

Senate Hansard 17 September 2007

MATTERS OF URGENCY

Indigenous Health

The DEPUTY PRESIDENT—I inform the Senate that the President has received the following letter, dated 17 September 2007, from Senator Siewert:

Dear Mr President,

Pursuant to standing order 75, I give notice that today I propose

to move:

That, in the opinion of the Senate, the following is a matter of urgency:

The need to act to 'Close the Gap' to achieve health equality for Aboriginal and Torres Strait Islanders within a generation.

Is the proposal supported?

More than the number of senators required by the standing orders having risen in their places—

The DEPUTY PRESIDENT—I understand that informal arrangements have been made to allocate specific times to each of the speakers in today's debate.

With the concurrence of the Senate, I shall ask the clerks to set the clock accordingly.

Senator SIEWERT (Western Australia) (3.55 pm)—I move:

That, in the opinion of the Senate, the following is a matter of urgency:

The need to act to 'Close the Gap' to achieve health equality for Aboriginal and Torres Strait Islanders within a generation.

Tomorrow is National Close the Gap Day, a day on which Australians across the nation will come together at a range of events and forums to show their support for closing the 17-year life expectancy gap between Aboriginal and Torres Strait Islanders and other Australians. They are calling for all Australian governments

to take action to achieve health equality for Aboriginal and Torres Strait Islanders within 25 years through: increasing annual Indigenous health funding by \$450 million to enable equal access for Aboriginal people to health services; increasing Indigenous control and participation

in the delivery of health services; and addressing critical social issues, such as housing, education and self-determination, which contribute to the Indigenous health crisis.

The gap in life expectancy in health outcomes between Indigenous and non-Indigenous Australians is an international embarrassment. We are the only First World country that has failed to make progress on the health and life expectancy of our first peoples. In fact, most developing and so-called Third World nations have made better progress with population health, despite the chronic hardships they face. On average, a person from Bangladesh, for example, can now expect to live for 10 years longer than an Indigenous Australian.

As the Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, pointed out at the release of his Social justice report 2006, the fact that a wealthy country like Australia cannot fix a health crisis that affects only three per cent of our citizens is simply not credible. The greatest threat to Indigenous Australians is disease, and many of the diseases they face are easily preventable and have long since been eradicated from our non-Indigenous population.

Australia has the dubious distinction of being the only developed country that has not yet eradicated trachoma.

Other First World nations have, within the last decade or two, managed to significantly reduce the gap for their first peoples. Canada, New Zealand and the US have all reduced their life expectancy gaps down to between five to eight years, as opposed to our outrageous 17 years. Infant mortality rates for Indigenous

Australians are now almost twice as high as those in New Zealand and the US. Indigenous babies in Australia are 2 1/2 times more likely to die before the age of one than their non-Indigenous counterparts. If they are in the NT or WA, they are three times more likely to die. They are also twice as likely to have low birth weight, which places additional stress on their development and makes them more vulnerable to poor health in later life. The WA Aboriginal child health survey reported very high rates of recurring ear infections, recurring chest infections, recurring skin infections and recurring gastrointestinal infection in Aboriginal kids in the west. A comprehensive study would, we believe, likely reflect similarly high rates across the country.

Recent research into the rates of ear infections in the NT carried out by the Menzies School of Health Research showed that 80 to 90 per cent of Aboriginal children have persistent ear infections within the first three years of their lives. Hearing problems as a result of easily prevented and treated ear infections, especially otitis media, are a major factor in poor educa40

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tional outcomes for Aboriginal kids, who simply cannot hear or understand what the teacher is saying.

Let me touch for a brief minute on the Northern Territory intervention. The government, I have no doubt, will come in here and argue that it is their contribution to closing the gap. Let us have a look at some of the material that has come out just today. Today we had a leaked briefing from the Aboriginal Medical Service Alliance of the Northern Territory, on Crikey.com, that suggested that medical checks are failing to reach more than 10 per cent of the at-risk population. They claim that the health check component of the intervention is largely incompetent, probably unethical, underfunded and absolutely ignores the long term. They claim that

the intervention is in breach of the National Health and Medical Research Council guidelines, the Medicare guidelines and the health screening guidelines issued by the Royal Australian College of General Practice. It is estimated that, as a consequence of the lack of experience and training in Aboriginal child health of the medical task force, they have a diagnosis rate of about 50 per cent below known disease and illness rates. The rate of diagnosis of ear infections is a whopping 77 per cent below that which would be expected on the basis of expert research. The diagnosis of otitis media, a middle ear infection where kids have fluid behind their eardrums and hence experience significant hearing loss, is particularly difficult, especially if you are not experienced in working with young children, let alone with Aboriginal children.

If you were going into communities where there were known to be high rates of this disease, surely you would ensure that you knew what you were looking for and would be taking along the right equipment. However, this latest report from the NT found that, for 10 per cent of children referred to the ENT surgeon, that had in fact not been done. The level of hype around the NT intervention raises some serious ethical issues because of the manner in which it is raising false expectations within the community without having in place the resources to follow it up. This is hype; it is not actually dealing with the issue. Can you please remember these facts when you hear the government argue that they are doing something about closing the gap because we have this wonderful medical task force in the NT? Now we are starting to hear on the ground what is really happening.

