REPORT OF THE

STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

IN RELATION TO

ENVIRONMENTAL HEALTH IN ABORIGINAL COMMUNITIES IN THE KIMBERLEY REGION

Presented by Hon Mark Nevill MLC (Chairman)

Report 32

STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

Date first appointed:
December 21 1989

Terms of Reference:

1. There is hereby appointed a Standing Committee to be known as the *Estimates and Financial Operations Committee.*
2. The committee consists of 5 members.
3. The functions of the Committee are to consider and report on:
   (a) the estimates of expenditure laid before the Council each year; and
   (b) any matter relating to the financial administration of the State.
4. The Committee shall report on the estimates referred under clause 3 by or within one sitting day of the day on which the second reading of the *Appropriation (Consolidated Revenue Fund) Bill* is moved.
5. For the purposes of clause 3(a), the House may appoint not more than 6 members at any stage of its examination.
6. A reference in clause 3 to "estimates of expenditure" includes continuing appropriations, however expressed, that do not require annual appropriations.
7. The Committee may initiate investigations under clause 3(b) without prejudice to the right of the Council to refer any such matter.

Members as at the time of this inquiry:
Hon Mark Nevill MLC
Hon Muriel Patterson MLC
Hon Ed Dermer MLC
Hon Simon O'Brien MLC
Hon Ljiljanna Ravlich MLC

Staff as at the time of this inquiry:
Ms Lisa Hanna, Committee Clerk
Mr Paul Grant, Advisory Officer

Address:

Parliament House, Perth WA 6000, Telephone (08) 9222 7222
Website: http://www.parliament.wa.gov.au

ISBN: 0 7307 6430 3

CONTENTS

CHAPTER 1 EXECUTIVE SUMMARY AND RECOMMENDATIONS 1

Executive Summary 1

Recommendations 3

CHAPTER 2 INTRODUCTION 7

CHAPTER 3 THE GENERAL STATE OF HEALTH OF ABORIGINAL PEOPLE IN THE KIMBERLEY REGION 9

CHAPTER 4 PROVISION OF HEALTH SERVICES TO THE KIMBERLEY REGION 17

Health Services Provided to the Kimberley Region by the State Government 17

Provision of Specific Health Services 21

Lack of Suitably Trained Staff and Equipment 24

Turnover of Health Staff 26

CHAPTER 5 THE IMPORTANCE OF ENVIRONMENTAL HEALTH TO THE MAINTENANCE OF PHYSICAL HEALTH 29

A Change of Focus in the Provision of Health Services to Aboriginal Communities 30

CHAPTER 6 SOME OF THE MAJOR ENVIRONMENTAL HEALTH ISSUES FACING ABORIGINAL COMMUNITIES IN THE KIMBERLEY REGION 35

Nutrition and the Key Role of Community Stores in Remote Communities 35

Employment 38

Housing 39

Refuse Collection 41

Dog Control 41

CHAPTER 7 OVERLAPPING JURISDICTIONS IN THE AREA OF ENVIRONMENTAL HEALTH... 45

Commonwealth Government.. 48

State Government 50

Local Government.. 54

Co-ordination of funding and localised supervision of environmental health programs .. 61

CHAPTER 8 FUNDING AND TRAINING OF ENVIRONMENTAL HEALTH WORKERS........63

Environmental Health Officers........64

Aboriginal Environmental Health Workers........66

Commonwealth Funding of Local Governments for the Provision of Environmental health services........71

Shire of Broome – Provision of Environmental Health Services to Aboriginal Communities........73

Shire of Derby-West Kimberley – Provision of Environmental Health Services to Aboriginal Communities........74

Shire of Halls Creek - Provision of Environmental Health Services to Aboriginal Communities........76

Shire of Wyndham-East Kimberley – Provision of Environmental Health Services to Aboriginal Communities........77

CHAPTER 9 POSSIBLE SOLUTIONS........81

Greater Community Involvement in Environmental Health........81

Focussing the Confused Array of Agencies and Groups Providing Environmental Health Services to Aboriginal Communities........83

Environmental Health Officers and Aboriginal Environmental Health Workers........84

Elimination of Short Term Funding and Projects When Attempting to Deal with Long Term Environmental Health Problems........88

Dog Control........89

Local Government health and safety inspections........94

School Breakfast Programs........94

APPENDIX A: TRAVEL ITINERARY........99

APPENDIX B: WITNESSES AND SUBMISSIONS........101

APPENDIX C: SITES VISITED BY THE COMMITTEE........105

CHAPTER 1

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Executive Summary

1.1 The continuing poor health status of Aboriginal people throughout Australia is a cause for great concern. In the Kimberley region of Western Australia, Aboriginal people face the additional health burdens of a particularly harsh physical environment combined with remoteness from quality health services.

1.2 This report examines a number of key issues identified by the Standing Committee on Estimates and Financial Operations ("the Committee") in the broad area of environmental health as it impacts on remote Aboriginal communities in the Kimberley region of Western Australia. These issues came to light during a much larger inquiry conducted by the Committee into the provision of health services throughout the Kimberley region of Western Australia.

