We have only met three times. It is a bit difficult; we need to develop that strategic plan. I sit on the Cairns Base Hospital Ethics Committee. I sit on the Remote Area Issues Committee of the federal government, and I sit on the National Health Advisory Council and the Research Agenda Working Group of the Strategic Development Research Committee.

I could give you the role statement. I do not know whether you have seen this document about what we do. There is a lot of confusion from people about what we actually do, because they expect us to go and give needles to people or something; we do not do that. Through all the committees that I sit on, we try to influence good practice. We are funded by the federal government, and we have a governing committee of our representatives.

CHAIR—Is that via the Department of Health and Family Services?

Ms Flick—Through the Office of Aboriginal and Torres Strait Islander Health Services, a federal department. We are incorporated under the Aboriginal Corporations Act. Our governing committee is made up of one male and one female representative from each community of Cape York, and they meet four times a year to give broad policy advice to me and my staff.

Mrs DE-ANNE KELLY—Thank you, that was in your submission. I just did not know where you fitted into the scheme of things.

Ms Flick—We have audit reports and we are accountable for our funding and we negotiate that funding; but we are accountable to the communities about our outcomes and we produce for them reports, a bi-monthly newsletter and a newspaper that comes out every three months.

Mrs DE-ANNE KELLY—Thank you. Could I move on then to the question of the overall problem? We have had the opportunity to go and visit some of the communities in the Torres Strait and some of those in Cape York, which has been very helpful. It seems to me that the message that we have been getting is that the problem is not just a clinical one but really a whole-of-life problem: everything seems to be a difficulty. As Dr Nelson said, there are people who are trained but have no prospect of ever having any meaningful paid work. There is ready access to alcohol for people who have nothing else to do with their lives. There is perhaps a lack of knowledge about basic approaches to health and hygiene and nutrition and caring for children.

There appear to be two problems as a result of that whole-of-life difficulty that the communities face: there are immediate problems that really need to be addressed now. In one of the communities, we were told that there were 31 of their children failing to thrive—for a variety of reasons, but it appeared that alcohol was a major difficulty. This came from some of the elderly ladies in the community who had formed a group. We were told that the parents were spending most of their money on alcohol and were then finding themselves incapable of caring for their children. Those children—obviously, you, being trained, would know this better than I—really face a very dismal future if they are not being nourished. That is a real and immediate problem for them: in five years time, they are going to be five years older and will be finding it difficult at school if their growth and their mental capacity have been impaired.

But then there is also the long-term planning problem of what do you do with a community that needs work, that wants something to do, that wants to improve their housing and that wants to address better education for their children? There seem to be two problems and there does not seem to be, to my way of thinking anyway, anything immediate being done about the immediate problems and any long-term planning for a more whole-of-life approach to solving this. I am sorry to take so long, but I am leading up to a question.

You mentioned that you felt that consultation was not always useful, and I think

the instance that you gave about going to the Cairns hospital to talk about immunisation was very valid. There are certain things you simply do not have to consult about. But the communities have constantly been telling us that they really want to have charge of their own destiny. There are things in their immediate community that they would like to spend money on, that would solve some of those immediate problems.

One of them said to us, with regard to the problem of alcohol, that if they could just have an alcohol free area and a safe house for children to go to for a period of time—and this was their solution and certainly not ours—to remove the children from their families for a short period of time, in the care of some of the responsible older citizens, that would really assist. In that way, consultation has a place, because obviously they have come up with solutions themselves, which are quite innovative in some cases.

So in a way I challenge your question about consultation. If what you are meaning is constantly going back and doing reports year after year that get shelved and never acted on, then that is very poor. But obviously they want a great deal more autonomy. Could you comment on what you see needs to be done about the immediate problems now, particularly with the children failing to thrive? What do you see needs to be done about long-term planning? How do we put decision making and responsibility in funding into the hands of the communities, for the solutions that they have?

Ms Flick—My comment about consultation was about the provision of medical services. There are various things that need to be done. There are things that we have some control over and things we do not have any control over. We insist that the clinics deliver good medicine, and I do not think that there needs to be consultation about that. They just need to get on with the job. The issues about social things in the community are matters for community councils that we do not have any control over. Community councils are representative. They have elections every three years, and those groups need to negotiate with the community councils about safe housing. If we are asked to write support letters, we can; but, as an outside organisation, we do not get involved in that internal community process.

The third thing is taking a regional approach about trying to deal with alcohol; but those are the hard, long-term things. These things have been with us for a long time, and they are going to take a long time to change. We know the children are not being fed. We know there is a lot of violence in the communities. Doug Gladman will report to you shortly. We know that thing is happening. That is a discussion that needs to take place with the community councils.

Mrs DE-ANNE KELLY—Yes. I accept your saying that nothing can go forward without them having decided what it is that they need to do. The responsibility and decision making should rest with them. But they say to us that they do not have the funds to implement their changes. I do not mean this as a criticism, but we did receive some criticism of your organisation. I take on board the fact that you have only been there for three years, and it is always easier to blame someone else up the ladder. One community

said that, with 17 staff here in Cairns, if only one of those staff had been sent to their community to assist with drug and alcohol teaching or training, that would have been of great assistance. Let me quote, if you do not mind: 'The money never gets to the grassroots. The money goes to Cairns, to the Cape York Health Council, and stays there.' But you do not allocate funding, as I understand it: is that correct?

Ms Flick—We do not allocate funding. We are funded by the federal government as a multidisciplinary organisation to take a regional approach to all of these issues. The state government funds local community councils and local clinics, and that is where people should be requesting their funding from.

Mrs DE-ANNE KELLY—Do you make recommendations to state and federal governments on where funds should be allocated with regard to housing? Or is it purely the clinical delivery?

Ms Flick—No, we can make recommendations about anything. We have certainly made recommendations about housing. We are involved in a process of trying to address the alcohol problem, but that ultimately has to be addressed from inside the community. There is nothing that we can impose on them. We cannot shut down the canteens; we cannot do those things.

Ms Staples—Can I add something? It is really important to make it clear that we are not involved in any of the regular processes in which government allocates money for housing, et cetera. Our involvement in making recommendations is where we have seen that there may be a problem. We will do the research, come up with a report showing needs and then make recommendations as a result of that overall policy picture that we have found. We are not involved that closely with government. We are a community organisation which is doing its policy work outside.

Ms Flick—I also think that we would need to discuss whether putting an alcohol worker into a community would address their ongoing problems. It has not been put to us that that is what they would like. If it were put to us, I would certainly take it on board to lobby for a position for them, but I often do not think that the community understands what our role is. The traditional role is that Aboriginal health services deliver health services, but we do not; we lobby for improved health services. We try not to deliver. We have been piloting a couple of mental health programs, but I do not want to get into service delivery. I think that there is enough of a job outside of that, to lobby for better services. There is a community expectation that we will do something, but we are not set up to do it, and I think that is what you are getting complaints about.

Dr NELSON—To paraphrase the criticism that Mrs Kelly is conveying, it was to the effect that 'They have 17 staff and they get a lot of money to employ these people. Instead of giving them the money, they should just give the community the money directly and we will employ somebody to look after drug and alcohol issues.' That was the context of their criticism.

Ms Flick—I have heard this before.

Dr NELSON—But also the same community made again another thematic comment to the effect that 'We are so busy working, trying to provide services in health, education and housing programs et cetera, we need somebody full-time just to fill in government applications. We know that there are funding programs available out there at the state and Commonwealth level, but we do not know where they all exist. We do not have the time to write these submissions.' Is that perhaps a role that Apunipima should be doing?

Ms Flick—Absolutely. They are very welcome to contact us to help to identify those sources of funding. It is one thing that we do for a lot of communities. I know the particular one that you are talking about, by the way, and they are very welcome to talk to us about these things.

Mrs DE-ANNE KELLY—This is not meant as a criticism at all, but, having seen the situation there, we have all been rather touched by it. How often do you and your committee go out to the communities? How many times a year?

Ms Flick—Our field staff are in the communities most of the time. The community relations officer would spend eight months out of 12 in the communities. He is up at Hopevale at the moment. There are two other staff up the top at the moment. We spend a lot of time in the communities. We have 17 communities that we try and service.

We will never change things while we are in the community all the time. If I am in Kowanyama every day, nothing will change. It is my work at a federal and state level about policy that will change what happens on the ground. So there is no point in us being in the communities every day where people can see us, because what can we do? We do not deliver the services. We can fill in some submissions for people, but they can telephone us to do that. Our job is to be creative and innovative and think about how we can force government to deliver these services.

It is not our job to deliver them, it is the government's. The people need to be clear about that. The government has a responsibility to work with them to deliver services. They also have a responsibility to their own community to ensure that they protect the lives of all those people who live in the communities. So it is not our job to do that. We would never change anything, but we do have field staff who are in the community.

Mrs DE-ANNE KELLY—In your submission you mentioned a lack of sufficient funding. In what areas do you see a lack of funding?

Ms Flick—I see a real need for proper care of aged people, and hopefully we will get some money from ATSIC shortly to do a needs survey and we will have a document then to lobby government as we enter the UN Year of the Aged. A lot of people are being

sent away to old people's homes, and some of them last a month or two and die because they do not want to be sent away. So that whole area needs to be looked at. Funding will probably need to be made available for them to stay and be taken care of closer to their homes.

There is obviously a need for renal dialysis to be made available closer to people in the communities. That is a high cost item. If you look at the projections provided by Dr Tim Furlong, the renal doctor at the hospital, you will see that we expect a massive increase in people requiring haemodialysis and peritoneal dialysis in the next few years. So the government needs to respond to that. The cost of bringing people down to visit the hospital three or four times a week to have dialysis is very high. There is not unlimited accommodation in Cairns—they usually bring their whole family down with them. There is then a cut between the children and their language and their culture. So that is a high cost item for us, to get renal dialysis out into the communities.

There need to be more programs of support in cases of violence against women and children in the communities; there needs to be funding for that to happen. People have identified the homelands movement as another area which is a high cost item, but cost-effective in terms of what is being spent on taking care of people who live in the communities as compared with those who have moved back onto their homelands. We started negotiations with the army about trying to work with them to build airstrips so that we can have evacuations from homelands. Those are all high cost items. We have got Japanese encephalitis now detected on the Cape. If people decide that a vaccine is appropriate, then that is a high cost item.

CHAIR—I was just wondering about your thrust on having a large regional strategy. That is what government look for—advice on implementing what you are saying it should implement but in a way that is relevant to the region. But even that needs to be flexible, doesn't it? One of the things I have noticed is just how different each community is. Each has got particularly different problems from another one, because of geography and for a whole range of other reasons. How are you building that kind of flexibility into an overall regional structure?