A recent report by the World Health Organisation found that the health of Aboriginal Australians is lagging a century behind the rest of the population. Per capita, access to primary health care remains at 40 per cent of that enjoyed by other Australians. Half of the

Aboriginal population over the age of 15 already show signs of chronic disease. Despite the fact that they are three times as sick as other Australians, their access to primary health care, as measured by the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme, is only 40 per cent of that of the general population. That is despite claims by the government that they are spending a large amount of money on Indigenous health. For every \$1 spent through the PBS and MBS on a non-Aboriginal Australian, only 40c is spent on an Aboriginal Australian. The work done by Access Economics for the AMA estimates that an additional \$460 million a year is needed simply to bridge the existing gap between the health needs of Indigenous Australians and the current spending.

I seek leave to table a report by the National Aboriginal Community Controlled Health Organisation, or NACCHO, and Oxfam titled Close the gap: solutions to the Indigenous health crisis facing Australia. I have contacted all whips about this and I understand that leave will be granted.

Leave granted.

Senator SIEWERT—The Australian Greens believe that this report provides us with a strong basis on which to proceed. I commend this report to the chamber and urge all parties to take on board its recommendations, which relate to access to primary health care, the number of health practitioners working within the Aboriginal Health Service, the responsiveness of mainstream services, greater targeting of maternal and child health, increased funding and support and actually setting national targets and benchmarks towards achieving health equity for Aboriginal Australians. The AMA put out a very good report in May that provided a long list of successful Indigenous health programs. We recently helped co-host an exhibition in Parliament House of photos by Oxfam which documented some of the successes in Aboriginal health.

The central point here is that the positive outcomes of these successful initiatives show that this is not an intractable problem. It is not a case of not knowing what to do but simply a matter of scale. The reach of these programs and the level of resources and infrastructure behind them are simply inadequate, given the extent of the problem and the levels of chronic illness that need to be tackled. What we need is a pure and simple commitment to better primary health care on the basis of need; more resources which tackle the issues are essential.

We also need to put more effort into tackling the social determinants of poor health so that we can reduce the level of chronic disease and the massive demands that chronically ill people place on our medical health system. We need to tackle this through prevention, through healthier living, through better homes, through better environments in which people live and also to ensure that people have a sense of control over their lives. We need to set ourselves clear targets that we can measure and be accountable for our progress against. That is why I also believe that the report and the recMonday,

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ommendations put forward by Tom Calma, our Aboriginal and Torres Strait Islander Social Justice Commissioner, are essential in helping us to close the 17-year age gap in life expectancy between Aboriginal and non-Aboriginal Australians.

Closing the gap is absolutely essential within the next generation. People are not saying this can be done overnight. What is being said is that we need to do it within a generation and that there is a clear plan for doing that. We urge—beg, in fact—the government to target the resources that are needed to address these issues. As I said, we know that we can do these successful programs; there are successful programs on the

ground. We need a commitment to start addressing them properly and not take the funding away from groups that are implementing them. (Time expired)

Senator HUMPHRIES (Australian Capital Territory) (4.05 pm)—As one of the co-sponsors of the Close the gap exhibition that was held recently, showing the positive outcomes that have been achieved in recent years, I am very pleased to take part in this debate. Although I appreciate and share with Senator Siewert an understanding of the enormity of the task facing us as a community, I do not for an instant want to downplay the extent of progress in this area and the way in which Australians have, in a very real way in recent years, come to grapple with this issue in a much more tangible and effective way than has been the case in the past. I will spend some time, in my remarks today, talking about the progress that has been made in dealing with the significant disadvantage of Aboriginal Australians with respect to health.

The first thing to put on record, of course, is that the challenge in closing the gap between the standards of health of Aboriginal Australians and other Australians is a truly enormous one. Health outcomes for Aboriginal Australians are, frankly, unacceptable. They are far behind those of other Australians, and it remains a major national challenge to deal with the difference between those two sets of statistics. For example, in 2003 babies born to Indigenous women weighed, on average, 219 grams less than babies born to non-Indigenous women. Babies born to Indigenous women were more than twice as likely to be of low birth weight—less than 2½ kilos—than were those born to non-Indigenous women. Indigenous babies are more likely to die in their first year than non-Indigenous babies. For example, in 2002-04 the infant mortality rate for Indigenous babies was highest in the Northern Territory, where 15 babies died out of 1,000 births, and in Western Australia, where 14 babies died out of 1,000

births. The rate for the total Australian population is only five deaths per 1,000 births.

It is possible to quote a very large number of areas where those sorts of depressing statistics are replicated—in areas like cardiovascular disease, cancer, diabetes and chronic kidney disease. It will not be difficult for anyone in this debate to quote at great length such statistics, which have been very carefully compiled by a variety of health bodies in this country. Australia needs to confront those statistics with great energy and commitment—with the same kind of energy and commitment that would behove any major national challenge of these dimensions. Our response has to be well informed by the life experience of Aboriginal people and the cultural environment in which those people live.