1.3 The Committee found that the current arrangements for the provision of environmental health services to Aboriginal communities in the Kimberley region are *ad hoc*, poorly coordinated, lacking in both goals and appropriate methods of assessment, and generally ineffective in improving the living conditions, health and general well-being of Aboriginal people. The general view of many people who made submissions to the Committee was that the health of Aboriginal people in the Kimberley region has not improved, and has in fact significantly worsened, over the last 30 years.

1.4 The Committee has identified the following inadequacies with respect to the current environmental health programs operating in the Kimberley region:

1.4.1 Programs are initiated and implemented at the Commonwealth, State, and local government level, by a number of different agencies, with constant overlapping of programs, and little cooperation or exchange of information.

1.4.2 Local governments are either expressly lacking in statutory powers or are unclear of their jurisdiction in the area of environmental health in Aboriginal communities.

1.4.3 Funding for environmental health programs is generally only for short term projects of less than 12 months duration, which subsequently fall by the

wayside when funding ceases, thereby resulting in the subsequent rapid loss of any benefits obtained from these projects.

1.4.4 The training, qualifications, pay arrangements, reporting relationships and career structures for Aboriginal Environmental Health Workers are inadequate.

1.4.5 There is a need for local governments to take a more active role in Aboriginal communities in the areas of public health education and dog control.

1.4.6 Malnutrition and a lack of fresh healthy food continues to be a serious problem for Aboriginal children in the Kimberley region.

1.5 The Committee is of the view that the expenditure of limited public financial resources on the purchasing of expensive acute care hospital facilities, or on the employment of large numbers of highly skilled medical staff, in all towns in the Kimberley region is not the most effective way of addressing Aboriginal health problems. The practical transport and social problems caused by the remoteness of the region, and the difficulty of attracting and retaining enthusiastic, appropriately qualified, health staff will always pose great difficulties to such an essentially urban Australian approach to Aboriginal health. Rather, the Committee believes that genuine social and economic benefits, over both the short and long term, can be gained by concentrating a much greater percentage of total health expenditure in the Kimberley region on programs aimed at improving the environmental health conditions existing within Aboriginal communities.

1.6 The Committee has made a number of recommendations designed to bring about legislative and administrative changes which will clearly define the roles and responsibilities of the various levels of government involved in the provision of health services to Aboriginal communities in the Kimberley region. Central to the Committee's recommendations is that local governments be given primary responsibility for implementing environmental health programs and enforcing environmental health standards in all Aboriginal communities within their respective Shire boundaries.

Recommendations

RECOMMENDATION 1

The Committee recommends that the primary focus of State Government spending in the area of Aboriginal health be on the provision of basic community-based health programs, public health education, and environmental health programs.

RECOMMENDATION 2

The Committee recommends that the *Health Act 1911*, the *Local Government (Miscellaneous Provisions) Act 1960*, and the *Local Government Act 1995* be amended so as to vest in local governments the primary responsibility for the development, implementation, and enforcement of environmental health programs and standards in Aboriginal communities.

RECOMMENDATION 3

The Committee recommends that the Health Department of Western Australia, through the Executive Director, Public Health, and the regional public health units, have responsibility for monitoring and evaluating the effectiveness of the environmental health programs of the local governments. The Committee further recommends that the regional public health units continue to provide consultative services and expert advice, as well as managing the implementation of State-wide public health programs, that is, immunisation, infectious diseases, and the monitoring of Aboriginal community store content and prices in order to promote healthy stores.

RECOMMENDATION 4

The Committee recommends that local governments have sole responsibility for the employment and supervision of all Environmental Health Officers, Aboriginal Environmental Health Field Support Officers, and Aboriginal Environmental Health Workers, operating within their shires.

RECOMMENDATION 5

The Committee recommends that formal and consistent training courses be developed for the professional qualifications of "Aboriginal Environmental Health Worker" and "Aboriginal Environmental Health Field Support Officer" within Western Australia. The Committee further recommends that standard Job Description Forms be developed for these positions, and that a career structure be put in place allowing for the advancement of persons who hold these positions within local governments throughout the State.

RECOMMENDATION 6

The Committee recommends that each of the four local governments in the Kimberley region be funded by the State Government to employ at least one Environmental Health Officer/Aboriginal Communities on a full-time permanent basis.

RECOMMENDATION 7

The Committee recommends that the State Government provide sufficient funding to each of the four local governments in the Kimberley region to ensure that enough Aboriginal Environmental Health Workers are employed to provide a permanent full-time presence in each of the larger Aboriginal communities in the Kimberley region, and to provide a regular visiting service to all Aboriginal communities in the Kimberley region.

RECOMMENDATION 8

The Committee recommends that environmental health programs for Aboriginal communities no longer be funded by way of short term grants issued at the discretion of the Office of Aboriginal Health of the Health Department of Western Australia.

RECOMMENDATION 9

The Committee recommends that all State Government funding for environmental health programs in Aboriginal communities be by way of recurrent three year funding made to local governments and to the regional public health units. These recurrent payments should be recorded as ongoing programs in the annual Budget Papers, tabled in Parliament each year.