Ms Flick—Aboriginal people have always lived regionally. We have not always lived in states or communities or towns, we have always related to each other regionally. That is why the Kimberley people relate to each other—that is where the law travels, that is where things happen. The Cape people have related to each other regionally, the Centre people relate to each other regionally. So it does make sense to have a regional organisation. It has untold difficulties. This is not an easy job. It is not an easy job to try and bring about change and then have to respond to why we do not give them one of our workers to go and work in a community to address alcohol. We are trying to get dialysis machines into communities, we are trying to work with a hospital, we are trying to screen research applications so that people are not taken advantage of, we are trying to ensure that federal and state government policy is implemented on the ground.

That is the kind of regional approach that I think does work but it does not make it easy. This is not an easy task at all but I think it is a sensible one. We have an alliance with the Torres Strait. There is CATSA, the Cape and Torres Strait Alliance, where we work on issues together. We have had a joint suicide summit recently. The meeting at Pajinka was about the way in which we wanted to work together to lobby government as a region.

We now have JE; that is in the Torres Strait and on the Cape, so these things do travel. We have a lot of movement between the two regions, and that means communicable diseases that are crossing the border. We have a whole thing that comes down through Papua New Guinea, people that come onto the Torres Strait. So you need to take a regional approach, I believe. But I am not saying that this is easy. This is not an easy task.

CHAIR—Neither is the one before the committee.

Mr ALLAN MORRIS—You have been helpful in clarifying that, because there has been a lot of confusion in our minds as to what your role was. I would like to go back to something that Dr Nelson said, to make it very clear because I think it may be slightly misleading. Your submission says that it does not matter who provides a service, whether it is indigenous or non-indigenous, but you are, from recollection, quite strongly of the view that the ownership of the service is preferably locally determined. I have been trying to find the quote. I think what you were saying was that it is academic who the actual provider is, but the ownership of how the provision is made should be locally determined or influenced, and locally empowered.

Ms Flick—Yes.

CHAIR—I like the word ‘empowerment’ there. ‘Ownership’ has other connotations, but ‘empowerment’ allows a better definition.

Mr ALLAN MORRIS—In that context, what has come through from all the communities, not just here but in other parts of Australia as well, is this complication of our constitutional and state responsibilities, and the interrelationships between people working in the communities—the teachers, the police, the health workers. We hear that health workers stay in the clinics in some cases; they do not go outside. That may be exaggerated. The schools do not necessarily talk to different people. There is not necessarily a whole of life approach, because they report to their superiors up the line. We then hear of teachers who are conscripted, who do not want to be there and who leave as soon as they can. It was encouraging, for example, at Kowanyama, that amongst themselves they have managed to overcome some of those barriers between state departments.

Is there any serious discussion taking place now in terms of your strategies or your planning with the state government as a whole of government approach, to see if you can

actually establish a whole of government approach within the communities, so we can actually integrate it all? That is what they seem to be asking for. What they have all been saying to us is, 'If we could actually pull together all the things that are here, then we could probably do a lot better.' Is that being talked about?

Ms Flick—That has been talked about locally. I might say at the outset that I have been involved in this work for 28 years, most of it in rural and remote areas, so I do have some experience. I do not back away from my comments about not really caring who delivers the services so long as they are well done. But you need to lock in either the ministers or the director-generals. There is no point in talking to local staff about how to have a whole of government approach to a community, or to a project in a community. That is where the difficulty seems to be.

CHAIR—I think what Mr Morris is suggesting is that your lobbying might be done at a government level. Rather than just the health sector, you need the education sector as well, to get those two heads together. If the school needs some resourcing to run a nutrition program, that is another way that—

Ms Flick—Yes, we have been doing some of that work. We have been working with some of the schools. We have been working with some of the police. We have a joint project at one community with the police.

Mr ALLAN MORRIS—I mean at the state government level, the government level. I do not doubt that you yourselves, amongst your own regional community and department officials, have good relationships. But, as you said, you have to get to the top levels. Unless there is a whole of government approach coming down the line, it seems that you are dependent on the personalities.

Ms Flick—We did get to the top level before there was a change of government in Queensland. Then there was a change of government and, really, we have not pursued it.

Mr ALLAN MORRIS—We are trying to be bipartisan here in the sense that we are just trying to find an answer. It seems that from the point of view of the three major parties the whole of life approach and the whole of government approach are almost essential if you are actually going to make any program. Do you have any proposals? Have you put anything forward on how that could work, what kind of mechanisms could do it, what kind of machinery could actually make that work?

Ms Staples—Barbara has asked me to make a comment. What comes to mind here is that the Queensland government has been espousing a whole of government approach generally across the board. We have not seen anything on the ground in Cape York, except one example I have mentioned, where they tried to take a whole of government approach with the state minister recognising that there was an enormous need in relation to youth suicide. He put out $1 million to be shared across the state government departments.

Instead of those government departments sitting down and taking that whole of government approach, they could not get away from the old rivalries. Instead they divided it up. We had one government department come to us that had $75,000 to do something about youth suicide, so they were going to put in four workers for six months. That is totally useless. It seems that, even where there is the theory of whole of government approach, the departments are falling down. Aboriginal people have been saying for decades that this is required. They know what you have seen about the lack of coordination.

Mr ALLAN MORRIS—The state government's submission to us did indicate a whole of government approach. We have talked to them at government level and talked at community level and are now somewhere in the middle saying, 'How do we make that happen?' You get a *Hansard* of the transcript of today. Perhaps after today you might have some thoughts to offer and add to your evidence, because some of these questions will come out of nowhere and it is unfair to expect an instant answer. With hindsight, you may be able to offer some further comments.

The remote area medical benefits scheme has been a bit confusing for us as well. It is certainly one that I agree with. I agree with the idea of bulk billing for general medical services. The scheme is only fairly new. How is it working? You are part of the advisory group on that. Is it getting to the stage where you think it will make a difference, in terms of funding and so on, or is it going to be simply extra funds for state health which they then determine by their own parameters?

Ms Flick—No, state health are not going to decide what to do about that money. A group of organisations are monitoring that process. It has always been difficult to get doctors to go to some of these remote regions. One of the ways we thought it would happen would be to encourage them to come and live in Cairns and increase the number of flying doctors going into the communities. That has happened and there is an increase which should allow for better management of chronic diseases. It should be a much more sustainable process in terms of the doctors getting to know their patients by seeing them more regularly. People will be seen and treated in a much more efficient manner. I think that the outcome, in the end, should be good once it settles down.

Mr ALLAN MORRIS—The fear in the past has been that the state governments would simply pull money out of any extra money that came in. Is there no sign of that yet in your monitoring?

Ms Flick—No, they will not be allowed to pull out money. It is being managed by a group of us and we would certainly—

Mr ALLAN MORRIS—No, the extra money comes into the Medicare bulk billing, but then the state budget could be reduced at the same time. There has always been a concern about access to Medicare providing access to cost shifting. Are you seeing any signs of that?

Ms Flick—Not at the present, but we would certainly be alert for that kind of cost shifting exercise.

Mr ALLAN MORRIS—I guess you are watching it pretty closely and we should all be doing so. I go slightly further. The complications with the Commonwealth programs, particularly in aged care and in some of the other programs, are departmentally based. State governments cannot access things, for example, like HACC programs. They could be accessed if there was a regional health service with its own autonomy but a state department cannot.

It seems to me that one of the complications we have with the far north is that your communities are relatively small and, therefore, you cannot have the not for profit providers or the community organisations to provide access, so you get almost a fragmentation by force. When we were talking to some of the communities, they were looking for hostel or nursing home care and, unless the local council applies for it, it cannot happen. If the local council applies, they cannot use the nurses because the nurses work for the state government. You have almost a structural impediment to integrating whole of health servicing, particularly with aged care.

I suspect you will also find that some of the youth programs and others which are normal Commonwealth mainstream programs, which should be available to you, are not available simply because of that impediment. Have you canvassed with the state government whether there is any way they could structure themselves so your communities could get access to them? It has happened with Medicare already, so that is an improvement. The aged care ones certainly disturbed all of us; I think we all found a real weakness in the access to aged care support and also disability accommodation. In Bamaga they got some housing, which was a major breakthrough. But those normal programs which are available for frail aged and people with disabilities, and some of the youth programs, technically cannot be assessed by a state department, therefore your people cannot get access because the provider is a state department. Maybe you could take this on notice.

Ms Flick—That is an issue for the state and Commonwealth governments. I do not see how it could possibly influence that.

Mr ALLAN MORRIS—It is an issue for them, but the advocacy—

Ms Flick—It has been identified for a long time. That was identified in the royal commission report. It has been identified in other reports. So there needs to be—

Mr ALLAN MORRIS—What I am looking for is advocacy of how it could be done.

CHAIR—You are looking for wisdom.

Ms Flick—We will have a think about that.

Mr ALLAN MORRIS—I think we all recognise that the problem is there. Maybe you could take it on notice and think of some ideas as to how it could be done.

Ms Flick—We would be interested to look at that.

Mr ALLAN MORRIS—For example, would it be possible for the local council to contract out some of the work to the health clinic so they could get access to part of the nurses, not necessarily all the nursing staff? At the moment the nursing staff cannot take on community aged care packages or nursing home capacity because they are state government employees. It may be that the local council could take on the program and contract part of the work to the health clinic. I am looking for ideas as to how we can break that impasse. We know it is there. People are grappling with it but there is a lot of uncertainty about the programs themselves.

Ms Flick—We will take a look at that.

CHAIR—You could take that one on notice.

Ms Flick—Yes.

Mr ALLAN MORRIS—Perhaps when you read the *Hansard* you might be able give us some ideas. We are looking for ideas from people who are experienced in the field.

CHAIR—Twenty-eight years of wisdom.

Mr ALLAN MORRIS—We do not have the answers; like you, we have the questions. Another thing that disturbed me, when we went around and talked to the local councils and so on, was that the environmental health water testing seemed to be predominantly or solely for bacterial testing, although at Kowanyama, or it might have been at Pormpuraaw, they were saying that DPI came through and tested for salt and mineralisation. But it seemed the water testing was seen to be simply about bacterial testing and not necessarily mineralisation or salt, which can be equally damaging over the long term. Is there any program that you know of that actually does test for that on a regular basis across the state?

Ms Staples—We have only very recently—in the last month or so—put on an environmental health officer. She has identified that that is a problem. My recollection of the briefing she gave me was that testing appeared to be fairly random and it certainly was not coordinated with different groups. As you would have picked up, it indirectly becomes a health problem because the level of some of those other things in the water means that you have enormous deterioration immediately with any sort of infrastructure you put in relating to water. It is not an area on which I can comment any further, except that we

have identified very recently that that is an area that needs to be looked at.

