EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 23 SEPTEMBER 2009

SESSION ONE

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 8.34 am

KICKETT, MR DARRYL MILTON
Former CEO and Spokesperson, Aboriginal Health Council of Western Australia, examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the review of Western Australia's current and future hospital and community healthcare services, and also its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and drug problems. You have been provided with a copy of the committee's specific terms of reference.

At this stage I would like to introduce myself and the other members of the committee. I am Janet Woollard. The other members of the committee are Ian Blayney, Peter Watson and Lisa Baker. We also have with us David Worth, our principal research officer, and Hansard staff.

The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As this is a public hearing, Hansard officers are making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Before we proceed to the questions that we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

Mr Kickett: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

Mr Kickett: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

Mr Kickett: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

Mr Kickett: I have just one question. I am no longer the chief executive officer of the Aboriginal Health Council of Western Australia. I ceased in that position on 10 September. The chairperson requested that I attend today as the spokesperson.

The CHAIRMAN: That is all right, Darryl. When you introduce yourself, you can say that you are Mr Darryl Kickett, former chief executive officer.

Thank you very much for appearing here us today. As you are aware, we are conducting two reviews. Really, in some ways I guess they interact with one another. So we would very much like your comments about those reviews, and particularly where you can identify that there are needs and gaps in general healthcare and community healthcare, and in relation to prevention and treatment of alcohol and drug problems. We will ask you to give a summary of where you think the problems are, and then committee members will interject. We have some questions that we would

like to ask you, but they may come out as you are making your summary, so rather than formally go through those, would you like to paint your picture as you see it and we can take it from there.

Mr Kickett: I guess the perspective that I am coming from is that the members of the Aboriginal Health Council of Western Australia are currently looking at the life-expectancy gap for Indigenous people in comparison with the rest of Australia.

Mr P.B. WATSON: Is that for Aboriginal people in Western Australia compared with the rest of Australia?
[8.40 am]

Mr Kickett: It is all over Australia. For the average, the 17-year life expectancy gap is national. You can have a look at what it is in Western Australia as well, and you will find that it is very similar to the national average based on the 2006 state health department of Western Australia report in terms of the morbidity and mortality figures. In some areas, it is a lot worse, of course. We can talk about those as we go through.

If you follow the thread of life expectancy, it starts, of course, with education—access to education and the achievements in education. It ought to be able to provide you with the wherewithal to achieve employment and, with that employment, to purchase some things for your personal needs and your health care and for your shelter and sustenance, including housing. We know that, in education, housing and health, there are huge gaps between what has been achieved by non-Aboriginal people compared with what has been achieved by Aboriginal people. Each year reports commissioned by state and federal governments are piling up in the libraries and other places.

Mr P.B. WATSON: Is it getting worse or plateauing?

Mr Kickett: I think in some areas it is getting worse. I think issues with mental health are blowing out of all proportion. The suicides across the state give testimony to that.

The CHAIRMAN: I welcome Peter Abetz and Lisa Baker.

Mr Kickett: I am just following the thread of life expectancy from education through to employment and housing and how they really provide life support systems to individuals, families and communities. Health is one of the major life support systems for anyone, including Aboriginal people.

The CHAIRMAN: I think you said that problems begin with access to education.

Mr Kickett: Yes

The CHAIRMAN: I wonder whether you agree that problems begin before access to education. We have certainly been informed as a committee that, right from birth, Aboriginal people are missing out on basic screening tests and that means that when they enter the education system, they may have hearing and visual problems and may be entering the education system with foetal alcohol system. There is an abundance of both health and environmental factors prior to the education system that have not been addressed that are causing that inequity when Aboriginal people enter the education system. You may want to address those issues.

Mr Kickett: I was just about to address that through the health area. If you look at health as a life support system, you then have to consider that, with life expectancy, it starts at birth. If babies are born under weight or premature because of lifestyle issues around the mother—alcohol, drugs—you then are scripting the child to either die early because the kidneys are not developed properly or, as you say, suffer from hearing or eyesight problems. If the teachers fail to recognise them in the early years, the child will suffer. My son had otitis media but we did not pick it up until he was in his teens, so he failed to learn. Luckily, when we found out, we were able to give him some support that allowed him to get an apprenticeship. Now he is earning more than me in the mining industry.