RECOMMENDATION 10

The Committee recommends that recurrent funding by the State Government to local governments for environmental health programs in Aboriginal communities be made available to the local governments to spend on environmental health projects in Aboriginal communities within their shires as they see fit (that is, such funding is not to be conditional on the funding being spent in any particular community or on any particular project), subject only to the regular assessment of the effectiveness of each local government's program by the Executive Director, Public Health and the regional public health units of the Health Department of Western Australia.

RECOMMENDATION 11

The Committee recommends that the *Dog Act 1976* be amended so as to expressly provide that that Act binds the Crown.

RECOMMENDATION 12

The Committee recommends that a dog control program be established in each Aboriginal community in the Kimberley region, and that these programs be administered by the local governments.

RECOMMENDATION 13

The Committee recommends that the Minister for Local Government consider recommending to the Governor that regulations be made, pursuant to Section 53 of the *Dog Act 1976*, which will prohibit the keeping of the more potentially dangerous breeds of dog in Aboriginal communities in the Kimberley region unless they have been desexed.

RECOMMENDATION 14

The Committee recommends that those provisions of the *Health Act 1911*, the *Local Government (Miscellaneous Provisions) Act 1960*, and the *Local Government Act 1995* which relate to the health and safety requirements and standards for the construction and maintenance of buildings in Western Australia, and which currently do not bind the Crown, be amended so as to expressly bind the Crown.

RECOMMENDATION 15

The Committee recommends that any future building legislation enacted by the State Government contain a provision which expressly states that that legislation binds the Crown.

RECOMMENDATION 16

The Committee recommends that the State Government, through cooperation between the Health Department and the Ministry of Education, examine the feasibility of introducing a school breakfast program for children of Aboriginal communities in the Kimberley region.

CHAPTER 2

INTRODUCTION

2.1 The Committee was first appointed on 21 December 1989. Under its terms of reference, the Committee is required, *inter alia*, to consider and report on any matter relating to the financial administration of the State.

2.2 In June 2000, the Committee resolved to inquire into the expenditure of public funds on the provision of health services in the Kimberley region of Western Australia. The following terms of reference were adopted for the inquiry:

> *"The Standing Committee on Estimates and Financial Operations shall conduct an inquiry and report to the Legislative Council on the allocation and expenditure of public financial resources on the provision of health services in the Kimberley region of Western Australia having regard to:*
>
> *1. The facilities and resources available to, and working conditions of, the State Government health service providers in the Kimberley region.*
>
> *2. The provision and effectiveness of public funding for health services in remote areas of the Kimberley region.*
>
> *3. The provision and effectiveness of public funding for community education and preventative health programs in the Kimberley region.*
>
> *4. The provision and effectiveness of public funding for specialist medical services in the Kimberley region.*
>
> *5. The provision and effectiveness of public funding for health services to Aboriginal communities in the Kimberley region.*
>
> 6. *Any other matters in relation to the provision of public funds for health services in the Kimberley region."*

2.3 The Committee advertised the above terms of reference in relevant newspapers, and called for public submissions. Public hearings were conducted in the major towns of

the Kimberley region during the week of August 21-25 2000 (see Appendix "A"). Further public hearings were conducted in Perth.

2.4 Due to the volume of evidence gathered, and the wide variety of issues raised during the inquiry, the Committee has chosen to prepare a number of separate reports, each based upon a specific issue that the Committee has identified as significant in relation to the provision of health services in the Kimberley region. This report is the first of these separate reports arising from the inquiry, and shall deal with the issue of environmental health in Aboriginal communities in the Kimberley region.

2.5 The Committee would like to thank all those persons and organisations that made submissions to the Committee and/or appeared as witnesses in hearings before the Committee. In particular, the Committee expresses its gratitude for the assistance given to the Committee by the staff of the Health Department of Western Australia ("HDWA").

2.6 The Committee would like to note, however, that a significant number of individuals approached by the Committee expressed reluctance to make any submission to the Committee due to a fear of intimidation and prejudice in their employment position.

2.7 Whether these fears are real or imagined, the Committee found during the course of the inquiry that there is an inordinately high degree of fear and mistrust both between and within the various government agencies, private organisations, and individuals working in the area of Aboriginal health in the Kimberley region. Whilst the Committee makes no specific recommendation regarding this situation, readers of this report should note this very important aspect of the difficult environment in which health service providers operate on a day-to-day basis in the Kimberley region of Western Australia.

CHAPTER 3

THE GENERAL STATE OF HEALTH OF ABORIGINAL PEOPLE IN THE KIMBERLEY REGION

3.1 Aboriginal people are the major consumers of health services in the Kimberley region. Eighty percent of total hospital bed-days across the six hospitals in the Kimberley region over the period 1993-1998 were for Aboriginal patients.[1]

3.2 The Kimberley region is the northernmost region of Western Australia, and lies adjacent to the Northern Territory. In 1999, the population of the Kimberley region was 29,527, which is approximately 1.6% of the Western Australian population.[2] The Kimberley Aboriginal population, estimated by the Australian Bureau of Statistics in its 1996 Census at 11,467 but most recently estimated at up to 15,500 people, comprises between 40% and 50% of the regional population and is spread out over 421,130 square kilometres.[3] Over a quarter of the total Western Australian Aboriginal population reside in the Kimberley region.[4]