Mr ALLAN MORRIS—If your environment officer has any suggestions to put forward as to what we can recommend to governments, we would like to hear that. We will recommend to the parliament; whether they ignore us or not is another issue. If you have ideas you think are worthy of consideration about anything we are asking today, please let us know. You can see where we are coming from and what we are trying to do. We are trying to give government your ideas, effectively, because you are more experienced than we are.

CHAIR—We also plan to write to the Queensland government. There is a whole series of questions and that is one of them. So we can get all this information coming from different directions and help drive it before we actually table a formal report.

Mr ALLAN MORRIS—We have been spending a fair bit of time on education, particularly of health workers and so on, and we will go into that further. The general theme was that people would like to see better trained indigenous workers, who actually understand the culture, and certainly better trained people overall. One of the shortcomings seems to be that we have schools, we have councils and we have health workers, but we do not seem to have anybody whose job is to help them liaise, so the teachers liaise in their spare time, the nurses liaise in their spare time, and it depends on the personalities and the shift in staff.

There does not appear to be any particular role for people to link the various organisations together. I guess you would call them community development officers, wouldn't you, in your sense? But if they are there they work for the council and they are seen to be part of that mob. There seems to be that vertical separation, from the state departments right down. Is there a need to have someone who is seen to be owned by the total community whose job is to help make sure the barriers are broken down within the communities—a liaison function of some form? Is that a way to try to overcome that, or is there another way?

Ms Flick—I do not know. That really is an internal matter for communities themselves about how they need to relate. What we have—

Mr ALLAN MORRIS—The thing is who would pay for it—whose budget? That is a complication.

Ms Flick—What we have encouraged is the setting up of health action groups, which include representatives from all of those places, that come together to talk across the board. There is a very successful one at Wujal Wujal. They meet regularly once a month. There is the clinic staff, the council staff, the police.

Mr ALLAN MORRIS—That is item 6?

Ms Flick—Yes.

Mr ALLAN MORRIS—How is that going?

Ms Flick—It is very good. They come together and talk about issues across the board.

Mr ALLAN MORRIS—Can you give us more information about that subsequently?

Ms Flick—Of course.

Mr ALLAN MORRIS—Item 6 mentions the service to the two Cape communities in relation to emotional, social health and wellbeing. That is the kind of thing I am talking about; I had noted that. If that is relevant it may be useful as a model for us to pick up on.

It was interesting to talk to people about the homelands movement and the outstations. That appeared to be very productive in a broad community sense. We picked up that there may well be a conflict there with schooling, that in some cases the whole family may go to the outstation for a week or two which means the children go for a week or two. There seemed to be therefore a potential conflict between keeping the children in school to educate them and strengthening their cultural connections. Is there an answer to that?

Ms Flick—There is a remote area teacher education program that some people in the Cape are enrolled in. The people who are going back to their homelands are identifying their own people who will go into that course and hopefully set up a school.

There is a plan that I would like to get to you about the Port Stewart community. This is a community that was forcibly removed by government in the 1960s. Their houses were burnt down and they were moved to Bamaga; they were told they were going to have some medical tests. They have taken 30 years to come back home. Many times they set off and were rounded up by the police and taken back up north, but they have come home.

The health council and land council and Balkanu and ATSIC have committed ourselves to the re-establishment of this group—there are 60 to 100 people living in Port Stewart. They have had a planning study done by the Centre for Appropriate Technology that was commissioned by us. So there is good advice, there is planning, and roadworks, sewerage and all these sorts of things are included in the report. We had a meeting with government agencies to implement the recommendations from this report and to try and secure funding to build. The main thing they wanted to do was to put a building in the middle of the community which would hold a store, a school and the clinic. We are still trying to get that much, so this is not easy business.

Mr ALLAN MORRIS—You have a report about that?

Ms Flick—We have the full report with all the recommendations, and we are wondering which government department will come forward and say that they can fund part of it or all of it. So even though we do this planning—it is sound planning, it is good planning—it is hard then to have the recommendations implemented because the government is not coming to the table.

Mr ALLAN MORRIS—Is there a precis of that history? I am interested in your comments. Can we have that?

Ms Flick—Of course you may.

Mr ALLAN MORRIS—We do not have it yet, do we?

Ms Flick—No, but we can supply that to you today. If you can give us the answers about who is going to implement that, this man and his family will be really excited.

Mr ALLAN MORRIS—I guess in a sense we are trying to pick your brains, because we think the experience and wisdom is in the communities and if we can just try and marshal it—

Ms Flick—This is the hard work, this is the hard stuff that we do. We get to a certain stage, we do proper planning, we do scientific research, and then the next hard part is lobbying to get it happening. That is why we do not have an alcohol—

Mr ALLAN MORRIS—Hopefully, our report will come up with some proposals—

Ms Flick—That is why I am doing 2½ jobs.

Mr ALLAN MORRIS—which will be actionable and hopefully we will give you something to work with that may be constructive. But the better sourced we are in terms of our understanding and the better advice we get from you, the better we can report. Puggy, did you have anything you wanted to add?

Mr Hunter—I would just say, hearing what Barbara is saying, that what she keeps saying is old news to us. Action, I suppose, speaks louder than words.

Ms Flick—May I just make a comment before we leave this? I want to put it on record that the comments that I have made are very general. In fact, some good things are happening and there are some very talented and committed people out there. So the comments I am making are very general.

CHAIR—Your submission has made that clear and we are encouraged by that. There are some good things happening but it is not happening fast enough, that is fairly clear. My proposal, colleagues, is to break for refreshments.

I just have one more comment. In your submission, on page 22, you referred to the results of a training strategy which would have been available in early 1998. I am wondering if that is completed yet. It could be something that we would find useful. It is a rural health support education training grant.

Ms Staples—Can you give me a little bit more detail?

CHAIR—It says:

Under a Commonwealth Rural Health Support, Education and Training Grant (RHSET), Apunipima, the Rural Health Training Unit, Cairns Sexual Health unit, and Cairns District Health Service are jointly developing a culturally appropriate training package for sexual health workers . . .

You made reference to it in your opening statement. If the report has been done, we would like to see it; if it is being done, as soon as it is ready that would be useful.

Ms Flick—The curriculum is being developed by the Rural Health Training Unit in consultation with us.

CHAIR—It says that it is an assessment report.

Ms Flick—We are already doing the sexual health worker training. We are already doing it.

CHAIR—In the submission it says:

Initial results from the program will be available in early 1998.

That is at page 22. If those results are in some form, we would like to see them. I suppose we have been sending you hints that making submissions to our committee is one way that you could lobby very effectively. We are determined on this, in a bipartisan way, to take the politics out of it and get better progress. It would be very helpful to you to do some lobbying through our committee.

Mr ALLAN MORRIS—This is not the end of your submissions?

Ms Flick—No.

Mr ALLAN MORRIS—You can send us some more stuff.

Ms Flick—Let me make it quite clear to you that this really is a difficult task, that we have a courageous organisation that is committed to pushing the limits and that we

have very committed staff. We are not going to save the world and we are not going to please everybody, but I want to make it very clear that the work we do, I believe, is very useful, given my own experience, and will matter in the end. But it will take a long time.

CHAIR—I thank you very much for your time and effort and we look forward to further contact with you.

Sitting suspended from 10.39 a.m. to 10.53 a.m.

GLADMAN, Mr Douglas James, 200 Toogood Road, Bayview Heights, Queensland 4868

CHAIR—Welcome. In what capacity do you appear today?

Mr Gladman—As a private citizen. I work with the Tropical Public Health Unit on injury prevention, and I appear before you in relation to the research I have undertaken over the last two years throughout the Cape into aspects of health that include a number of issues.

CHAIR—Before proceeding I need to point out that, whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the House of Representatives itself. Any deliberate misleading of the committee might therefore be regarded as contempt of the parliament, but it also offers to you parliamentary privilege so you can be fearless in the truth which you would like to place before us today.

We have a submission from you, but I understand that you wish to speak to certain charts and information. If there is any additional information that you are going to use on the overhead presentation, highlight that as we go so we can have it incorporated.

Mr Gladman—My presentation will be somewhat different from the preceding presentation in that I intend to take you to the coalface to identify the issues as they really are. I want you to know what the people themselves—not their representatives—are saying. I also want to identify the real issues, both statistically and qualitatively. The last couple of years I have spent living in the Cape with the people. These are the issues that are of grave concern to me and they are through my eyes and the eyes of the people that I have been associated with.

Overhead transparencies were then shown—

I have refined it to three issues today. Most of the material I will be presenting will be in relation to the issues associated with alcohol, but I would also like to address the other two issues. I am desperate to ensure that the other two issues are recorded because a number of things have surfaced as a result of my research.

Firstly, I would like to talk about tobacco. I will be brief on this but I need to address it. I get a lot of research work in the Cape and I would like to put on record that the submissions in relation to the statistics given by Barbara Flick are very well founded. The statistics coming out of the Cape are useless and should not be used. The past years of statistical data should be used with a lot of scepticism. When I did my work in the Cape, I found that, in some instances, the percentage of illnesses recorded at some clinics measured up to 160 per cent. In some instances, they were copied from the month before, and basically it was very dangerous material.

In regard to the hospital segregation data which is mostly used in health circles, I have grave reservations about using this data in the Cape. I have seen an awful lot of people going home from clinics and, basically, if these people were in a bigger or more urban location, they would normally be kept in overnight and recorded as a hospitalisation.

CHAIR—To interrupt you, are you saying that the statistics are unreliable? Do they overstate the situation or understate it?

Mr Gladman—They understate it. The unreliability of the information is compounded for a number of reasons. The process of filling out clinical register forms is bad. The forms were badly designed. I understand there are processes in place to overcome this, but I am not yet convinced.

The only way I could obtain this information was through a clinical file audit for a whole year in a community. While nurses were doing a very poor job with clinical registers, they were doing a wonderful job with clinical files. This research is based on the facts from clinical files of every incident that occurred in a community for a period of one year. It is also based on quality material obtained from five other communities, where I sat down with cases of serious incidents, had a look at all the issues around those incidents and recorded them. That included talking to the communities themselves, the families, the nurses and everyone involved. It included two successful suicides, one unsuccessful suicide and an attempted murder. It included falling out of mango trees et cetera—all types of injuries. It also included focus groups and elders and visits to prisons and rehabilitation farms. The research was extensive.

Briefly in regard to tobacco, in one community I found that one-fifth of the store's takings—the only store in the community—was tobacco. The community of 649 people were spending $5,000 a week on tobacco, nearly eight per cent of their total income—7.4 per cent from memory. I thought it would be advantageous to have a look at tobacco. There are five SLAs in Queensland—statistical local areas—where the number of Aboriginal people actually exceed 50 per cent. I looked at lung cancer in those five SLAs as opposed to the rest of Queensland.