Mr P.B. WATSON: Is that where you are heading now after this job?

Mr Kickett: I am doing some more health stuff down south with Nyoongah people. You are right, it is important to make sure that the kids have a decent start to life, and that is where the life expectancy is measured from. I think a number of factors are involved with health, such as the opportunity to screen children at school and make sure that these things are picked up early. I do not have any evidence of whether that is happening in a much more strategic sense. I was talking to Dr Peter Flett about the possibility of running a massive screening program across the state. I think that is still in the discussion stages.

The CHAIRMAN: Were you asking for that program to be coordinated? Currently, there are programs in regional community health centres. In your discussions, have you asked Dr Flett if those programs can be taken to remote Aboriginal communities? How would you like to see such programs implemented?

Mr Kickett: I think he was talking about 90 communities across the state where it may happen. But we would like to see it done with the full involvement of the 20 Aboriginal medical services across the state, because they are on the ground and are able to do the follow-up and what have you. They may already have those people as clients on their books.

Mr P.B. WATSON: You were saying that you were going to do some work down south. There is a perception that all the problems are up north. There are huge problems down my way. They happen right throughout the state. But attention is given to up north, and rightly so because there are probably different issues there. This is widespread all over Western Australia, is it not?

Mr Kickett: It is. There are 33 000 people living in the metropolitan area and down south and the state population is around 70 000. Almost half the people live down south, yet there has never been a strategic approach to fixing up the health, housing et cetera for people down south.

Mr I.C. BLAYNEY: Where is the line between north and south?

[8.50 am]

Mr Kickett: I am talking about starting at the line from Jurien through to Esperance and below when I talk about the south, because that is what we call Nyoongah country. There are also around 25 000 Nyoongah people. They are the largest, single-language group in the whole of Australia; yet, apart from the South West Aboriginal Land and Sea Council, we do not have any regional structure that addresses the governance of service delivery. In fact, one of the keys to improving the situation is these regional structures. We are certainly very interested in what Lieutenant General Sanderson is saying about the importance of regional governance and we would like to follow up with him about how we can make that happen for the Aboriginal population down in the metro south area.

The CHAIRMAN: Currently, we have the Aboriginal Health Council covering the whole of WA. You then are saying that you see the need to have a regional council for the north of WA.

Mr Kickett: There is already a regional structure in the Kimberley, for example—the Kimberley Aboriginal Medical Service Council—which has around 13 Aboriginal medical services or nursing outposts maybe in the Kimberley. They provide support services around governance, financial management, human resources, management and backup services for the workforce and equipment.

The CHAIRMAN: There is no equivalent to that from Jurien to Esperance.

Mr Kickett: There is no equivalent to that in any other area of the state.

Mr P.B. WATSON: Darryl, can I just ask a question. When we were in Albany we had a Nyoongah representative come along and say that he thought that it should be that the Aboriginal people, instead of going to Aboriginal health should go to their local doctor and become part of the community instead of the Aboriginal health service looking after them. He was saying that it does happen in Albany. He was saying that we have not really got an Aboriginal health service in Albany. The local Nyoongahs go to the local doctor and have good relationships. Do you think that

the government should be doing more to encourage that, to bring them into the community, use the services that everyone else uses, and let them be confident in doing it?

Mr Kickett: There are a few issues around that. I think you need to give consideration to the doctor. In a lot of cases we found out the doctor already has a full quota of clients and has cut off the provider ceiling. The client then has to wait two to three weeks to get an appointment. But there may be opportunity to develop partnerships with private GPs, and that is essential if you are going to close the gap in life expectancy. They will need to see the GP. They will need to be able to get a healthcare plan if they have a chronic disease and to be able to have that disease monitored and to be able to have access to pharmaceuticals, so that we give them the best chance of living as long as they can, given the carrying of that disease. I am not sure whether the private GPs you are talking about have the capacity to actually do the follow up, so if someone does not turn up at the GP—for example, if they have got diabetes—after the three months, they ask if they have turned up, and if they have not —

Mr P.B. WATSON: That is a very good point.

Mr Kickett: The Aboriginal medical services have Aboriginal medical health workers, of course, who are our outreach, who go out into the homes of the families and track down these people who have not turned up.