3.3 In 1996, 1,951 Aboriginal persons resided in the Shire of Halls Creek (comprising 59.1% of the Shire population), 3,958 Aboriginal persons resided in the Shire of Derby-West Kimberley (comprising 54.6% of the Shire population), 3,423 Aboriginal persons resided in the Shire of Broome (comprising 25% of the Shire population), and 2,138 Aboriginal persons resided in the Shire of Wyndham-East Kimberley (comprising 24.4% of the Shire population).[5] However, it should be noted that the Aboriginal population of the Kimberley region is highly mobile and such population assessments can be misleading due to the movements of Aboriginal people attending traditional activities, sporting carnivals, religious celebrations and funerals.[6]

---

1 Submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, p. 2.

2 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, pp. 8-9.

3 Submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, p. 2.

4 Submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, p. 2.

5 *A Social Health Atlas of Australia*, 2nd Edition, Volume 6 (Western Australia), by John Glover, Kevin Harris and Sarah Tennant, Public Health Information Development Unit, December 1999, p. 52.

6 *Review of Health Services in the Kutjungka Region of Western Australia*, by John Wakerman, John Tregenza, and Ilan Warchivker, Centre for Remote Health and Menzies School of Health Research, Alice Springs, October 1999, pp. 15-6.

3.4 The Kimberley Aboriginal population is a relatively young population with a birth rate significantly exceeding the death rate, and it is a population which is expected to continue to grow rapidly for the foreseeable future.[7]

3.5 As at August 1995, there were 156 Aboriginal communities in the Kimberley region, of varying size and proximity to the regional towns of Broome, Derby, Fitzroy Crossing, Halls Creek, Wyndham and Kununurra.[8] At present, there are approximately 180 discrete Aboriginal communities with populations ranging in size from small family groups to large communities of over 700 people.[9] Most of these communities are situated on 'C' class reserves (*"for the use and benefit of Aboriginal Inhabitants"*), owned by the Crown in right of the State of Western Australia through the Aboriginal Lands Trust, and leased to the respective Aboriginal communities by way of 99 year leases (which will expire between 2070 and 2090).[10]

3.6 The Committee was told during its hearings that in a number of remote Aboriginal communities in the Kimberley region, the English language is in fact not spoken by many of the inhabitants. This unfortunate situation leads to further isolation of these people from mainstream society and from public health and education services.

3.7 The rate of use of community health services in the Kimberley region is 43-51% higher than expected based on the State rate, with an average number of occasions of service (that is, an attendance by a patient for treatment of any sort) of over 21,000 per year.[11] Aboriginal people are the recipients of 80% of all community health services provided in the Kimberley region.[12] Along with immunisations, the most common community health services provided in the Kimberley region are with respect to endocrine/nutritional conditions (8.5% of presentations), nervous system and sense organ conditions (8.5%), infectious and parasitic diseases (7.7%), and skin and subcutaneous tissue conditions (5%).[13]

---

7 *Kimberley Regional Aboriginal Health Plan*, by Dr David Atkinson, Ms Catherine Bridge, and Dr Dennis Gray, December 1999, p. 33.

8 *Map of Kimberley Region Aboriginal Communities*, Aboriginal Affairs Department of Western Australia, August 1995.

9 Submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, p. 2.

10 Information derived from *Broome ATSIC Region Land Information*, November 1995, *Derby ATSIC Region Land Information*, September 1995, and *Wunan ATSIC Region Land Information*, June 1995, all prepared by the Aboriginal Affairs Department of Western Australia.

11 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 12.

12 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 13.

13 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 13.

3.8 Aboriginal people comprised 75-85% of the patients transported by the Royal Flying Doctor Service ("RFDS") in the Kimberley region in 1998/1999.[14]

3.9 The number of Aboriginal deaths in the Kimberley region is approximately 10% higher than that expected based on the State rate, although the number of non-Aboriginal deaths in the Kimberley region is in line with the State rate for males and significantly lower for females.[15] The median age of death between 1986 and 1996 for Kimberley Aboriginal men was 56 and for Aboriginal women 61 years, compared to 72 years for Western Australian non-Aboriginal men and 79 years for non-Aboriginal women.[16]

3.10 The prevalence of premature birth amongst Aboriginal people in the Kimberley region approaches 20% compared with around 6% in the Australian population as a whole.[17] Related to this high incidence of premature birth is the fact that some sexually transmitted diseases, particularly gonorrhoea and syphilis, are much more prevalent amongst Aboriginal people than non-Aboriginal people.[18]

3.11 Of a group of five year old Aboriginal children from the East Kimberley that took part in a HDWA screening program, 13% were found to be anaemic and 24% suffered from intestinal worms.[19] A survey of a group of 5-14 year olds in a coastal Aboriginal community in the north-east of the Kimberley region found that 93% of the children had hookworm infection.[20]

3.12 Underdeveloped or "Failure to Thrive" children are common in Aboriginal communities. The cause of this underdevelopment has not been positively identified, and there are conflicting views within the medical community. It is likely that a number of factors are relevant. Dr Matthew Ritson noted the following underlying causes of the "Failure to Thrive" children that he had personally treated in Halls Creek over the last few years:

---

14 Submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, p. 2.

15 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 9.