I do not want to dwell too long on this, but this is what I have found. That graph is pretty well self-explanatory. The top one relates to males and the two lines that seem to be running together are actually what is happening over North Queensland and Queensland itself. The black line is what is happening with lung cancer in those five SLAs that have more than 50 per cent Aboriginal people. The facts are rather frightening over the last few years, since the early 1980s, for the women in particular. The graph at the bottom shows the women; the men have been all over the place. These are not high numbers by the way, but they are dramatic. I will get away from tobacco now—

CHAIR—Is that figure in your report?

Mr Gladman—No, that is not in my report. I pulled out lung cancer purely

because it is topical and there are also a lot of other issues where the same trend is being shown.

CHAIR—Is it in somebody's report?

Mr Gladman—I have no idea. I can make it available to you without any problem.

CHAIR—That is what I am saying. If you could find a way to do that, I would appreciate it. Is that last figure one of them?

Mr Gladman—Yes. I was using this purely to hammer home to this committee that tobacco is an issue and that there is too much money being spent on tobacco. We have too much of the community's income going on tobacco and other issues that should be going to the children.

In relation to age specific injuries in the community, this is what I came up with. I will not bore you too much with these graphs. To give you an idea, I could not even put the rates per 1,000. We had to come back to rates per 100. The ages are between 16 and 44. It cuts off like a knife at 44 for some reason. I presume this is related to the introduction of alcohol in the early stages but I am not sure of that. It is dramatic when you look at those rates per 100; we are used to running in rates per 1,000. They are injuries to people in the communities.

If we look at where injury sits in relation to the community, this is what we come up with. For the record, I can find no relevance between the times of the year, the wet and the dry season and remoteness in relation to volatility in the communities. I looked at different years and the evacuation rates from the communities are all over the place. What is interesting is that the rate stays about the same. More than 34 per cent of all actual evacuations out of the Cape are from injury. That includes, of course, all the women who have babies, who are evacuated. The total percentage of evacuation is, in fact, 34 per cent, which is extremely high and a big cost on the community—and all, of course, preventable.

If we look at the overall injuries of what is happening here, the frightening part is that the biggest single injury in the Cape is head injury. Upper limb injuries and so on drop down. The only bright light in all of this material is the fact that burns were quite low and I have no knowledge as to why.

I would like to move on to what I consider the most important aspect of health in the community and this is alcohol. These factors show what is happening. Unlike the Australian statistics which show that 47 per cent of Aboriginal people are regularly drinking, in communities in the Cape the figure is as high as 90 per cent and, in this particular community, 93 per cent. This concerns me because the recent review on drug abuse suggested that, because of the higher number of non-drinkers than drinkers in communities, regulation of alcohol would be simple. This is not possible in these

communities. We have 93 per cent of the community regularly drinking and they are spending 40 per cent of their income on legal alcohol—I have not made any allowances for sly grog—and 93 per cent of the community over the age of 16 are drinking almost 10 litres of full-strength beer every week. They are doing that over three days of the week. It is an appalling situation.

I am throwing this at you now because I have had recent discussions with Dr Richard Hazelwood, the paediatrician in these communities. He has already diagnosed FAS in the communities. He considers it to be the tip of an iceberg; we have major problems with foetal alcohol syndrome coming through in the children at the moment. He has grave concerns that we may even have a large part of a generational problem.

Dr NELSON—In the 93 per cent of the community who are drinking 9.77 litres of beer, are we talking about male and female?

Mr Gladman—Yes. I did not break them down. I could have kept going but my main focus was on identifying the causal effects of injury and the influence of alcohol.

Dr NELSON—You included in that those who would drink, say, one glass of beer a week, as well as those who might drink three cases?

Mr Gladman—No. What happened was that to obtain that information there were nine health workers and two trainee health workers, who were teenagers. We sat around a table and discussed every person off the computer out of the health clinic. We attained from that particular discussion that the person who was a transient person in the community was not included. We used the people who lived in the community and who went every week to the canteen and drank regularly. We did not include the person who has a drink on birthdays, at Christmas or whatever the case may be.

CHAIR—That is only a can a day, roughly. That is low.

Mr Gladman—It is close to 30 cans a week.

Dr NELSON—That was cross-correlated with the official sales of alcohol through the canteen, I presume.

Mr Gladman—Yes. I would like to get back on to the illegal sales. I do not know if you understand the sly grog principle, but when you have 90 per cent of the community drinking a lot of them are addicted. The addiction is such that, when the money runs out, if they are offered a can at $10 a can—this does happen regularly—they take the can. It is on tick. Moselle, which a lot of my case studies have shown was used in violent outcomes that were not linked to what was sold at the canteen, is often in the community. This is $50 a cask. A bottle of rum is around $100. But what happens is that when his CDEP payment or her family allowance or his pension arrives, that sly grog guy or girl is there to take the money off them as it arrives. The sufferers are, as you mentioned earlier, the

children. This is the real world. This is happening. I have seen it happen and I know it happens. I have made no allowances in that 40. We are looking at close to 50 per cent with cigarettes and alcohol, and I have made no allowances for the sly grog in that submission.

When we had a look at the alcohol and how much was involved in injuries, this is what we found. We found more than half. That is very clearly understated, for a number of reasons. The understatement could be identified by saying that the people may come in two days after with an injury and they may have sobered up in the interim. It could well be that the assailant was under the influence of alcohol and the person who sustained the injury was not. It could in fact result in the nurse not identifying that the person was affected with alcohol.

When you look at what has happened with the injuries with alcohol, it is appalling. You find that the head injuries among women are far too high. They are not only high, they are scandalous. Upper limb injuries among males were very high but a lot of those were from fighting and so forth. In fact, there were 43 tooth-knuckle injuries in there. Those tooth-knuckle injuries are very dangerous injuries. There were five evacuations and one amputation in that community from tooth-knuckle injuries.

CHAIR—I am trying to follow your report. What figure number is that?

Mr Gladman—I would have to refer to it but it would be in the alcohol section. There are a lot of graphs in between what I am presenting here, that is my only problem. I would have to go back to my report. If you gave me access to the report I could tell you where I am up to.

CHAIR—I will try and follow.

Mr Gladman—Going into the causal effects of injury, looking at why this is happening, why they are having accidents, what the cause of it all is, this is what I found. I found that without alcohol, when no alcohol is involved, it is like any other community. This is less than half the injuries. Assault by fists, objects, knives and rape is there but it is not excessive; injuries not otherwise specified—in other words, we were not really sure what caused them—are high; falls, including sport, coming all the way down; transport accidents, too high of course for a small community. This is a community of 649 people, by the way. We came all the way down, with burns quite low, and with suicide and self-inflicted, fortunately, although there, quite low without alcohol.

When we look at alcohol, suddenly this is what we find. This is more than half the injuries which occur in the communities, which is more than a third of your evacuations. We find that 74 per cent of all those injuries are from person to-person conflict. There is an awful lot of anger. When you peel away the flash health centres and everything, peel it all away and have a look at the real world in there, there are a lot of people that are hurt, that are angry, that are needy. We will go more into that as we go on, but we see there

that that is a very sad situation.

When we put those two graphs together—in other words, with and without alcohol—an interesting situation arises. I have no explanation for this. This is what we find. The blue is no alcohol. The red is with alcohol. We find that, except for assault and suicide, you are less likely to have an accident in a community if you are blind drunk than if you are sober. So we come to the big issue there. It is very easy to say, 'Ha, we can stop a lot of this happening. All we have got to do is stop them fighting. That is all we have got to do: be at the canteen and when they start to fight, stop them.' That is what would normally be the solution that some might consider, and I will go into that a bit further on.

If we look at what day of the week it is happening, this is what we find: when there is no alcohol involved, that is when we find our accidents happening, more on Wednesday. It had me beat for some months, this Wednesday business. Why without alcohol would it happen more on Wednesday? It was the day the flying doctor arrives, and some people held off to go to the doctor, but it is a simple explanation. But when alcohol is involved, this is what we find. This is a very important graph, when you have a look at the context of the next graph I am going to show you. On Monday, Tuesday, Wednesday they have a little; on Thursday they have quite a high amount; on Friday and Saturday most of the accidents and injuries occur. The volatility, by the way, which is associated with that and which affects family breakdown, et cetera, is also happening during those periods.

This is a graph that is not in the report, but one that I should make you well aware of. I have done two different ones of these too, by the way, one for pensions, which is somewhat different from this one for family allowance. I have a strong suspicion that less pension money is going to the canteen than family allowance, which simply means that the older people in the community are looking after kids while perhaps a lot of the money, through temptation, is going into the canteen from young mothers, et cetera, or under pressure from their spouses or boyfriends.

We have a look at the money there, then we have a look at the canteen income in the second graph and then we have a look at the accidents as they are happening, at the bottom. We have money going direct into a community from which 40 per cent is going into the canteen—without the sly grog. A lot of these accidents on the other days are sly grog too, by the way; on Mondays and Tuesdays sometimes that arrives and causes a bit of trouble. But the injury numbers on the bottom graph clearly state a correlation between the three issues. We would expect that. It happens in our Caucasian society as well, but more dramatically in this, and a higher percentage of the income.

I would now like you to consider what I said earlier about intervention. When I did this research, I was also asked to look at the social factors and impact on the community of injuries as they happen. So I lived in the community, I went out at night with the nurses—it broke down the barriers of shame with a lot of the people who were injured—

and I spent days sometimes with families and people to obtain information that I needed. I did it fishing, I did it sitting under the mango tree, I did it with all sorts of issues, but this is the real story. The real power of this is in the qualitative material that I have derived from these people. Professor Ernest Hunter and I sat down together and we decided what type of information we would need. This is what we looked at.

Within all these case studies—and these are in addition to the file audit, by the way—this is what the people are saying. The event up there becomes the accident. We looked at responses and outcomes. There are an awful lot of problems in responses and outcomes which I have identified in there—equipment, unsatisfactory service, et cetera—but they can be overcome. The outcomes are not good, either. We have people who may be disfigured, and the outcome is sometimes death. But, when we look at what is behind here, this is the real issue.

Go back to that graph where we said, 'Hey, 74 per cent have had a person-to-person confrontation.' I needed to know what the precipitating factor is. It is grog; there is no doubt about that. The precipitating factor is alcohol. But, when we have these predisposing and underlying factors, that is where the real issues lie. The real issues I have already heard you mention here today—the clan issues, the divided communities and issues that are associated with that.