We must accept that the answers to these problems will be extremely expensive. We must also accept that the solutions go beyond simply putting in place a variety of services which either are not there at the moment or are there at grossly inadequate levels. We must act with the knowledge of the background to the failings of existing services—a background which is very complex and needs to be well understood. There are issues like the remote locations where many Indigenous Australians live; the lack of suitable infrastructure for other social services like housing and education, which are very much part of the total picture with respect to Indigenous

Australians; the low literacy levels that Indigenous Australians experience; the lack of a pattern over several generations of interaction with health services; and lifestyle issues such as high levels of alcohol and substance abuse. Most importantly, in examining the solutions to these problems we have to accept that there have been many generations of dispossession and disadvantage which have damaged severely the capacity of Aboriginal families to address endemic health

problems in their communities.

But it is vital for an informed and a fair debate on this subject that we present a balanced view of the health issues facing Indigenous Australians. An approach which emphasises only the distance that we as a nation have yet to go, and does not note and record the progress that we have made on these subjects, runs the risk of persuading many people that the problem is indeed insoluble. The endless trotting out of these statistics about poor results in Aboriginal health will tend to lead people to the conclusion that we simply cannot win. We can sustain better outcomes, and indeed the truth is that we have done just that in a number of key areas in recent years.

Senator Siewert said that we are making no progress. With great respect, that is untrue. The available information about health outcomes for Indigenous people, while still far from acceptable, does point to some real progress in a number of key areas. The all-cause Indigenous mortality rate, for example, in the Northern Territory, South Australia and Western Australia, where such a large proportion of our Indigenous community lives, has decreased by 16 per cent over the period 1991 to 2003. I mentioned the Indigenous infant

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mortality rate. Again, it is an unacceptably high rate of infant mortality but that same rate has declined by 44 per cent over the period 1991 to 2003. With great respect, to suggest that because the life expectancy of Indigenous Australians is lower than it is for people in Bangladesh does not establish the proposition that we are therefore not making any progress against that benchmark. In fact, we are improving the position of many Indigenous people, and in many respects we are able to point to ways in which all Aboriginal people have had better outcomes in a variety of areas. Death caused by circulatory disease declined at a

faster rate for Aboriginal and Torres Strait Islander people than for other Australians, and the gap between outcomes for them and for the rest of us have narrowed. New figures from the Menzies School of Health Research show a marked improvement in the life expectancy of Indigenous people born in the Northern Territory. The report, released in April, compares figures from the 1960s with data collected in 2004. That study shows some very interesting things with respect to the life expectancy of Indigenous men and women in the Northern Territory. Life expectancy of Indigenous men in that period has increased by eight years—from 52 years of age to 60 years of age. I do not deny for one instant that 60 years compared with other Australians is still completely unacceptable, but it is real progress and we should note that in a balanced debate about these issues. The increase in life expectancy for Indigenous women in the Northern Territory has increased even more dramatically from 54 years of age to 68 years of age. That is important to note in a debate like this.

Part of the reason for that has been a very substantial additional investment, particularly in the last few years, by the Australian government. In fact, there has been a real increase in spending on Indigenous health of 210 per cent since the 1996-97 financial year. At that time we were spending federally \$110 million on Indigenous health; today we are spending \$440 million each year on Indigenous health. Even that benchmark is being greatly overshadowed by very significant new announcements with respect to health spending in this area. The most recent budget announced new funding of \$112.5 million over four years for three new measures to increase Aboriginal and Torres Strait Islander people's access to primary health care, to improve child and maternal health outcomes and to improve the quality of Indigenous health services through accreditation

mechanisms and support.

The last four budgets—and there were processes such as the budget itself, COAG and the Intergovernmental Summit on Violence And Child Abuse in Indigenous Communities—committed over \$470 million to improve Indigenous Australians' health. Those are real benchmarks of progress. Although I accept that inputs are not the same as outcomes, it is very important that when we talk about these things we look at the ways in which these issues have changed over the last few years. Senator Siewert, it is not true to say that we are going backwards; it is not true to say that we are making no progress. (Time expired)

Senator MOORE (Queensland) (4.15 pm)—The debate this afternoon is a positive one that I think we can share. Oxfam and the National Aboriginal Community Controlled Health Organisation, which is a daunting title, released their discussion paper—which Senator Siewert sought to table this afternoon—in April 2007, earlier this year. We can look at the front page together and see a benchmark from which we can move forward. There is a stunningly beautiful photograph. Oxfam are renowned for their ability to get the message across in photographs, which I think sometimes tell peoples' stories much better than we can effectively debate them in this place. Apart from the stunningly beautiful photograph of Mornington Island in Queensland, there is a statement from Professor Mick Dodson, which I will quote. I am sure that people will continue to do this. It is a quote that I live with because I think it is one that we can hold onto as we continue this debate. Mick Dodson stated:

The statistics of infant and perinatal mortality are our babies and children who die in our arms. The statistics of shortened life expectancy are our mothers and fathers, uncles, aunties and Elders who live diminished lives and die before their gifts of knowledge and experience are passed on. We die silently under these statistics.