16 Submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, p. 2.

17 Submission by Dr Richard M. Smith, D.Sc, Medical Scientist, Miln Walker & Associates Pty Ltd, August 30 2000, p. 3.

18 Internet site: http://stdservices.on.net/std/social_aspects/aborigines.htm

19 *The National Environmental Health Strategy 1999*, Publications Production Unit, Commonwealth Department of Health and Aged Care, Canberra, 1999, p. 25.

20 *The National Environmental Health Strategy 1999*, Publications Production Unit, Commonwealth Department of Health and Aged Care, Canberra, 1999, p. 25.

> *"The main one is the high presence of gut parasites ... . If I had to make a guesstimate, I would say that about 40 per cent of the total problem is due to the parasites and poor hygiene, probably about 30 or 40 per cent is due to a lack of food, about 10 per cent is due to poor parenting practices, and 10 per cent is due to other factors."*[21]

3.13 For the financial year 1998/1999, the health costs to the State Government for treating diseases affecting Aboriginal children under the age of seven years in the Kimberley region was over $1 million, as set out in the table below[22]:

Hospitalisation Data for Kimberley Health Region 1998/99 for Aboriginal and Torres Strait Islander Children under 7 years old

Type of Illness	**% of Total Cases in WA**	**Total Cost**
Infectious and parasitic diseases	87%	$34,879
Gastroenteritis	45%	$253,776
Otitis media and URI	39%	$126,848
Respiratory infections/inflammations	42-46%	$301,559
Bronchitis, asthma, whooping cough & acute bronchiolitis	31-35%	$259,201
Miscellaneous skin disorders	23%	$22,275
Disorders of the eye	41-60%	$27,811
	TOTAL	**$1,026,349**

3.14 A factor that influences many Aboriginal people, in terms of seeking help for existing health problems, is an acceptance of illness as a normal part of life. This is related to the fact that ill health is very prevalent among many urban, fringe, and rural Aboriginal people. As one witness told the Committee:

---

21 Dr Matthew Ritson, Medical Practitioner, Transcript of Evidence, September 13 2000, p. 4.

22 Submission by Mr Haydn Lowe, Chief Executive Officer, Aboriginal Affairs Department, August 11 2000, p. 3.

> *"Aboriginal people have an expectation that they will go to the doctor a lot, or to the clinic a lot, and at every opportunity, if you want people to be healthy, that is when they need their public health information."*[23]

3.15 The 1996 Census revealed a high level of socioeconomic disadvantage amongst a significant proportion of the population in the Kimberley region. Some of the more significant statistics are set out below:

3.15.1 Whilst 9.6% of Western Australian families living outside the Perth metropolitan area in 1996 were single parent families, the rate in the Kimberley region (grouped according to local government areas) was much higher – Derby-West Kimberley (22.1%), Halls Creek (21.3%), Broome (17.1%), and Wyndham-East Kimberley (16.7%).[24]

3.15.2 Whilst the percentage of low income (less than $21,000 per annum) families located in Perth in 1996 was 17.7%, with an average of 20.6% for the rest of the State, the percentages in the Shire of Halls Creek and the Shire of Derby-West Kimberley were 38.2% and 30.3% respectively.[25]

3.15.3 Whilst the percentage of dwellings rented from Homeswest in 1996 was 4.6% in the Perth metropolitan area, and 5.7% for the rest of the State, the Shire of Derby-West Kimberley had a percentage of 15.2%, the Shire of Broome had a percentage of 12.3%, the Shire of Halls Creek had a percentage of 10.6%, and the Shire of Wyndham-East Kimberley had a percentage of 10.5%.[26]

3.15.4 Whilst the percentage of dwellings with no motor vehicle in 1996 was 9.5% for the Perth metropolitan area, and 7.8% for the rest of the State, the percentage in the Shire of Halls Creek was 33.1%, and the percentage in the Shire of Derby-West Kimberley was 27.4%.[27]

3.15.5 Whilst the percentage of males aged 15 to 64 years and females aged 15 to 59 years in receipt of unemployment benefits in 1996 in the Perth

---

23 Ms Isabelle Ellis, Transcript of Evidence, August 21 2000, p. 12.

24 *A Social Health Atlas of Australia*, 2nd Edition, Volume 6 (Western Australia), by John Glover, Kevin Harris and Sarah Tennant, Public Health Information Development Unit, December 1999, p. 30.

25 *A Social Health Atlas of Australia*, 2nd Edition, Volume 6 (Western Australia), by John Glover, Kevin Harris and Sarah Tennant, Public Health Information Development Unit, December 1999, p. 34.

26 *A Social Health Atlas of Australia*, 2nd Edition, Volume 6 (Western Australia), by John Glover, Kevin Harris and Sarah Tennant, Public Health Information Development Unit, December 1999, p. 68.