The CHAIRMAN: Darryl, in proposing that there be a southern regional council, do you have evidence for the Kimberley-Pilbara regional council of the number of people who are employed in that council? How many communities are they able to reach, so that from the structure that they have in place at the moment, they are able to look at the southern area and say that maybe in the north there are 30 outlying remote Aboriginal communities and for the southern area, which may have maybe 20 outlying Aboriginal communities, in order to provide the same level of service or resources, or in fact additional services or resources because of some gaps there may be in the northern area, this would be how? Have you prepared a plan in terms of not just that we would need a council but also from that council we would need this number of Aboriginal health workers, this number of doctors dedicated to this area, this number of people within public health?

Mr Kickett: The main funder for primary healthcare in Western Australia is the commonwealth government. The state provides some, but the main funder is the commonwealth. What you are talking about, if you draw comparisons, is that there is nothing to measure in relation to any other regional structure in WA, because there is not one. What we do know from the statistics is that for the Kimberley the statistics are still terrible and each other region is terrible. I will give you an example. In the Pilbara, for example, in the 25 to 44 year olds, which are the Aboriginal workforce in the Pilbara, the death rate according to the 2006 report from the state government is that the death rate is eight times the mainstream average. Nationally we are looking at two and a half times, but in that age group in the Pilbara it is eight times the mainstream average. If you look down south, in the southern area the death rate from diabetes, for example, is 20 times the mainstream average. In the goldfields it is even worse. So really, in terms of closing the gap in life expectancy, these regional structures might be a way to provide the coordination that is required for the implementation of policy at the regional level in partnership with the other key providers. You need to know who they are. They are the state government and, of course, the private GPs, if they do exist there, but in a lot of cases the private GPs may not be a bulk-billing GP, whereas the Aboriginal medical services are, so you will find that Aboriginal medical services out in those areas, and in Perth as well, also service the non-Aboriginal community clients on that sector coming in to receive services because it is a bulk-billing service.

The CHAIRMAN: We have not yet, as part of these hearings —

Mr Kickett: The Aboriginal is incumbent to service the non-Aboriginal clients. I will just make that point.

The CHAIRMAN: I was just think that we have not, as yet, invited anyone from the northern Aboriginal medical services to give a presentation to this committee. Therefore, while some members of the committee—I believe Lisa went up last year and has a picture in her mind of that Aboriginal medical services; and probably Ian Blayney, the member for Geraldton, also has a picture because he comes from Geraldton, which would have outlying centres; and probably Peter Watson —

Mr P.B. WATSON: Geraldton is sort of the same.

The CHAIRMAN: It is not, because you have not got them down there. I certainly, and I do not think Peter, would have that understanding of how those services work. Whilst you are saying that we need to have a regional structure between Jurien and Esperance, we probably need to do some more homework in terms of how the Aboriginal medical services function in the Kimberley and Pilbara.

[9.00 am]

Mr I.C. BLAYNEY: I think they are all different; that is the problem. The Geraldton one is probably the interesting one because it is a mixture. It is sort of half southern, half northern. It has got a bit of both.

Mr Kickett: The Geraldton Aboriginal Medical Service is probably one of the highest performing Aboriginal Medical Services in this state.

Mr I.C. BLAYNEY: I would say in the country probably; it is very, very good.

Mr Kickett: It has a lot of non-Aboriginal clients as well.

Mr I.C. BLAYNEY: Not many. I think now it is about 87 per cent Aboriginal, and they have closed the book.

Mr Kickett: Yes, but they are also doing outreach to Mt Magnet and Meekatharra.

Mr I.C. BLAYNEY: Yes, they are just starting there.

Mr Kickett: Yes, but they do not come down south, I do not think, past —

Mr I.C. BLAYNEY: Coorow or somewhere around there, I would say. Probably Jurien Bay, I would say.

Mr Kickett: What is the town north of Jurien?

Mr I.C. BLAYNEY: Green Head, Eneabba.

Mr Kickett: Yes, those places.

Ms L.L. BAKER: Darryl, I am interested in your opinion on, I suppose, the different models of delivery. So the community-based Aboriginal health care versus the public sector ones. Are you okay to make some comments about that for me?