That quote is important for us to hear, but it is not negative; it is actually a statement that gives us the challenge which we are expected to take forward. The Close the Gap campaign—which has been so effective across our country in engaging people in the community in effectively considering the issues facing Aboriginal and Islander people in our community—looks at our history. As Senator Humphries said, you cannot just make a simplistic statement about what should happen; what we should do is understand the complexities of what has happened. It is an important year to do that. Firstly, we now have the opportunity to consider the impact of 40 years since the referendum gave Indigenous people the right to vote in this country. Secondly, we can look at the movement forward, taking a snapshot of what has happened before and together facing the negatives that we have heard but not being overwhelmed by those negatives, because if we do that we will not move forward.

The statistics are there and, as Professor Dodson said, the statistics about the life expectancy of people, the unacceptable infant mortality rate and the way of life of so many people in our community roll off the tongue. We can have an inordinate number of debates, as we have done, and the Productivity Commission has a huge volume of statistics, most of which are negative,

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but what we can do is learn from them. We have the ability to learn from those statistics. One of the really effective things about the Close the Gap campaign is the research of processes that have worked, and we can learn from those. It is not just about extra funding, although there must be greater funding. Senator Humphries pointed out the growth in funding over the last couple of years, but it is not enough by itself. When we have Mick Dodson's words in mind, we hear what those statistics mean to Indigenous people:

they are about their families, the people who mean most to them. You cannot just quote statistics; you have to concentrate on what can be done to address the problems. The problems are known. We have had these debates in this place before and we know the issues that Senator Siewert outlined. So many reports have been tabled in this place and as far away as the United Nations, talking about issues of disadvantage in indigenous populations, not just in Australia. That came out in the recent debates about the international declaration on indigenous peoples. The issues that are confronting indigenous peoples are not peculiar to our country. What we have to address is that the issues for Indigenous people in our country have been bad. This generation has an opportunity to put in place steps forward, as the Close the Gap campaign is asking us to do, within a generation—a time frame of 25 years. I think that most of us would be thinking positively about being around for 25 years. At the end of that time, we will be able to take another snapshot and be able to objectively assess whether the things that have been put in place in 2007 effectively, objectively and cooperatively made advances. At the end of those 25 years, which is part of the process around the Oxfam Close the Gap campaign, we will be able to see what advances have been made around the issues of mortality rates, longevity, education and housing—all those things that we know about. It is our hope and our challenge that in 25 years time we will be able to say these plans have worked.

Maybe we will not have solved all the problems. In fact, there has never been any act which has solved all the problems. But the people who are sitting in this place in 25 years should be able to say that, in 2007, measures that were cooperatively agreed—as the Oxfam report says, amongst all levels of government and engaging all the people who are citizens of this country—have made a genuine difference. That is the challenge:

to make a difference. Rather than concentrating on the past and what has not worked, we should acknowledge

the past and not pretend that it did not happen.

Way too often people become too defensive and try and come up with excuses about what happened—how much money was spent and where it could have been misspent. They concentrate on those things instead of doing what Oxfam has asked us to do: look at the workforce; improve access to education and culturally appropriate primary health care; acknowledge what is happening now and the knowledge that we have.

The Productivity Commission report of two years ago left us in no doubt about the state of our nation now. There is no grey in this area. We have the statistics. They have been gathered and will need to continue to be gathered. When we are looking at those statistics, when we are groping to come up with ways to ensure that life expectancy is improved and we are looking at ensuring that maternal and child health statistics are improved, I think it does us good to continue, as Professor Dodson said, to see the people who are behind those statistics. Somehow it makes it a stronger argument when you are looking at those issues and statistics as being people and family members.

One of the encouraging things about the whole discussion around the Close the gap report has been the way that there has been community engagement. I think that things like the photographic exhibition which Senator Humphries referred to in his contribution have a really valuable role to play in ensuring that we see what does work. Many have been able to look at that photographic exhibition and see those glorious, positive photographs of people who are part of our community now. We need to go back in 25 years time and have photographs taken of those same families to ensure that they are still here—and to map the progress of

that wonderful little boy who is on the front cover of the Closing the gap report to see where he is in 25 years. That is the challenge. There is an understanding about the work that we are doing and the focused funding—the funding that is not linked to punishment.

My concern about what is happening at the moment in the Northern Territory is that any value achieved by the influx of medical help and the influx of people involved in the process is linked to a sense of punishment.

That is not the expectation of Close the gap—it is not about people coming in from outside to work on the community. We are well beyond that. The expectation of Close the gap is that we will work with the community to achieve outcomes. When that can be achieved then people can gather together and say that we are part of a wider Australia. All the advantages that any one of us has should be available to everyone—in particular, in this campaign, to Aboriginal and Islander people—no matter where they live. One of things that I think has been the most damning over the last couple of months is that there seems to have been a focus almost exclusively on the Northern Territory. Close the gap is not a campaign for people who live in the Northern Territory; Close the gap is a campaign for Aboriginal and Islander people across the whole country no matter where they live. And that is the challenge for us. In terms of positives, I look to the work that is

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being achieved by the mums and babies program in Townsville. That is exactly the kind of program that does work. It has been celebrated in Close the gap. I think that if we can work together in that way then in 25 years we will be able to show success and not continued concern about the challenges that we have not met.