27 *A Social Health Atlas of Australia*, 2nd Edition, Volume 6 (Western Australia), by John Glover, Kevin Harris and Sarah Tennant, Public Health Information Development Unit, December 1999, p. 72.

metropolitan area was 6.2%, and 7.9% for the rest of the State, the percentage in the Shire of Halls Creek was 40.6%, the percentage in the Shire of Derby-West Kimberley was 34.1% (or 1,560 people), the percentage in the Shire of Broome was 21.5% (or 1,872 people), and the percentage in the Shire of Wyndham-East Kimberley was 17% (or 976 people).[28]

3.15.6 Participation rates in the Community Development Employment Projects ("CDEP") scheme in 1996 in the Shire of Halls Creek (38.9%) and the Shire of Derby-West Kimberley (29.4%) by eligible persons (males aged 14-64 and females aged 15-59 years) are slightly under the unemployment benefits recipient rates, which indicates that a majority of unemployed persons in those shires are involved in a CDEP scheme project.[29] In 1996 the total number of CDEP scheme participants of Aboriginal descent in the Kimberley region was 3,881 (consisting of 1346 participants in the Shire of Derby-West Kimberley, 1094 in the Shire of Broome, 789 in the Shire of Halls Creek, and 652 in the Shire of Wyndham-East Kimberley).[30]

3.16 The 1997 Environmental Health Needs Survey of Western Australia found that 25 Aboriginal communities in the Kimberley region (that is, approximately 16% of all Kimberley Aboriginal communities) had an average of 10 or more people living in each dwelling, including caravans, dongas or improvised shelters.[31] A deficiency of at least 700 three bedroom houses for Aboriginal people in the Kimberley region was recently identified, in addition to significant unmet needs for ongoing housing maintenance[32]:

> *"A senior person in Aboriginal health (not currently working in WA) stated to the consultant a few years ago that Aboriginal people like to live in close proximity for cultural reasons and therefore person to person spread of diseases would not be reduced much by providing more housing. While it is true many people like to live reasonably close to their extended family, very few people live by choice with*

---

28 *A Social Health Atlas of Australia*, 2nd Edition, Volume 6 (Western Australia), by John Glover, Kevin Harris and Sarah Tennant, Public Health Information Development Unit, December 1999, p. 96.

29 *A Social Health Atlas of Australia*, 2nd Edition, Volume 6 (Western Australia), by John Glover, Kevin Harris and Sarah Tennant, Public Health Information Development Unit, December 1999, p. 96.

30 *A Social Health Atlas of Australia*, 2nd Edition, Volume 6 (Western Australia), by John Glover, Kevin Harris and Sarah Tennant, Public Health Information Development Unit, December 1999, p. 96.

31 Submission by Mr Haydn Lowe, Chief Executive Officer, Aboriginal Affairs Department, August 11 2000, p. 5.

32 *Kimberley Regional Aboriginal Health Plan: Executive Summary and Recommendations*, by David Atkinson, Catherine Bridge and Dennis Gray, December 1999, p. 4.

> *eight or ten people in a two bedroom house. The reality is that most people have little option and have never had the option."*[33]

3.17 Over-crowded living conditions, combined with a lack of water for hygiene purposes, and heat and humidity, are a major contributor to the spread of communicable diseases, particularly skin infections and skin infestations, within Aboriginal communities.[34]

3.18 An unfortunate side effect of poor health and poverty has been high levels of suicide, domestic violence, and sexual assaults on minors within the Aboriginal population. The Committee found that whilst most witnesses acknowledged that these serious social problems existed, they were reluctant to discuss the issue in any depth. There is anecdotal evidence to suggest that Aboriginal communities which have law and order problems are also the most likely to have poor environmental health conditions.[35]

3.19 Dr Stuart Garrow, Director of the HDWA Kimberley Health Service's Kimberley Public Health Unit, pointed out to the Committee that there have been some noticeable improvements in the area of Aboriginal health in the Kimberley region over the last 14 years. Dr Garrow noted that there have been no babies dying from meningitis in the Kimberley region for seven or eight years, and no children placed on drips for gastroenteritis.[36] Disease like leprosy, tuberculosis, rheumatic fever and syphilis have also been brought under control.[37]

3.20 It was stressed to the Committee by Dr Garrow that the most significant deterioration in Aboriginal health in recent years has occurred in the areas of alcohol-related conditions, renal disease, heart disease and diabetes – lifestyle illnesses that cannot be eliminated from a community overnight by the provision of additional hospital beds or expensive medical equipment, but which can only be curbed by sustained health and lifestyle campaigns over a 10 to 15 year period.[38]

---

33 *Kimberley Regional Aboriginal Health Plan*, by Dr David Atkinson, Ms Catherine Bridge, and Dr Dennis Gray, December 1999, p. 16.

34 Submission by Mr Haydn Lowe, Chief Executive Officer, Aboriginal Affairs Department, August 11 2000, p. 5.

35 Submission by Mr Haydn Lowe, Chief Executive Officer, Aboriginal Affairs Department, August 11 2000, p. 7.

36 Dr Stuart Garrow, Director, Kimberley Public Health Unit, Transcript of Evidence, August 22 2000, p. 2.

37 Dr Stuart Garrow, Director, Kimberley Public Health Unit, Transcript of Evidence, August 22 2000, p. 2.

38 Dr Stuart Garrow, Director, Kimberley Public Health Unit, Transcript of Evidence, August 22 2000, p. 2.

CHAPTER 4

PROVISION OF HEALTH SERVICES TO THE KIMBERLEY REGION

Health Services Provided to the Kimberley Region by the State Government

4.1 The HDWA is the State Government Department responsible for providing a range of public health services to the Kimberley region. The HDWA services in the Kimberley region are implemented and managed by a regional health service – the Kimberley Health Service ("KHS").