This is what I have come up with—and these are only examples, by the way; there are hundreds of these—in the context of injuries that are looked at, a male or female under the influence of alcohol from binge drinking on the part of either or both parties makes them vulnerable to accidents and injury. We have even identified that there is a high period of risk for the children while people are at the canteen. I think someone else mentioned that today: what happens to the kids when they are there? Get them to a safe place. I have shown that accidents suddenly start happening with children after the canteen opens. The issue of falling out of the back of vehicles happens sometimes with alcohol, but there are other issues in relation to that that need to be addressed.

No. 2 is a very, very serious issue: it is the breakdown of the family structure. The males in the community quite often come home and are not sure where they stand in relation to their situation. There is a breakdown of the family structure which has happened through a lot of issues, including dispossession and the changes and the needs of these people through mission changes right through to their present situation.

There is overcrowding in houses. Goodness me, bring your relatives in for a week but, okay, leave them there for a month and see who fights—you will be fighting your relatives. But these people are overcrowding the houses. Non-defined boundaries are happening. Now, you would have been to Pormpuraaw. I can tell you that the new fencing that has gone into Pormpuraaw has reduced a lot of the volatility. People suddenly own something so people do not walk on it, but you have been to other communities, surely, where a boundary does not seem to mean anything.

As to the environmental factors which are dangerous, you have been to communities. Surely you have wondered why all the star pickets are thrown up on the roof and bits of bikes and so forth are up on the roof. They are up there because, if someone comes home drunk, they are not going to hit someone over the head with it. It is a known fact—that happens. Loaded guns available to kids have been an issue; there have been a number of shootings. Broken glass—a lot of children have been cut around the feet. Do not get me wrong: a lot of the communities are doing something about this, or trying desperately to do something about it at a local level, but there are a lot that need help and guidance to do it.

But the big one that I am concerned about is children subjected to household and community acceptance of alcohol and violence. I go to a community and, on a Wednesday, a lovely person says to me, 'Come and see me Sunday, Doug; I'll be sober then.' These are beautiful people for whom it has suddenly become a way of life to go to the bloody canteen and get pissed. It is wrong. This way of life has been pushed on them, which I will explain a little bit more later. And there is continual exposure, through community behavioural issues, with no counselling.

There is counselling needed desperately in these communities—desperately. You know, while Port Arthur was on, I was in a community up there that was so desperate for counselling it was incredible. I thought, 'If they could only see that I see a Port Arthur every day of the week.' I see a kid who was in a car who went out and killed himself some way out of town, and his mates went looking for him. He was thrown out of the car and was dead, and the car was 50 yards up the road or whatever. One boy had to sit there for three hours with that kid to keep the birds off him while the other guy went to get the ambulance. No counselling!

I sat with a justice committee meeting at one of the communities you have been to where we discussed the issues that need to be addressed. We talked about jealousy, we talked about payback, we talked about grog. The night before I had been out with the chairperson of that community and he said, 'Doug, will you give me a hand?' I said, 'What's wrong?' He said, 'A silly young fellow here has knocked off a police vehicle and he's just driven it till he's completely destroyed it.' I said, 'Oh, God.' He said, 'We've got to get the forklift to get it.' So I went with him.

At the justice committee meeting on the Tuesday, the next day, they told me, 'Doug, about that boy yesterday: we know he is hurting inside, we know he has a problem, we will have to talk to him, but at least no-one has been hurt.' That kid hung himself two nights later. At that same meeting, two elders came to me and said, 'We want to talk to you'—and I will lead into what they had to say as I go from here. They were two elderly women, probably the women you spoke to—I do not know.

I have got to know a lot of people very well, and I would have to say that the most honest people that I have met in my life, in all my work I have done in research or whatever, are Aboriginal people. They are totally honest and wonderful people. I have a

good friend in the community who has been very ill. He is a health worker. About two weeks ago I called in to see him. I said, 'What's wrong, mate?' He said, 'Doug, it's the grog; I've got to give it up.' And he started to cry. I came here with this presentation today with that person in mind to show you what he is up against. This is what this person is up against.

For this person to succeed he is up against, on one hand, the breweries and the alcohol industry who have a wonderful, wonderful outlet in the Cape. You have 90 per cent of the community drinking; it is a brewery's dream. I know that after they have attained certain levels of sales they have sent up a pallet of free grog, for God's sake, and they are promoting their interests. They have an obligation to their shareholders. That is what they are supposed to do; that is their obligation. We have an addiction, and you cannot tell me—I do not have any figures on this—that, with 90 per cent of the community drinking, a lot of them are not going to be addicted.

I would like to go back to Barbara's statement here earlier when she talked about access to the community for their own good and the community having a say in whatever happens. That is one of the most fundamental things that I feel should happen. It should be community owned and driven, it should be sustainable and should have ongoing support. But, with 90 per cent of people in that community drinking, if you put around a survey to see if the canteen should have extra hours or whatever, what do you think is going to happen? Is it democratic? I am not sure how you address that one. It is another spin-off to what Barbara was getting at.

The society's monitoring effect of the canteen is the single biggest issue addressing the communities at this stage. The misconception in communities that wonderful things come out of having canteens, that we can do all these wonderful things in communities, is a joke. Of course, it looks on the surface to be like that. But there is pressure on them to get more money all the time, and the only way they can do that is through the health of their people. I am not sure how you overcome that.

I was very interested in your statement, Brendan, about whether we can we give them an incentive. Maybe we can; I do not know. It crossed my mind when I was sitting here that maybe that is an incentive. Maybe that can be used as part of the income they normally get to retard the drinking. That is a possibility; I do not know. We will roll into that shortly.

There is a lack of direction for inter-agency application and programs. I do not want to be facetious on this, but, goodness me, it is time departments got together. I look at alcohol programs in different departments going different ways, and no-one knows what is happening. I look at departments which have two programs going for the same thing within the department. An inter-agency approach is needed. I have strong views on how it should happen, and I will present that to you when I finish this.

This poor guy here, to attain abstinence from alcohol, has to fight all these. He is

one little guy who is crying to me. I cannot help him, but you people can. You can make breweries more responsible, you can push them to ensure that X amount of low alcohol beer is put into communities. You can see that they put some sort of money towards the health of the people. You can make them more responsible. You can help the addiction by ensuring that social justice issues are levelled out, that each person in the community has access to rehabilitation, has access to detox, has access to after care. You can ensure that in some way or other—and this is the curly one—the social and monetary effects of the canteen can be overcome. Before we can do anything about alcohol, we have to address these issues.

The last one is the one that is music to my ears, when I hear this committee saying we need an inter-agency approach. I use the word 'inter-agency' and not 'interdepartmental'. I see it as a prime need for groups such as Apunipima to lead an inter-agency approach and to be in the process of pulling all the government departments together with a common goal. We should have a process of going back and saying, 'Look, access to funding is granted only if it meets the strategy of alcohol reduction in the Cape.' If that funding goes within departments, then the whole thing would fall into place. That is my view.

I would like to go back to the social issue I was talking about in the justice committee, where two elderly women asked me to come to talk with them. I knew them quite well and I had spent quite some time with them. We sat under a tree straight across from the canteen. One of them said, 'Doug, I am watching alcohol kill my people.' This lady did not drink. She said, 'Do you see those three girls walking up the street there? They are my granddaughters. My daughter is drunk half the time. She only sees them on Sundays and Mondays. What can we do? The oldest one is 13, totally corrupted; the second one is 11 and mostly corrupted. All they want to do is grow up and get to the canteen. But the little one is four, and we have to show her something else.'

When I thought about it, what she was trying to say to me was this: currently, in their eyes, that is the door that is open. In normal urban societies, you pick up your kids from school and you take them to ballet lessons, piano lessons and sport, football or whatever that is what a lot of councils are trying to do for their children, but it is not happening. These are not all the doors, but these are some of the doors that I thought would help. We have to get something to compete with that. The answer is in competition. It is no good taking away the grog: they will drive out of town and get it or else get it from the sly groggo. We have to compete. I pulled a sum out of the air when I put this together in the last few days. Employment, culture, sport, recreation, the arts and participation in community programs could all be used in competition with that, with a responsible program.

I put it to you that alcohol is at the moment the single most important issue affecting health in the areas where I have been—and that is right across the Cape. It is a system that has been put into place by stealth. It is no-one's fault. Everyone thought that giving the people a canteen was the right way to go. Everyone thought that this was the

right thing, but it is caught up in such a complex situation at the moment that the only way of unravelling that situation is through an inter-agency approach.

The health department cannot do it—what could the health department do about some of those issues I was speaking of earlier?—but they can be a participant. Your department can be a participant and his department can be a participant, but it has to go right to the top. They are looking at the inter-agency approach in communities. I can tell you that they are keen to do it. I have already been involved in the inter-agency approach.

CHAIR—We have seen quite a few examples at the school, at the council and the health clinic. Doug, your enthusiasm and your commitment are coming through. I would like to listen to you more, but with the way we are going we will not have time for questions and we have still another witness to talk to. I do not want to cut you off, but how much time do you need to finish your presentation?

Mr Gladman—I would like to get one more point over to you. Since I have done this report, it has created a lot of furore and has had very wide exposure. I even had the indigenous policy unit from Social Security come to me. They supplied a lot of the material in the report. That report was an example of an inter-agency approach. I used Social Security, the ACC and these departments, and Apunipima were the driving force behind it. The policy unit has now come and said, 'We want to be involved. How can we direct our money somewhere, so that it will help the kids to get nutrition?'

The inter-agency approach is there, but someone has to coordinate it, and it has to be an outside agency and not a department. I look at Apunipima and think, 'That is perfect.' They could pull all the departments into a coordinated approach, even just doing it with the issue of alcohol on the Cape. We are looking at 90 per cent of the community drinking, as against the figures for the rest of Australia. People are talking about FAS—foetal alcohol syndrome—and goodness knows the outcome of that: we are talking about a generation of kids who cannot be helped, who are coming through with low IQs, ADD and facial disfigurement. The cost to society is going to be enormous, from the police, corrective services, education and health onwards. It is the real world, and you have to address these issues. That is the way I see it, anyway.

CHAIR—Could you table the figures where you have correlated the direct income of the canteen with income from the community? We would like that. It is the first time I have seen that in any form other than anecdotal comment. You have documented that.

Mr Gladman—There are two of those. I have not presented the other one, which is on another issue. It shows the pension money, where not as much of the pension money is getting through as the family allowance money is.

CHAIR—We would like to see a lot more of your information. We leave you the invitation to continue to forward information to us and we will get it on the record.

Mr ALLAN MORRIS—Thank you, Doug. Firstly, I am surprised at the accident rate. We have been told in most places that we have been that the car accident and alcohol thing was a real problem. Your figures had that as a relatively small factor: in fact, a high number were non-alcohol related. It may be how they have been reported rather than actually how they occurred.