Mr Kickett: Yes. I just wanted to finish off that question you asked. Now there is a division of responsibilities—but it is not like a formal division; it is an informal division—between the state health provider, community health services, and the Aboriginal community control sector. Those are medical services and then you have got the GP Divisions and the RFDS. They are the main service providers around primary health care for Aboriginal health.

The CHAIRMAN: When does that group meet, so that maybe we could talk to people who belong to that group who are providing those services?

Mr Kickett: I was going to say it is very important for you to have a discussion. They have these things called regional planning forums for Aboriginal health, and they are set up across the state. They have operated in the Kimberley for more than 10 years with all those stakeholders sitting on it. They do up regional health plans. They identify what the gaps are in the service provision and

access to primary health care. Also, they look at specialist care and secondary care, but the others in the other regions in the state are only just getting up to speed. For example, Kalgoorlie in the goldfields has recently had its first meeting. The metro is really yet to meet, but they have the south metro and north metro area health services of state health, and they are starting to, I think, meet with the other providers. So you can see that in terms of planning and development it has been very ad hoc between the stakeholders, and it is only just starting to come together because of the COAG funding.

The CHAIRMAN: Who coordinates them, if we were to contact them to see whether we could listen to and meet with those people?

Mr Kickett: Kim Snowball's office in the WA Country Health Service. He is also in charge of the COAG rollout, so he is the man. I think it would be very important if you would meet with him because he is —

The CHAIRMAN: We have met with him to discuss the WA Country Health Service, but we were not aware of these regional planning meetings; and so we could possibly follow up with him in relation to that area and the needs that you have identified with us.

Mr Kickett: Yes, because I think this came from Canberra, for example, and from Perth that the COAG funding for the rollout was meant to be tracked through the regional planning forum to make sure that there is some kind of collaboration around the gaps in service provision.

The CHAIRMAN: Could I just ask you, in terms of your mentioning the many areas where there is a gap between Aboriginal people and non-Aboriginal people, what is the biggest gap, or are there too many gaps for you to be able to give an answer?

Mr Kickett: It is huge in terms of what Ms Baker said. I think there are a few key target areas that ought to be focused on. Child and maternal health, of course, is a big area. That is one where we have just got funding from the commonwealth at the Aboriginal community control sector to set up centres of excellence within the Aboriginal Medical Service. So we have targeted three at this stage; and we are going to go back for more funding once we have got those three up as centres of excellence for child and maternal health, ensuring that women who become pregnant have access to care in each trimester, that they stop smoking and all those kinds of things. Another area that we have focused on and we need to pick up properly eventually is chronic disease care. Chronic disease has become a big issue. It has been recognised in the COAG funding, and self-management of chronic disease has been recognised. So we need to rally around that to be able to provide proper chronic disease care, not only by the Aboriginal Medical Service but also by private GPs. The GP Divisions have been involved in this discussion at the national and WA state level and at the regional level.

The CHAIRMAN: So heart disease, diabetes.

Mr Kickett: Yes, heart disease, diabetes. We have also got a health promotion strategy going in the health council since I have been there. We have been funded by the state government and we have employed through the medical services in the regions six health promotion officers who are studying at the same time to get qualifications around health promotions, and they will be the key in the regions to drive better messages around health promotion from the community perspective, to try to make sure that people do not smoke, that they do not consume alcohol to the extent where it is abused, and that their lifestyle stuff is improved around diet and exercise, because that holds the key, of course, to preventing disease further down the track. A third big area is mental health that we need to have a look at, because a lot of the people with mental health problems are turning up at the Aboriginal Medical Service and the medical services are not equipped to deal with it; neither is the community in general because there has been no real strategy. Only recently, I think, there has been a mental health strategy developed by the state government and it is about to roll out, so we will see how that goes.

The CHAIRMAN: It was interesting that, again through the hearings I guess, we have been made aware of the fact that in non-Indigenous people the diagnosis of a mental illness was very much taboo 20 years ago and is now more accepted by the community, because we know that so many people suffer from a mental illness; whereas with Aboriginal people that diagnosis is very much taboo still. In discussions with Aboriginal people, rather than talking about mental problems, it may be that people should be asking an Aboriginal person, "What is your state of wellbeing?" rather than, "Do you have a mental illness?" Could you maybe discuss that a little further?