4.2 The KHS is composed of nine separate health service units, supported by a Corporate Office:

4.2.1 Broome Health Services;

4.2.2 Derby Health Services;

4.2.3 Fitzroy Valley Health Services;

4.2.4 Halls Creek Health Services;

4.2.5 Kununurra Health Services;

4.2.6 Wyndham Health Services;

4.2.7 Kimberley Aged Care Services;

4.2.8 Kimberley Public Health Unit; and

4.2.9 Northwest Mental Health Service.[39]

4.3 The KHS is responsible for providing the following key public health services in the Kimberley region:

4.3.1 Six public hospitals: Derby Regional Hospital; Broome District Hospital; Fitzroy Crossing District Hospital; Halls Creek District Hospital; Kununurra District Hospital; and Wyndham District Hospital.

---

[39] Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 7.

4.3.2 Six community health centres: Derby Community Health; Broome Community Health; Fitzroy Crossing Community Health; Halls Creek Community Health; Kununurra Community Health; and Wyndham Community Health.

4.3.3 Thirteen clinics or nursing posts (some permanently staffed and others operated only on regular visits) located in the larger Aboriginal communities.[40] The HDWA has recently designated 17 locations as remote area nursing posts, to be located at the following Aboriginal communities (where, in the absence of a resident medical practitioner, nurses will be trained and supported to provide care in areas that traditionally fall outside nursing duties): Balgo Hills (Wirrimanu); Billiluna; Dodnun; Gibb River Station; Imintji; Kalumburu; Lombadina; Looma; Mount Barnett (Kupungarri); Mount Elizabeth; Mount House; Mulan; Noonkanbah; One Arm Point (Bardi); Oombulgurri; Wangkatjungka; and Warmun.[41]

4.3.4 Numbala Nunga Nursing Home, Derby.

4.3.5 Kimberley Public Health Unit, Derby.

4.3.6 Kimberley Aged Care, Broome.

4.4 The total funding to KHS for the 2000/2001 financial year is $49.5 million (with $47,350,300 of that amount being recurrent funding).[42] The total replacement valuation of the HDWA owned hospitals, clinics and other facilities in the Kimberley region is in excess of $106 million.[43]

4.5 As at July 2000, the KHS had approximately 838 permanent and casual “active” employees in 69 different occupational categories, including 34 General Medical Practitioners, 226 Registered Nurses, 50 Enrolled Nurses, and 33 Aboriginal Health Workers.[44] The KHS also employs a significant number of short-term contract employees, particularly Agency nurses.

---

40 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, Attachment B, Term of Reference 1, p. 1.

41 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 15.

42 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 1.

43 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 3.

44 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 5.

4.6 Major capital works are planned for the KHS over the next few years with the replacement of Halls Creek District Hospital and the construction of new facilities at Fitzroy Crossing District Hospital.[45] The State Government is also in the process of outsourcing the ownership, management and replacement of the Numbala Nunga Nursing Home in Derby, with a Request for Proposal being advertised on Saturday, May 20 2000.[46]

4.7 Recent initiatives of the State Government include the provision of $1.1 million to provide a satellite renal dialysis unit at Broome, and the setting aside of $1 million for the construction of a new clinic at Balgo Hills Aboriginal community, which will include provision for a home dialysis facility.[47]

4.8 Dental health services provided by the HDWA in the Kimberley region are managed centrally from Perth, with public dentists operating out of Derby and Fitzroy Crossing. School dental therapists provide services, in conjunction with a private dentist, in Broome and Kununurra.[48]

4.9 There are a small number of private general practitioners based in Broome and Kununurra.

4.10 There are five town-based Aboriginal community controlled primary health care services or “Aboriginal Medical Services”, which are independent non-government organisations, in the Kimberley region (that is, one in each town, except Wyndham).[49] There are also six Aboriginal community managed remote community clinics and four Aboriginal community clinics with community nursing services provided by the Sisters of Mercy.[50]

4.11 The KHS provides funding to the various Kimberley-based Aboriginal Medical Services for sessional work undertaken by their medical practitioners in public hospitals. In the 1999/2000 financial year, such payments totalled $267,000.[51] Apart from such payments, and specific project funding through the HDWA Office of

---

45 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 3.

46 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 3.

47 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, pp. 3-4.

48 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 16.

49 Submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, pp. 2-3.

50 Submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, p. 3.

51 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 27.