Mr Gladman—No. There is a reason for that. For the particular community I took those figures from, one of the few areas where they might differ was in road accidents, because they have a canteen, but they are very remote and they do not have a lot of vehicles. Other communities that have higher vehicle numbers have high accident rates. Even without canteens, other communities have even higher accident rates, for obvious reasons.

Mr ALLAN MORRIS—That may explain it. I was puzzled by that. The inter-agency approach is obviously a thing we are all seeking. We may be calling it a whole of government approach or whatever. I do not understand the Queensland system fully—I am from New South Wales, and I am not sure I understand ours, either—but what would your advice be? Would there be a lead agency? If you were setting it up yourself, how would you design it?

Mr Gladman—I would go to an organisation such as we have heard about earlier and say, ‘We want a complete alcohol strategy for the Cape.’ I would accept, for the interim, that that would include all of the relevant departments, at a very senior level. I have already discussed these issues with the Assistant Commissioner of Police, with senior levels of the Social Security, and with senior levels of Health, and they are all right behind the inter-agency approach. All the relevant people want to be involved, but no single department wants to lead it. That is the problem.

Mr ALLAN MORRIS—Whose budget? You are talking about them devoting part of their budget to a common—

Mr Gladman—No; I am inclined to ship them their budget. As the funding comes to them, they have a common goal. I know of three recent suicide prevention programs—and I try to get to them all, obviously, through my work—all of which had great intentions, but some did not even know the others were running. They could be coordinated and collective. They were from three totally different departments, by the way.

Mr ALLAN MORRIS—I am saying that the barrier now is that each department has its own budget and its own chain of command. Such an inter-agency approach requires them to forgo some of their sovereignty into a common pool of funds and a common strategy. What we find around the countryside—and not just with Aboriginal Affairs but in general—is that departments want to keep their money and their structures to themselves.

Mr Gladman—Their structures. I really believe that the money issue is not the issue. I really believe a common goal is the issue, rather than keeping bums on seats or

whatever the case may be. If a common goal could be attained by all departments, that would be a start. If they are looking at reducing alcohol consumption on the Cape, for instance, each department has a vested interest. The savings in each one of those departments would be enormous. We need a coordinating factor. Everyone agrees. I have had nothing but enthusiasm for this. This has been going on for two years with me. Everyone is enthusiastic. What we need is a totally committed lead agency. That is my view, by the way, and I am just a novice in a lot of this.

CHAIR—With a very good presentation and enthusiasm, you have answered a lot of our questions. It is for us to go away now and try to do what we can.

Dr NELSON—When you say a 'lead agency', could you explain exactly what you mean by that?

Mr Gladman—I did not quite mean that. I meant a coordinating agency. I feel that the decision has to be across agencies at a senior level to determine policy direction. The funding coming into each of those agencies has to have the same direction within the strategy with the lead agency to pull them together to get everyone going for a common goal. They should not be making decisions or anything of that nature. Lead agency is probably a term that is a little dangerous; 'coordinating agency' would probably be a better way of putting it.

I do not believe that it is a job for a department because there is this department versus department issue that arises out of all this. Let us have an agency accepted by all departments. Through the work I have been doing I even have some of the local organisations who want to do something about all this together. The ACC, Apunipima and ATSIC are behind it. I have had a phone call from Colin Dillon, the national commissioner for deaths in custody, in the last two or three days and he is right behind it. Everyone is enthused. All we need is that coordinator to put it all into place. That is my view.

CHAIR—Thank you very much, Doug. It is up to us now and we will do what we can.

[11.35 a.m.]

KREGER, Ms Ann Janette, PO Box 7331, Cairns, Queensland

CHAIR—Welcome, Ann. In what capacity are you appearing before the committee?

Ms Kreger—I am appearing in a private capacity.

CHAIR—Before we proceed I wish to point out that whilst the committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives itself. Any deliberate misleading of the committee would therefore be regarded as contempt of the parliament, but the process offers to you the extension of privilege so that you can be fearless in the truth which you would like to place before us.

Everyone gets an opportunity to make submissions to inquiries and we are particularly pleased to hear from people like you who have a wealth of experience and therefore a lot of wisdom to offer the committee, and we offer you an ongoing interaction on that. I understand that in addition to the brief letter you have sent, you have a submission to make to us today. In the interests of brevity though, if it is a written submission, you can simply table that and we can have it recorded into the evidence. You do not have to read it all and there may be questions which the committee members would like to ask you. Perhaps you could start off by giving us a summary of your experience and advise us how you intend to make your submission.

Ms Kreger—My background is in nursing. I have been a nurse since 1970. I entered the area of remote area nursing in Australia in 1982 and, really, all my efforts and professional activities since that time have been involved in that area. Since the beginning of this year, I have been studying. I have moved into town and I am based here in town, working at Cairns Base Hospital.

Prior to that my experience has been in the area specifically to do with health care in indigenous communities in remote areas. I have worked in clinical practitioner roles, management, research and education—

CHAIR—Are you the one who is doing the PhD studies?

Ms Kreger—No. My colleague has just submitted her PhD to do with remote area nursing. Unfortunately, the contents of that are not publicly available just yet but if you are interested and the proceedings are progressing, then I am sure that she would be willing to make those available at an appropriate—

CHAIR—I suppose that will not be until the end of the year, when she finishes her thesis—

Ms Kreger—In speaking with her, my understanding is that it is about three months. It then depends on the examiners' comments and whether there is a need for refinement and review of the content of that thesis. She has only just submitted that, but we would be happy to document other things that are public information. Some of this has been done fairly hurriedly so I have not referenced a lot of what I have done, but I am quite happy to do more work in this area in terms of documentation if you would like that.

CHAIR—You certainly sound committed from your letter. What do you propose to do for us today?

Ms Kreger—I have gone through and looked at the terms of reference and I must say that I found quite a lot of overlap in terms of the perspective I want to put which is really a nursing perspective. Nursing is an established discipline which has an established place in the health industry. As nurses, we would come up against very serious problems in terms of our professional requirements when we attempt to start practising in remote areas. That is my experience and that has been raised in the personal research which I did in 1991 and 1992 for the Council of Remote Area Nurses and the federal department. My practice last year in remote areas only confirmed that very little has changed in respect of any of the recommendations of the research that I conducted.

CHAIR—Which regional communities have you been in?

Ms Kreger—I used to be in this region what was called the assistant director of nursing for Cape York, which in effect was the senior nurse for managing the health services in Cape York, the area where Doug conducted his research. I have conducted research, interviewing nurses around Australia. I have worked in communities in Arnhem Land and in the Katherine region of Northern Territory. I have worked with indigenous community councils and with one council in central Australia, and I know Puggy from—

CHAIR—Puggy is well known to everybody.

Ms Kreger—I know him from my work in the Kimberley previously, prior to moving here to Queensland.

CHAIR—Just to introduce our committee: I am from Victoria. I represent a large region in the north-west corner of Victoria with a large number of Aboriginal communities. Dr Brendan Nelson, as you would probably be aware, is the member for Bradfield, a northern Sydney suburb. De-Anne Kelly is the member for Dawson, around Mackay in this state. Allan Morris is the member for Newcastle from north coast New South Wales—and Newcastle has done some good things with the training of indigenous workers. Bjarne Nordin is the secretary to the committee and, because this inquiry is so unusual, we have had the advantage of having Jim Kennedy seconded to us. Jim has aeons of experience with the department. An even more unusual step is Puggy Hunter's assistance. In fact, he has been on this tour with us up through the Torres Strait islands

and down the west coast of the Gulf communities over the last week. I am anxious about time because we have a community we want to inspect this afternoon, so I need to know how you intend to make your submission.

Ms Kreger—I was going to speak to some of the points here.

CHAIR—It looks as if you have got quite a few well documented—

Ms Kreger—Yes, it really is a lot, but I am happy to—

CHAIR—I suggest that you table that, but speak to certain salient points through it—and I know that members will have some questions.

Ms Kreger—That is fine. I will select the things that I think require emphasis at this stage. I probably would like the opportunity to refine this a bit more in terms of tabling, if that is acceptable, but it would not be dramatically changed.

CHAIR—Okay.

Ms Kreger—In relation to term of reference No. 1, the issue for nurses to do with effective coordination is the lack of objective data about day-to-day service delivery in communities. There tends to be a lack of management leadership, direction, planning and systems of support for those people who are actually providing the services on a day-to-day basis in these remote communities.

I acknowledge that I am generalising here. There are exceptions to all of these statements on occasions, but generally that is not the situation. What happens as a result of this, and I think you are very aware of this, is that it is what gets called by nurses 'bandaid care'. You are just patching up. It is going out the door, it is coming back and so it goes on.

The other thing that is very concerning is this attitude that somehow things are different out here. We can do things in a different way in remote areas. As a nurse, it seems to me that governments rely on the assumed expertise of particular advisers, rather than actual concrete research data on what happens and how it is done. In particular, there tends to be a failure to differentiate the roles, responsibilities, functions and activities of different health service providers at remote locations. If you look at the literature, you will see reference to service providers or health workers, completely omitting that there are nurses involved in that service delivery as well.

I suggest that we really need to research and observe. I have interviewed nurses about their practice. We are now finding that what they say they do is really based on what they think they should do, what they would like to do and what they think needs to be done, rather than what happens. This is what is so disturbing. I had the opportunity to help my colleague Jenny Kramer edit her work. What she observed is extremely disturbing

to me because she is finding that nurses are not necessarily fulfilling the requirements of nursing practices controlled by regulating authorities. No-one is making sure they are; no-one is even aware what they are or are not doing. There is a range of other people involved in all of this. It is influenced by medical practitioners, drug supplies and a whole range of functions. The ultimate concern is for the safety of the service that is provided and the impact on the clients who use those services.

I think there is a range of things that need to be observed: what actual care is provided; at what standard; by what personnel; and using what resources? Other things that need to be taken into account are: what visiting services are provided in those communities; how are those services organised; and what effects do they have on the day-to-day service delivery expected and provided by the nurses and the health workers in those communities? There is a range of gaps. There are dreadful impacts on continuity of programs that occur and on care delivered. The amount of follow-up is starting to be revealed in some of the evidence in Menzies—

CHAIR—There is a serious lack of continuity of staff, like six-month periods and—

Ms Kreger—I will go through to some of those structural things. Yes, there is a very serious lack of staff. In some ways it is assumed that it is only nurses who have high turnover. Where evidence has been observed, they are starting to realise that the continuity problems do not only exist with nurses and that there are serious problems for health workers in many locations in terms of maintaining their employment for a whole range of reasons. I do not presume to comment really on what the issues are for health workers or any other professionals, but I feel we have the right to comment on what we do observe within the teams.