[9.10 am]

Mr Kickett: Yes. I have been working closely with the staff in Narrogin around the suicides, and we have recently been asked about Balgo. We know, for example, that a mental health person comes down from Kununurra, I think it is, to Balgo once every six weeks. In Narrogin you have a mental health office service. Aboriginal people will not go into those offices. Many of our Aboriginal medical services have social and emotional wellbeing units funded by the commonwealth through the Bringing Them Home funding—and with Bringing Them Home, we are talking about the stolen generations. But a lot of their work is around that social and emotional wellbeing stuff for all the community rather than for just the stolen generations people. Everyone is affected, of course, by the stolen generations. With the state government, if you take a measure of a continuum, for example, from one to 10—10 being the worst case in mental health—the state mental health services are dealing with the people who are within the seven to 10 bracket, so the one to six people are not being addressed effectively. This is the story that Michael Mitchell from the WA state mental health services out at Graylands gave me. So we need to develop a strategy around the people who are not diagnosed as having a mental illness but who are suffering from trauma and grief. So in Narrogin we have started with a psychologist named Darrell Henry, who was involved in the Gordon inquiry, to address strengthening the families from within to deal with the grief and trauma from deaths, suicides—from whatever it is they have trauma about—in a much more strategic way, and that really involves a community-development approach to build that strength within the families. It is about empowering the families to deal with that, to be able to problem solve, to be able to negotiate services with the mainstream and to be able to shepherd people who really need that high-level mental health care into the mental health services where they can receive it. Darrell has been funded by Oxfam Australia. Dr Jacobs, the mental health minister, has made a decision not to fund Darrell Henry's operation in Narrogin, so we need to look at other ways of getting funding for that.

Ms L.L. BAKER: I know Darrell quite well and met with him last year about this, or earlier this year. How is the intervention that he is trying to put in place going? He was very, very stressed about the lack of progress when I spoke to him, particularly with education, the schools and whatnot. Have you got any update that you feel qualified to give us about how that is going?

Mr Kickett: In Narrogin?

Ms L.L. BAKER: Yes.

Mr Kickett: We know that over $700 000 has been generated for Narrogin, but it is going to organisations—for example, FaHCSIA gave DIA funding to help in Narrogin—about $200 000, I think. SWAMS, the South West Aboriginal Medical Service, has been given funding to provide a social worker and a family support worker in Narrogin, which is going quite well. But, clearly, what the people are wanting up there is an Aboriginal-specific service that is controlled by the Aboriginal community itself, because they want to deal with that internal grief and trauma in a way that they can do better with someone like Darrell Henry. I think it is his work up there—when he first came in, he ran workshops to explain what suicide is and why people are maybe killing themselves, and explained about grief and trauma, and I think that opened a lot of eyes of the community leaders and those who have been affected by suicide up there, and they were able, with his help, to set up a 24-hour watch to prevent suicide, and that has been rather successful since June last year.

Unfortunately, there was one death in Perth. A young Narrogin lad in Rockingham had an argument with his wife, walked around the corner to the park and hung himself. But in the mix of all that, of course, is drugs and alcohol, and, like Fitzroy crossing, for example, if there are ways to stop that, it gives the town breathing space. I remember talking to someone who was an absolute drunk in Canada, and she is now head of the healing strategy in Canada. It is my view that we ought to have healing centres set up and strategically placed across WA to provide a better way to heal these people of their trauma and grief—that is, within that one to seven bracket that I am talking about.

Ms L.L. BAKER: Have you had much pick-up on that idea of the healing centres in the discussions you are having at the moment with either the federal or the state government, Darrell?

Mr Kickett: We have had discussions with Lois O'Donahue and her team, who are doing the consultations around a national healing foundation through the Rudd government. I am not sure where that is heading.

The CHAIRMAN: I want to ask you a short question and then a longer question. The short question is: you said that you have been funded for three centres of excellence in child and maternal health. I wonder if you could tell me where those centres are. Then the longer question that you can have a bit more time to think about is: can you tell us, from your experience, what you would see as the best example of liquor accords that have been introduced throughout various parts of the state? Whilst we are briefly looking at that in this inquiry, that will be a major focus of our next inquiry. So, first: where are those centres of excellence? Then could you give us the benefit of your knowledge in relation to what liquor accords have worked well. So, first, centres of excellence for child and maternal health.