Senator ALLISON (Victoria—Leader of the Australian Democrats) (4.25 pm)—I rise to join this debate.

I welcome Senator Siewert's motion and the Oxfam Closing the gap report. I want to talk about two things. On Wednesday last week several parliamentarians went to a dinner which was hosted by Vision Australia. One of the presenters at that dinner was Dr Katrina Rooper from the Department of Health and Community Services in the Northern Territory. She is part of the National Trachoma Surveillance and Reporting Unit in the Northern Territory. She talked about the impact of trachoma on Aboriginal communities. I remind honourable senators here today that trachoma does not exist in any other developed country around the world. But it does exist in our Aboriginal communities, where there are a large number of cases. The most shocking aspect of this is that it can be treated relatively easily. There is an antibiotic which if administered in good time—that is, when children get it; and they do, all the time—can solve the problem. For just \$22 million we could eliminate trachoma from every Aboriginal community.

I remind the Senate that trachoma in the end makes people blind. The eyelid becomes so deformed that it turns inward and the action of the eye eventually destroys the eyeball. So this is a hugely debilitating condition. It is hard to believe that, in this day and age when we know that there is a way of curing this problem—as I say, it cannot be cured if you do not get it early—we are not even taking that minimal step forward of providing antibiotics to those at risk. Those can be administered as a preventive measure and have the added benefit of clearing up a whole lot of other infections as well within Aboriginal communities. The other condition which is almost as debilitating which I often cite is scabies. It is a condition which, again, occurs in no other developed country around the world. But it affects every Aboriginal community. When I travel around with committees I go into schools and ask what the incidence of scabies is. Very

often the answer is that it affects 80 per cent of students. Scabies is caused by a mite that gets under the skin. It makes the skin so itchy that you want to tear your flesh off. What happens over time with scabies is that it affects all the major organs in the body. It is a major factor in Aboriginal people not living as long as non-Indigenous people. It too can be fixed. There is a simple ointment that can be applied to people who have scabies. In one wonderful school that we went to some time ago at Elcho Island I asked the principal about scabies and he said, 'We only have about a five per cent rate of scabies infection.' The kids were very bright and shiny. They had black hair and black skin and looked fantastic. He said that they hold scabies at bay by closing down the school for one day every term and going into people's homes with the clinic. They administer the ointment, they clean up dogs and they assist the community generally to keep scabies away. This is utterly crucial. If we want children to learn in schools then they have to be free of scabies. It is appalling that in so many communities 80 per cent of them are not.

We all know that if there were better housing, if there were better sanitation, if kids washed their faces and eyes so that they were less likely to get trachoma, if there were better jobs, if there were a better environment in many of these places, if there were better nutrition and if there were better health services generally—all of those things—then our Aboriginal community would not have such an appalling health record and shorter life expectancy. But the two examples that I have given could be done without fixing all those things. I am not saying the other things should not be fixed, but it is possible to fix those two things and it is disgraceful that this government, after 10 years, has not done so. I might also say 'the government before it', because governments have neglected Aboriginal health. This is not something that has happened since

1996. Governments have overseen an appalling record in this country. They pay lip-service to doing better in Aboriginal communities, but even the simple solutions to some of these debilitating problems are not adopted. Senator PATTERSON (Victoria) (4.30 pm)—I do not think anybody in the Senate would deny that there is more to do to improve Indigenous health and to reduce the difference in life expectancy between Indigenous and non-Indigenous Australians, but closing the gap will not be achieved by primary health intervention alone. There are a raft of other policies which impact on the health of our first Australians.

Let me remind people about the appalling record that we inherited from the Labor government in 1996, when only 53 per cent of all our children were vaccinated—a level of vaccination that was down around those of Third World countries. That was an appalling situation among not just white Australians but Indigenous Australians. Although I have not had time to find the figure, if I were a betting woman I would bet that the level of vaccination among Indigenous Australians was lower. Through an innovative social policy—not a health policy but a social policy—Dr Michael Wooldridge brought about an increase in vaccinations to a level of over 90 per cent. There is very little incidence of measles infection in Australia, but children were dying of measles before that. The incidence of

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measles infection has decreased in both the Indigenous population and the general population. The successful control of measles and other vaccine-preventable diseases such as diphtheria, polio, rubella and tetanus underlines the success of universal vaccination programs and their importance to Indigenous health. In addition, before we were able to vaccinate all children against pneumococcal disease, we had Indigenous young people being vaccinated against pneumococcal disease

because they were most at risk.

Measure after measure indicates an improvement in Indigenous health since the change of federal government in 1996. Senator Moore was talking about the workforce. In the four years from 2000 to 2004, which are the most recent figures we have, full-time equivalent doctors employed by Aboriginal and Torres Strait Islander health care services rose by 50 per cent. There was a 53 per cent increase in full-time equivalent nurses in that four-year period. The number of Indigenous health care workers increased by 19 per cent. I predict that we will see similar increases in the four years from 2004 to 2008.