CHAIR—We have been in communities where, if the nurses—and there have been male and female nurses, depending on where we have been—have had a long-term association with the community, there has been some progress. In other communities, they are in for a short term of six months and gone again. Without continuity a program cannot get going. The issue is: why don't they stay longer?

Ms Kreger—That is it and it has never been properly researched. I was asked to look at recruitment and retention, but I was not given the resources to do it. I do not know if you have seen the terms of reference for a report called *Enhancing the role of rural and remote area nurses*. It was done for the federal government.

CHAIR—We have seen so many documents.

Ms Kreger—Yes, it gives a superficial impression that recruitment was looked at but in fact all I did was ask employers—because we had no other way of doing it within a very short period and I was one person with very vast terms of reference—what they thought and look at literature that had never looked at remote area nursing specifically. It

still is an assumption of why nurses leave. There is not a lot of exit interviewing or any independent analysis of why nurses leave or why they stay, or what makes them leave or why they move to another community but not leave remote area nursing. They still have a commitment and we find that there is a high turnover between locations. A lot of nurses do stay in the field: why is that? A range of questions need to be asked and research needs to be undertaken.

Recruitment and retention are the most serious underlying problems in remote areas. This leads me to suggest that you cannot assume any educational initiatives will make a difference while you have this turnover. I am happy to provide bibliographic lists of what I think is pertinent research. I do not know the extent to which people will have time to read those or whether you want us to raise issues. It is sometimes assumed that we have researched these things but very little actual research has been done in the remote locations. Most of it is anecdotal or based on interviews with people who work there and what they say they do.

CHAIR—We need to get good, factual information onto the record. In addition to the four members of the committee here, there are another 10 and they read the evidence. There is an example of it here today, with all of these submissions. It needs to be good, reliable information.

Ms Kreger—I am not sure what you are saying in that. Basically, not a lot of research has been done. I think my colleague and I have probably looked as much at any of the research that has been done—

Mr ALLAN MORRIS—Has your colleague published any other material? She is doing her PhD now—

Ms Kreger—Yes, she has published. Her name is Jenny Kramer. If you do searches under the name J. Kramer you will find a range of things that she has published.

Mr ALLAN MORRIS—On this topic?

Ms Kreger—Yes, community health services, in general, and remote area health services. She has probably published more than anyone else in the field. In the absence of this research, nothing should be assumed. Assumptions are made a lot of the time about the fact that this service that is being offered is somehow safe, effective and to the benefit of consumers. As nurses with regulatory responsibilities, we have to say that that is not necessarily the case and should never be assumed.

Mr ALLAN MORRIS—If I contrast that with what you said earlier about the delivery of service not being the same, the implication is that nurses are not giving nursing treatment in remote communities in the same way that they would give nursing treatment elsewhere. That is anecdotal, and I accept that, but can you explain that.

Ms Kreger—We are talking about standards of practice, and I do not mean scope. We all accept that the scope, the approach, the circumstances require us to adapt how we practise our nursing. But we are saying that the rules that are there to protect the public for different reasons go out the door, that people are not necessarily assessed properly before interventions are initiated. We are not sure whether with the correct interventions, despite these practice guidelines, that people adhere appropriately to the guidelines that exist. We are not absolutely certain that those guidelines are even appropriate. What we are saying is that nurses are appropriate in the circumstances.

Mr ALLAN MORRIS—How can we address that?

Ms Kreger—I think what we are saying is observe, get more data and base planning on that. Get some proper evaluation of health services. Do not just talk to the managers, go and look at what is happening. Go and evaluate against mechanisms that are supposed to be in place for other health services.

Mr ALLAN MORRIS—That is to establish whether or not what you are saying is correct, or what level of differentiation. But if we accept what you are saying is correct, that would require there to be some external ongoing monitoring. The argument there would be that there is not enough money for the basic services in the first place, so any additional cost burden would then come out of the health budget.

Ms Kreger—I do not know how anyone is certain of how the money is spent now. We cannot be sure that it is spent effectively, efficiently, or for the best benefits of the people now. In my view we cannot be sure of that; we do not have the evidence to support that. I agree with you, I do think it has to be external, whether or not it has to be ongoing. But there are some basic things, like adherence to legislation, that pertain to professional practice. Nurses attempt to diagnose, and they do not have the educational preparation or the background. I do not know whose interests this is in. They do not always consult with medical practitioners when they need to, for a whole range of reasons that are often beyond the control of those nurses.

I am publicly saying these things that I do not necessarily want to have to say about my own profession, but nurses are not always in control. I have personally been to a regulatory authority saying that there are serious problems in the way the service is structured. The regulatory authority said, ‘You’re responsible for your own practice.’ I said, ‘Well can I report my own practice?’ The response was, ‘Oh don’t be silly.’ There is no effort, or no nurse regulators, people responsible for poisons and drugs regulations. I have these things listed. There are standards of practice, such as working within your individual level of knowledge and competence; infection control guidelines; poisons and drugs legislation; standards applying to health service facilities; equipment and vehicles; occupational health and safety legislation; health research guidelines, which tend to go out the window altogether in many of these communities; and anti-discrimination legislation, particularly in the categories of indirect and systematic discrimination.

Processes and procedures have established over time. I do not think you can actually lay it at the feet of anyone in particular. But given the history, the context, of indigenous people's circumstances, in the absence of adequate resources people have got used to doing things with less and doing things differently. Unfortunately, in the field, there seems to be an absence of scrutiny that steps back and says, 'All right, this might be the way it's always been but is this right? How does it measure up against what every other Australian is entitled to?' There is not much of that going on.

Mrs DE-ANNE KELLY—You mention in your submission the role of the nurse practitioner and that the traditional doctor-nurse demarcation needs to be re-examined.

CHAIR—That is actually the submission from the Australian Nursing Federation.

Ms Kreger—I might be able to discuss it, because I have looked into it.

Mrs DE-ANNE KELLY—It has Ms Kreger's name on it.

CHAIR—It relates to an issue about the role of nurse practitioner. It is a good question actually.

Mrs DE-ANNE KELLY—I will blame our secretariat, Ms Kreger. They have attached it to your submission. I still think it is a good question. You are able to answer it, I am sure.

Ms Kreger—I am happy to attempt to answer that.

CHAIR—It is a question I want you to ask.

Mrs DE-ANNE KELLY—I am trying to. I think it is a very interesting question. You just talked about the fact that rules are broken in remote areas—I think I could summarise it as that—through necessity and a variety of other reasons. I wonder to what extent you are seeing the nurse as practitioner. Are you suggesting the New Zealand model, where midwives have a Medicare type of provider number and doctors like Dr Nelson are practically dinosaurs?

Ms Kreger—I am not so interested, to be honest, in how the payment arrangements are determined, whether they be an employee, which they could well be in that role, or independent. Logically, in a remote area, and for many reasons, nurses will remain employees of services, unless the government does come to some arrangement where they could be funded.

Mrs DE-ANNE KELLY—Are you talking about funding, or an extension of their indemnity, or their capabilities?

Ms Kreger—There is a whole range of issues. One is how you fund them.

Initially, what we probably really need to talk about is a role—a designated, determined and clearly delineated role—through which you can identify the responsibilities for the practice and the scope of practice. Then you can determine the competencies, the levels of competence and how you assess people's competence to fulfil the requirements inherent in those responsibilities. Then you educate them for those and then you have monitoring systems. A lot of that is done through nurse regulatory authorities. At the moment, there is not that mechanism, we have not got that far.

The reality out there is that nurses order pathology, nurses take X-rays, nurses undertake the full range of responsibilities to do with drugs—be it supply, dispensing, prescribing and controlling. Because they are taking on these responsibilities without the associated education and regulation, we are not sure how well it is done. What we are saying is that some of this latest research—and the only research—is revealing that it is not done very well. In fact, what my colleague has found is that normal, usual nursing functions go out the door and this quasi non-medical, non-nursing function establishes that would not fit anyone's standards for medicine or standards for nursing. At the end of the day, it is the indigenous people who have this inflicted upon them.

Dr NELSON—I am starting to understand what you have been saying now. What you are saying is that because services are being provided to a group of people who are, by and large, poor and who are poorly educated, there are standards of nursing care that are being provided which are not always of an appropriate standard, nor are they monitored and regulated in any consistent way.

Ms Kreger—That is absolutely correct.

Dr NELSON—I must say that in the medical area you get three groups of doctors who work in Aboriginal communities: those who are extremely committed to Aboriginal people and to marginalised people in general, then you have the Christian crusaders, and then you have those who simply could not get a job anywhere else so they are basically forced to work in those sorts of areas. I presume that the nursing profession attracts similar individuals.

Ms Kreger—There is a range. You can get some of the most conscientious practitioners. One of the comments I make from my observations is that the conscientious ones are the ones who leave because they cannot condone or live with the professional standards that are there. My experience is that you can try and raise these issues in a lot of forums and it is nurses who are accused—you can be accused of racism, you can be accused of wanting to protect your domain, you can be accused of anything when you say, 'This is not good enough, this is not right,' or if you ask, 'Why is it like this?' There may be reasons why we cannot avoid some of this, but we do have guidelines and procedures aiming to protect the public in terms of health service delivery and they are not applied in a whole range of ways.

CHAIR—I was wondering whether that was an element in the lack of continuity—

Ms Kreger—Absolutely.

CHAIR—After six months of it they think, ‘I cannot cope with this.’

Ms Kreger—I think that is probably the case but we cannot confirm that. It is very hard in an environment where people are scapegoated for challenging existing practices. I can provide research that was particularly to do with nurses’ relationships with health workers, where nurses raised that they were not properly prepared to deal with people who had not had adequate literacy and numeracy skills, where the workload prohibited it. They raised this, and that was what they were accused of. That is documented evidence that is research based and that was done in the 1980s. It was completely ignored.

Dr NELSON—When we were at Bamaga, I picked up a health worker magazine and I noticed there was a story there about improper sexual relationships between nurses and clients or patients. Guidelines had been issued, something along these sorts of lines. It occurred to me at the time that there must be negligent—if not negligent, certainly unprofessional—things that are being done by nurses, by doctors and by Aboriginal health workers in Aboriginal communities. But is it documented and who polices it? Has there been any research on the extent to which this occurs? I think low income people and poorly educated people generally do badly in the health system, particularly if the wrong thing is done to them, but I presume it is more so. Is that what you are saying?

Ms Kreger—There are a range of human rights abuses that occur in remote communities that are not documented. But where they are documented, when attempts have been made to raise issues—I do know of attempts to raise issues, not in the particular area you are speaking about of sexual abuse—

Dr NELSON—No, that is just the one extreme end.