Mr Kickett: The three that we have been funded to support are one in Kununurra, one in Roebourne and one in Geraldton

The CHAIRMAN: Right. In that case, we will certainly tap into Ian, who comes from Geraldton, to find out more about that centre.

Mr Kickett: The lady—if you wanted to follow up personally—is Anne-Marie McHugh, who is coordinating that through the Aboriginal Health Council of WA in Perth here. She has come across from King Edward hospital—a midwife who is supporting that development through the partnership with Fiona Stanley's institute.

The CHAIRMAN: Lovely. We will look into that. Alcohol is a big problem for Indigenous and non-Indigenous people, but in relation to Indigenous people in both metropolitan and remote Aboriginal communities, what accords are you aware of that have been effective; and are there some accords that you think we really need to keep away from?

Mr Kickett: You are talking about the bans in Fitzroy Crossing and possibly Halls Creek?

The CHAIRMAN: Yes.

Mr Kickett: I think they are very important as a measure to give the town breathing space, as I have said. But, having said that, they also need to be coupled with a developmental program within the town that is going to give people hope, help steer the younger people away from alcohol, and work out how they can be gainfully employed, because kids going to school need to have a career path, and, of course, to get that employment is going to lead to longer-term improvement in health and wellbeing. I think that there ought to be a study around the state, not just in Fitzroy Crossing and Halls Creek, but in other suburbs in Perth where there may be, for example, police records that show a high level of arrests or incidents around alcohol, and maybe take some action—local action—in relation to preventing access to alcohol. I think it is something that is not just for Aboriginal people, but I think it is something for the whole community, because alcohol can be extremely destructive, as we all know.

[9.20 am]

The CHAIRMAN: One suggestion that was put to committee members was that possibly, in order to go into a hotel or a club in both the metropolitan and outer metropolitan area, you actually have a card, and that if someone has problems in relation to the abuse of alcohol, that card is taken away from them and they are no longer able to visit pubs, hotels or liquor outlets to purchase alcohol. What do you think of that suggestion?

Mr Kickett: I think it might have merit with people who are not only doing themselves harm but also doing their family harm and where children are neglected. I think Ted Wilkes, I do not know, about 10 or 15 years ago, when they had Manguri out at Sister Kate's—they identified about 15 families who really required one-on-one support to be able to deal with alcohol, drugs and even education outcomes. I believe that that is something that probably has merit with the revolving door stuff that is happening around welfare and police. If you track it down, you will find that it only a few of those families who are actually involved with it all, even in each town, and there ought to be some concentration on those families to help them better adjust to make a better contribution in the community.

Mr P.B. WATSON: Madam Chair, can I just ask you one question?

The CHAIRMAN: You can, but before you ask your question, I mention to committee members that we are about to run over time if we take Peter's question. If there is an urgent need after Peter's question, we will put them, but if not, we could follow up with questions that I am sure Darryl would be happy to answer.

Mr P.B. WATSON: I just wondered if there was a photo on that card or it was just a card, because it would be quite easy to use if you did not have the person's photo on it.

The CHAIRMAN: It was suggested that there be a photo and maybe a date of birth on the card, so that when people were given cards they were may be linked to liquor licensing and if a hotel took away that card from someone, liquor licensing was informed so that they would get flagged as well if someone was having problems.

Mr P.B. WATSON: So this is for everyone, not just Aboriginal people?

The CHAIRMAN: This is for everybody, yes. Again, we are running over time. If there is anything that you have not flagged, I could give you one minute to flag.

Mr Kickett: There is just one more little thing that you need to be aware of. Unless we manage effectively the blood of Aboriginal people, particularly those with chronic disease, we are not going to be able to close the gap. If we do not do that effectively in terms of blood pressure and sugar levels within the blood, as well as cholesterol levels, and if we do not have the private GPs forming a partnership with Aboriginal medical services and the state government's community health services and population health services to do that, we are never going to close the gap. I will leave it at that.

The CHAIRMAN: That was a wonderful summary. I thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via the corrections and the sense of your evidence cannot be altered. Should you however wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript. Thank you once again very much, Darryl.

Hearing concluded at 9.24 am