Another measure that Dr Wooldridge brought in was the Rural Clinical Schools Program, which funded the university schools of rural health. It takes a long time for those to have an effect, and that will be one of his lasting legacies. One of the lasting legacies of the Howard government will be that young Indigenous people are now being trained in Broome or Wagga or Traralgon and they are spending more time in their own communities and more time practising their skills in remote communities. That would never have happened without the innovation of the Rural Clinical Schools Program and the university schools of rural health.

Between 1999 and 2005, the proportion of ATSI primary health care services providing specific programs increased. I will give you some figures. Antenatal maternal programs went from 58 per cent to 70 per cent of services, women's health programs went from 73 per cent to 87 per cent of services, men's health programs went from 55 per cent to 74 per cent of services, and eye screening went from 57 per cent to 70 per cent of services. Specifically targeted maternal and child health programs have produced declines in preterm births from 16.7 per cent to 8.7 per cent, which is now comparable with the general population, and a

decrease in infant mortality.

Senator Moore mentioned the Townsville Mums and Bubs program. I went up to visit that program when I was Minister for Health and Ageing, and they were running it on a shoestring out of the garage, part of what they jokingly called the Taj Mahal—the Townsville Aboriginal and Islander Health Services. They said to me, 'Can you fund this, Minister?' It was really the responsibility of the Queensland government—it was an infant welfare program—but it is now funded through the Commonwealth. We managed to increase the funding to the Townsville Indigenous health service for that program to go ahead. When you go in there you see babies who are absolutely thriving. Mums feel confident about their parenting and children are thriving. It is a perfect example but really something that the state should have done something about. Aboriginal people have had increased access to the PBS and the MBS, and specific health checks have been introduced for children and adults.

The recent Northern Territory emergency response will have a significant impact on the health of Indigenous people, in particular children. It will also have an impact on health through the fact that there will be a greater police presence. One of the things that nurses say—and I think that Senator Adams will probably speak about this—is that they are subjected to terrible violence when they go out to remote Indigenous communities.

That discourages and dissuades nurses from being there, which would then have a negative impact on health. So we need to have the states, including Western Australia, coming up to the plate. Senator Moore said that we have focused only on the Northern Territory because that is where we have the power to intervene. The Northern Territory should be looking at more police to reduce that threat to nurses.

As I said, primary health intervention is not the only

way to impact on Indigenous health. There are other policies which have a positive impact on health. Look at the 'no school, no pool' program in Indigenous communities. School attendance goes up and the incidence of ear infections and scabies goes down. Senator Allison did not have time to mention that scabies has an enormous impact on the health of adults. As children grow up and become adults, they may have kidney disease as a result of scabies, and pools have an effect on that.

What happened in Wadeye? We had a 'no school, no pool' program, but the kids turned up to school and there were not enough seats and not enough teachers for them. If that had happened in South Auburn, Dandenong, Lilyfield or somewhere else in Sydney or Melbourne, there would have been an outcry. But the Northern Territory government get away with it because they do not have enough places or teachers to look after those children when they turn up. Another example of an indirect effect of a policy which is not a primary health care policy—

Senator Crossin—It's a Catholic school.

Senator PATTERSON—Senator Crossin, you will have your chance in a moment. The Cape York financial information management program has seen school attendance go up—an educational outcome; domestic violence go down—a social and health outcome; and better nutrition—a health outcome. The community

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stores policy recently announced by Minister Brough, which relates to the operation of community stores in the Northern Territory, although not a direct health intervention

will undoubtedly have an impact on health.

What we are doing is setting up a licensing system for community stores in the Northern Territory. Stores that

are licensed will be able to participate in the income management arrangements. A licence will be issued to community stores that are able to participate in the requirements of the income management scheme; that have a reasonable quality, quantity and range of groceries and consumer items, including healthy food and drink, available and promoted at the store; and that can demonstrate sound financial structures, retail practices and governance.

I have been to remote communities in my two roles as Minister for Health and Ageing and Minister for Family and Community Services. It is quite interesting to see the significant differences. Some stores are managed well—and some of them are managed by Indigenous people, who really have a motive to manage them well. They run cooking classes and they prepare meals for people to take away. They prepare school meals for children—and they are prepaid. What you see in those communities is a significant change in their health. Other measures that need to be taken into account—and you see considerable differences across communities—  
(Time expired)

Senator CROSSIN (Northern Territory) (4.38 pm)—I too rise to speak on this matter of urgency. Those in this place will remember that, prior to the APEC summit in Sydney, the Andersen-Wild report titled Little children are sacred was widely reported on in the national media. Of course, we all now know that that was the report of an inquiry instigated by the Northern Territory government into the situation of children in Indigenous communities. I think it is fair to say that, since APEC, Indigenous issues have fallen off the national media's radar. However, Indigenous issues are, as always, of critical importance not only to me but to the Labor Party. In this job, not a year goes by in which we do not see some sort of report into the gap between Indigenous health outcomes and life expectancy

and those of non-Indigenous people. We get it from the Australian Medical Association when they hand down their report card. We get it from the National Aboriginal Community Controlled Health Organisation, or NACCHO. In the Northern Territory we have some of the most outstanding Aboriginal community controlled organisations that you will come across in this country. And now, of course, we have the report from Oxfam.