Ms Kreger—Sexual harassment and that sort of thing, but a range of abuses.

Mrs DE-ANNE KELLY—Could you give us an example?

Ms Kreger—Inappropriate use of drugs, such as using fertility drugs in inappropriate ways on indigenous women. A lot of this is hearsay and your ability to pursue is very difficult. It is very sensitive and it is hard to get support from people who have responsibility in the area. I heard recently of girls as young as 11 and 13 being given Depo Provera because it sounded to me like there were issues of sexual exploitation in the community and, from the accounts I heard, these decisions were made in collaboration with the families. But I would suggest that the families are not getting the support, advice and assistance that is required to deal with that—I cannot assume that but my impression, as a professional who has worked with children, is that these children’s rights are not being protected for a whole range of reasons. Therefore, the sexual exploitation is being enabled to persist.

Dr NELSON—What are you suggesting should be done to address this?

Ms Kreger—My perceptions are that the federal government has a really critical role in ensuring that the sorts of monitoring, evaluation and research based practices are developed so that somehow there can be some links that require accountability. I may not be realistic in that expectation, but it is holding people accountable for what they are actually accountable for.

Health authorities do have responsibilities in their legislative units and in their poisons and drug regulations. The nurse registering authorities have responsibilities. I think we have to start asking these people to account for these practices. Admittedly, the systems that apply in urban settings—this has consistently been a problem—are not always easy to administer and sort out in a remote area, but these regulatory authorities and health authorities have a responsibility for every Australian. If those people happen to live in remote areas, they should be obliged to find a way to deal with it.

Dr NELSON—I noticed that in one of the health services that we visited in a remote area there was promotional material about the Health Services Commission. I am not sure what it is called in Queensland but it is basically a complaints unit. Perhaps we should find out as a committee what proportion of complaints received against health professionals by those sorts of bodies come from indigenous people and also whether they are city versus rural or remote. I suspect there would be very few.

Ms Kreger—They have only recently appointed indigenous people. You have to remember that these systems are based in cities. There are not always mechanisms that are appropriate to people, including non-English speaking people. Another area that is really not recognised in remote area health care is the extent to which people do not speak English. I have been to communities and been told that people speak English. But it is not functional English. You cannot actually understand them. Health workers fulfil a phenomenal role, but the service is not adequate. We need to recognise the rights of people to have proper interpreter and translation services. The confusion, misinformation and conflict that comes out of our assuming that people appear to understand English and speak a bit of English has not even been considered.

What I am getting at is that I am not sure how accessible these processes are to indigenous people. I would suggest most of those people do not even know. There will be a written form probably in a pamphlet somewhere telling people that there is some service so they can make complaints. But there are no real mechanisms that I am aware of at this stage. The Northern Territory is only just setting up systems. People have to know what their rights are in a health service before they can complain about a health service. People are not necessarily informed even with this supposed participation. That is where this concept of participation and consultation is abused because it does not involve a proper exchange of information so people know realistically what is available to them and what their rights are.

Dr NELSON—Perhaps there ought to be a charter of rights and responsibilities which Aboriginal people themselves understand in the community and which the employees in the health service, whether it is community controlled or whether it is government funded, understand and are signatories to when they go to work there. I know what you are saying. Some people feel that a lower professional standard is acceptable in a remote area, where someone is not looking over their shoulder, than it might be in downtown Brisbane.

Ms Kreger—Part of that I think we have to be realistic about. It is not just the odd practitioner thinking, 'Oh, I will do what I like because no-one's looking.' The fact is there is no mechanism that you would normally have in place, there are no cross-balances. I think a lot of people would be really horrified if we started doing some chart audits and looking at the frequency with which some children get administered their antibiotics, the appropriateness of the use and so on.

CHAIR—A previous witness went through one—

Ms Kreger—It is the evaluation, monitoring, planning and resourcing of these services that allows that to happen. It does not prohibit it through the systems that are in place.

CHAIR—I invite Puggy Hunter to comment on any of this, with a Western Australian Kimberley perspective. Is there something that you might say?

Mr Hunter—What we experienced in the Kimberley is that we get nurses that have no training; it is all on the job training. We have come across nurses crying because they have not been in that situation before. You are talking about refugee camp situations. You have no training process in place and I agree there is no assessment process. There are nurses who come up with ideas of how they can improve a whole range of things, then the bottom line is how many dollars you have to actually put these things into practice. The government is seeing that as a priority in reality.

Taking the point that Ann talks about with regard to accommodation, we have situations where we have up to four nurses living in one house. When you ask for accommodation or infrastructure there is not enough money so the decision on the council is whether you provide a service or you go and buy a house for a single nurse, so the training, the whole box and dice of trying to keep staff is there. You look at the length of stay in some of these places with staffing, it is just crazy. Crazy things happen out there.

I agree that no-one seems to care. There are complaints that community members have against health department doctors and some of our own doctors. We take them on but there is no mechanism to follow through, there is no process. You can go to every Aboriginal community and person and talk about some experience where they have dealt with the health department and we have a lot of sad stories out there, but there are no checks, no accountability.

CHAIR—I might suggest to you, Ann, that when you are happy with the document you forward it on to us. You have some wisdom there and we are grasping for it. With all those years of experience you have something to say.

Dr NELSON—May I make a suggestion? Perhaps we could give some thought to the fact that, in each state, there is a health services and conciliation organisation, and in some states it is adversarial and in other states it is about resolving problems. Perhaps there ought to be a person appointed to each, funding provided for it, obviously, to specifically look after indigenous services, or alternatively some process where, in consultation with the Nursing Federation, the Royal College of Nursing, the AMA and medical colleges and so on, we actually start to look at monitoring professional standards in Aboriginal medical services.

I think you are right. I think a lot of the problem, as an observer of this—and you would know much more about it than I ever will—is that a lot of professionals get affected by the virus of existential despair when they get there—'Why should I bother treating this fractured arm properly when I know it is going to be broken again next week? Why should I bother treating this kid's ear infection properly when I know that the fundamental problems are not being addressed?' Some practitioners who go to these areas I think themselves have problems of one sort or another.

Ms Kreger—I think there are elements of that. I would like to say you have got to look at the workload. You heard Doug talk about the dynamics in the communities. They are trying to provide a health service with the sort of morbidity and mortality that is presenting without the resources. You need to look at what resources there are. You cannot assume that any resourcing in these remote communities is adequate. You might have a community of 1,000 people. You might have a nursing ratio of five nurses for a 24-hour-a-day, seven-day-a-week service.

Go and have a look at how they run hospitals. Then have a look at how much after hours work is done in those communities, and think through what is the capacity of those individuals who are dealing with that degree of morbidity and mortality—and we are talking about mortality, too, and violent mortality, which is very disturbing to people who have to deal with it. How do they manage to even think clearly, in a way that means that the decisions are safe when they have been up all night, and then they are at work the next day? They have to be there because they have got a staff ratio of five, but someone is on holidays and someone is off sick, or one position has not been replaced, so there are actually only three of them holding the service. Or, like I saw in the Cape when there was a diarrhoea epidemic, two children died and they had about 30, 40, 50 kids coming in. They were trying to provide services 24 hours a day, which is beyond anyone's human capacity.

That is why I emphasise the need to scrutinise. Sit down and observe what services are provided with what resources under what conditions and at what standards, because you will find it is not adequate to deal with the needs of the people out there.

Dr NELSON—It is system failure as much if not more than individual professional failure.

Ms Kreger—One of the reasons I was very hesitant to raise this is it that it is very easy for the people who are out there to be blamed for the problems, and it consistently happens.

CHAIR—We are not interested in laying blame.

Ms Kreger—No, I know you are not. But that is an approach that happens.

Mr ALLAN MORRIS—That has been very helpful. I should point out that in the Queensland University medical faculty a couple of years ago a survey suggested that 80 per cent of the students thought Aboriginal health was their own fault, which is a very insightful comment.

I just want to diverge very slightly because of your experience and your obvious knowledge. We have been looking at this problem of relating the health services to the other community services, and in some communities we see the nurses working very well with primary health care and out in the community educating and so on, and in others not so well. When you are thinking about what you are putting in your submission there, have you any thought as to how we could better ensure the integration of the health system into the other parts of the community with housing and councils, and particularly education and primary health care, because it seems to me that—

Ms Kreger—It is not happening. Can I say publicly the reason it is not happening is because it is not resourced to happen. You cannot do both. You cannot have to be there and deal with what is coming through the door 24 hours a day and then somehow say, 'Oh well, all you guys wait—with your diarrhoea, your chest infections, your skin infections and your injuries—while I whiz down and spend the time that is required to do the liaison, develop the rapport, exchange the information that is required for the health promotion.'

Mr ALLAN MORRIS—Are nurses trained for that as well?

Ms Kreger—It depends on the education of nurses. Now tertiary graduates are trained in a whole range of community health. Hospital based nurses who have then done their subsequent degrees would have had a component of community health. Whether they have had much clinical experience, no, it is very limited. But the reality is not that people do not know.

I am the same. That is my background, my professional background, but I went and worked in the Territory last year. I did not have a hope in Hades of getting outside the door of the clinic, except to follow up very urgent things—to see whether this child that we needed to follow up was brought back to the clinic—not public health, not health

promotion, not population focus. That is my area of interest. Most of the time it is not to do with whether the person is capable.

Mr ALLAN MORRIS—Thank you. I wanted to ask and get it on record.

CHAIR—We are going to have to wrap it up.

Dr NELSON—I just wanted to make the observation that at Pormpuraaw, for example, where they were well staffed—they told us they felt they were well staffed—they had a good facility, the staff were happy, they found the place, they have no trouble getting nursing staff and keeping them, the director of nursing said, 'I enjoy being here; it is a good place to work', because they have the time to do the curative and the preventative and actually have a life.

Ms Kreger—And they have had their staff increased.

CHAIR—Operating to a plan, though. They had support.

Ms Kreger—I think again there are places where it works. I worked at a place called One Arm Point that Puggy knows and, at that time, with the health status as it was and the dynamics in the community, I did an enormous amount of that health promotion work. We were able to organise it that way. It varies from community to community and it relates to resources. Thanks for the opportunity. I will get something that I am happier with to you.

CHAIR—Thank you. We want to hear from you.

Resolved (on motion by **Mr Allan Morris**):

That, pursuant to the power conferred by section 2(2) of the Parliamentary Papers Act 1908, this committee authorises publication of the evidence given before it at public hearing this day.

CHAIR—Thank you, colleagues. Thank you, Puggy, Jim and Leonie, and thank you, Alan and Megan from *Hansard*.

Committee adjourned at 12.21 p.m.