The situation of our Indigenous people continues to be extremely dire. NACCHO and Oxfam Australia have launched a report called Close the gap. It is a policy briefing paper. It states that Aboriginal and Torres Strait Islanders continue to die nearly 20 years younger than non-Indigenous Australians. From a personal point of view, in the last couple of months I have attended a number of funerals for Indigenous people who have died between the ages of 37 and 53 from diseases which would normally strike down non-Indigenous people when they are at least 20 years older than those Indigenous people. So the facts are there. The real-life experiences are there for us to witness and participate in.

While Indigenous health issues have been problematic for many nations across the globe other than Australia, we seem to have the greatest difficulty in combating these problems. Close the gap states that Aboriginal and Torres Strait Islander infant mortality is three times the rate of non-Indigenous Australians and more than 50 per cent higher than for indigenous children in the USA and New Zealand.

This chamber is no stranger to such horrifying statistics. I and many other senators have raised many similar statistics in other speeches in this chamber time after time and year after year. My colleague Minister Scullion, from the Northern Territory, reflecting on poor Indigenous life expectancy figures, said in this chamber more than five years ago that 'average life

expectancy for Indigenous men is less than my'—that is, Senator Scullion's—'current age'. So what have Minister Scullion and this government done with an extra five years of their life? Perhaps that is a question that only that minister can answer. But all I have seen is a fundamental failure to show leadership on addressing Aboriginal life expectancy and a complete inability to work collaboratively with the Northern Territory government to achieve any of the necessary outcomes. The Australian Labor Party, on the other hand, in the lead-up to the election have recently released a new directions policy paper called An equal start in life for Indigenous children, in which we, as the alternative government, have outlined our policy commitment to helping Indigenous children as a way to make the greatest difference over the long term for Indigenous communities. The policy paper quite clearly articulates our position on this issue. We believe that the life expectancy gap between Indigenous and non-Indigenous Australians remains one of the most stark indicators of inequality in Australian society.

The Howard government has now had 11 very long years to try and minimise this gap. Labor has a plan to focus on the critical years between birth and eight years of age, particularly in terms of support for child and maternal services, early development and parenting as well as literacy and numeracy in the early years. Our plan represents a total investment of \$261.4 million over four years, comprising \$186.4 million in Commonwealth expenditure supported by \$75 million from the states and territories.

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Speaking of the states and territories, particularly over the last few months we have seen that the Howard government is more interested in blaming and riding roughshod over the Northern Territory government

than working collaboratively. Federal Labor recognises the important role that the Martin Labor government in the Northern Territory is playing in addressing Indigenous disadvantage in the Northern Territory. I think it is about time that somebody in this House recognised the significant resource commitments the Northern Territory government has allocated for addressing Indigenous disadvantage and publicly recognised the work that public servants—nurses, health workers and those employed by the Northern Territory Department of Health and Community Services—have undertaken in their working life in turning these statistics around. As I travelled around Indigenous communities in the previous couple of weeks, in relation to the federal government's Northern Territory intervention, Northern Territory public servants said to me that they feel their work over the last couple of years and decades has been worthless and that there has been no recognition of the substantial role they have played in trying to reduce this gap, particularly in health services. The Northern Territory government has committed \$286 million over five years to implement a closing the gap strategy. This funding package means that there will be 223 real positions created to help close the gap. This is a generational plan of action and it should be applauded. It is to the great disgrace of the opposition in the Northern Territory that they prefer to take cheap political shots at the Northern Territory government rather than working with them collaboratively on this. The Howard government has demonstrated that it prefers to sit on its hands instead of taking real action in closing the gap. We have a federal government that prefers to play politics instead of showing real leadership, working collaboratively with state and territory governments and putting the money on the table that will actually assist in closing the gap that we are debating today.

The Australian Labor Party have, as I have discussed, demonstrated our commitment to closing the gap. We agree with NACCHO and Oxfam that poor Indigenous health is affected by:

... social and economic factors: diseases triggered by poverty; overcrowded housing; poor sanitation; lack of access to education; poor access to medical care for accurate diagnosis and treatment; and poor nutrition.

These factors are all preventable living conditions and if addressed could have real health implications for Indigenous people.

I cannot let the opportunity go by in my remaining few minutes without mentioning trachoma. I know that Senator Lyn Allison mentioned it. Last week, we were both at a dinner for the parliamentary friends group for eye health and vision care. Vision 2020 Australia, in conjunction with a number of other health experts in the area of eye health, spoke at this dinner last week. I think it might have been the first time that Senator Allison had actually been alerted to the dire situation we have in this country in relation to trachoma. I have been pursuing this issue now for many years. I know that people in OATSIH, in particular one senior public servant, will know that this has been a passion of mine for the best part of six or seven years now.

Trachoma is a disease of poverty. It was eliminated from white Australia 100 years ago, and it is a disease that we know how to handle. It exists in Aboriginal communities. The fact that it does exist is a national shame. We are the only developed country in the world that has trachoma and without some concerted effort we may end up being the last country in the world with it. Countries such as Morocco and Iran have already eliminated blinding trachoma. This year in Niger, one of the most backward of all African countries, 61/2 million people will receive treatment for this disease.

Some Aboriginal communities have rates of trachoma that are among the highest recorded anywhere in the world.

The Howard government just pays lip-service to interventions

on trachoma and has not made any significant commitment or change. Nine hundred thousand dollars to develop a policy, to train health workers and to set up a national database may well be a good start, but it needs to fund the medicine that goes into the eyes of these people. (Time expired)

Senator ADAMS (Western Australia) (4.48 pm)—I rise to speak on something which is very close to my heart. Being perhaps one of the only nurses in the parliament,

I was very fortunate to attend a conference at Broken Hill for the Council of Remote Area Nurses of Australia, CRANA. People who attended this conference came from all over Australia—125 of them plus a number of allied health people. All the things we have heard from those opposite today on this are actually being tackled by these nurses, and—guess what?—the Howard government actually supports the organisation. When the Northern Territory intervention was being brought together, health professionals played a very important part. CRANA was the organisation that the government went to, and they were very careful in the way that they asked the government teams to approach the issue. There was to be no 'big stick' approach, though we heard from the other side that this was the intention. It certainly was not the intention. These people have done the most wonderful job in briefing the health teams going through the Northern Territory. This is CRANA's 25th year of operation and it was their silver jubilee meeting. On top of their agenda was finding solutions to the health issues impacting on remote communities and to the health workforce crisis

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gripping Australia. It was the most wonderful conference. I could go on all afternoon talking about the different presentations that were made. It is important to note that nurses and midwives—safe providers of primary health care—are living and working in most communities no matter how small or isolated. Remote area nurses provide a model of care that needs to be acknowledged, and I am sure it is acknowledged by the Howard government. CRANA believes that this model can be part of the solution to the healthcare crisis in Australia.

I will identify some of the key recommendations that were made to improve health care in remote areas, but, firstly, I think it is very important to note that the Australian government cosponsored this conference. It recognises the important role CRANA plays in supporting the remote health workforce across Australia.

The government put \$25,000 towards the funding of the conference. It also funds the CRANA secretariat to enable CRANA to manage their programs as well as to engage with stakeholders at all levels to develop policies, protocols and initiatives that improve and support remote nursing practice. The government has provided \$881,000 over three years for this. CRANA provides the bush crisis line, which is a 24-hour free-call telephone service staffed by qualified psychologists. That service provides crisis debriefing and counselling for job related trauma to isolated remote health practitioners and their families. I note that one of CRANA's recommendations is that by July 2008 no nurse should be left to practice in isolation. Single nursing posts must be abolished. I certainly agree with that given some of the stories I heard.

A health research education officer who coordinates and teaches in the Remote Health Practice program at the Centre for Remote Health provides mentoring, clinical supervision and assessment of remote area

nursing students and provides academic leadership and resources to CRANA. There was a very good presentation by Vicki Gordon and Sabina Knight, and these two people were asked to coordinate the child health check teams and brief them on what to expect and how to go about their role as they move through the 73 communities in the Northern Territory.

Something that is very important and that I would like to see extended is the First Line Emergency Care, or FLEC, program, which aims to increase the access of people living in remote areas to high-quality emergency care through a program of upskilling of remote practitioners. If these practitioners are not upskilled, they will not stay there, so it is very important that this program, which includes remote emergency care and the maternity emergency care program, is delivered by volunteer trainers. These trainers come from a number of our intensive care areas. Most of them are state employed professionals, but they are there as volunteers to focus on the multidisciplinary advance emergency and trauma management skills.

At the moment this program receives \$590,000 over three years, but that amount needs to be doubled. The facilitators are brilliant and it has got to the stage now that defence and mining organisations are requesting that these teams adapt their programs to help them as well. This is recognition of what the Howard government has done in providing this sort of support over the three years, but, as I said, it really needs to be increased. There is also an Indigenous program, which aims to upskill health professionals who service the Aboriginal community controlled health services in emergency care. This includes the production of culturally appropriate teaching resources and simulation material.

With the Prime Minister's announcement of enrolled nurses now being able to train in hospital settings, I see this as a great way for Aboriginal health workers to

become enrolled nurses and have the support and backing of working in a hospital environment rather than try to sit in a lecture theatre. That is not the way they learn; they learn by hands-on experience. So I think the Prime Minister's announcement for enrolled nurses to return to hospital based training is very good and I support it.

The comment made after this great weekend by Christopher Cliffe, the President of CRANA, is important: Let's mobilise and utilise nurses, the most trusted and abundant of our health professionals. Remote Area Nurses already provide a high level of service to some of the sickest and most disadvantaged people in Australia; with a shortage of doctors their role is even more important. The nursing and midwifery profession isn't running from the daunting challenges, in fact they are eager to address it head on. I plead with the federal, state and territory governments to meet this call from nurses and midwives, and enable them to tackle the increasing needs of remote and rural communities across Australia.

(Time expired)

Question agreed to.

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