Aboriginal Health ("OAH"), State Government funding to the Aboriginal Medical Services in the Kimberley region is minimal. The Commonwealth Government provides the bulk of annual funding for Aboriginal Medical Services. The Kimberley Aboriginal Medical Services Council, Inc. stated the following in their submission to the Committee:

> *"Data recently obtained on state Aboriginal health program expenditure through the Office of Aboriginal Health revealed that of the $42.5M in grants to Aboriginal organisations from 1993 to 1999, only $5.9M or 14% was allocated to the Kimberley. The six Kimberley Aboriginal community controlled health services (ACCHSs) make up one third of the total number of WA ACCHSs. Of the $39.3M provided to WA ACCHSs over the period, only $3.9M or 10% was granted to Kimberley ACCHSs. The Broome Regional Aboriginal Medical Service and Yura Yungi AMS in Halls Creek received the lowest level of grant funding in WA in spite of these areas being identified in the Regional Aboriginal Health Plan as having the lowest per-person primary care expenditure.*
>
> *The inequity is more glaring if only discretionary 'health program' funding is considered (health promotion, cervical cancer prevention, 'heart health' etc). Of the $19.0M in 'health program' grants to Aboriginal organisations in WA over the period, only $545,041 or 2.9% came to the Kimberley and only $215,500 or 1.1% to Kimberley Aboriginal community controlled health services.*
>
> *The lack of transparency and the inequity of such funding allocation decisions reasonably raises questions about competence and/or corrupt process in the administration of state Aboriginal health programs."*[52]

4.12 The philosophy behind the community-controlled Aboriginal Medical Services is to empower Aboriginal communities to provide health services to their people wherever State Government provided health services are lacking.[53] The nature of the health services provided by the Aboriginal Medical Services are, due to their size and funding base, essentially limited to basic, general practice, medical care. In many

52 Submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, p. 4.

53 Mr Kevin Cox, Special Projects Officer, Kimberley Aboriginal Medical Services Council Inc., Transcript of Evidence, August 21 2000, p. 18.

respects, however, in practice the services provided by the Aboriginal Medical Services essentially duplicate the services provided by the HDWA.

4.13 By way of illustration, the Committee understands that in the town of Halls Creek, both the Halls Creek District Hospital and the community controlled Yura Yungi Medical Service provide general practitioner medical services only during normal business hours. This situation results in a duplication of general practitioner services during business hours in Halls Creek, but with no doctor being available at either the hospital or the Medical Service after hours.

4.14 Little education, preventative or environmental health programs are undertaken by the Aboriginal Medical Services. The Committee believes that the Aboriginal Medical Services may become more effective health care providers as, over time, more Aboriginal persons gain professional qualifications in medicine, nursing, health education, and health administration. However, in the short term, much of the funding currently provided to the Aboriginal Medical Services could perhaps be better spent on public health education, disease prevention programs, and environmental health programs.

Provision of Specific Health Services

4.15 Councillor Lyn Page of the Broome Shire summarised the general perception in Broome regarding health care in her evidence to the Committee:

> *'It is a bit of a joke in Broome now. They say, "Great place to have a holiday but don't get sick".'*[54]

4.16 Many of the witnesses who appeared before the Committee acknowledged that health services in the Kimberley region, even in the regional centres of Broome, Derby and Kununurra, could not realistically be resourced to the same levels as the Perth metropolitan area.

4.17 Dr Mark Dawson, Senior Medical Officer, Broome Health Service, acknowledged that rural practitioners cannot be expected to supply the same level of service as city practitioners. Rural general practitioners must rely to a much greater extent on clinical observations and their personal experience to judge the severity of illnesses and whether specialist involvement is required. Dr Dawson pointed out that most people who choose to relocate to the Kimberley region from the metropolitan area are

---

[54] Ms Lyn Page, Councillor, Shire of Broome, Transcript of Evidence, August 21 2000, p. 2.

aware that they are taking a risk with respect to the lower level of health services available in the Kimberley region.[55]

4.18 People residing in the eastern part of the Kimberley region who require treatment in a fully equipped hospital are generally referred to Darwin as the nearest appropriate medical facilities.[56]

4.19 The KHS is heavily dependent on the RFDS to transport acutely ill patients from remote areas to one of the district hospitals, the Derby Regional Hospital, or to Perth. RFDS only has a maximum of two planes available in the Kimberley region at any time.[57]

4.20 The Patients Assisted Travel Scheme ("PATS") provides funded transport from rural and remote areas to either Perth or regional hospitals where specialist medical services may be accessed. PATS, however, does not apply to screening services like x-rays, mammograms, CT scans and ultra sounds.[58] Furthermore, serious or urgent dental problems are not covered by the scheme.[59]

4.21 The cost of PATS in the Kimberley region has risen steadily in recent years from $1,414,140 in the 1995/1996 financial year to $1,961,300 in the 1999/2000 financial year, although the number of individual trips provided has remained relatively stable, as set out in the table below: [60]

Individual Trips Provided Under PATS in the Kimberley Region

Financial Year	1995/1996	1996/1997	1997/1998	1998/1999
No. of Individual Trips	1790	1651	1708	1590

55 Dr Mark Dawson, Senior Medical Officer, Broome Health Service, Transcript of Evidence, August 21 2000, p. 8.

56 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 7.

57 Submission by Mr R. D. Spence, F.R.C.S., F.R.A.C.S., received September 8 2000, p. 2.

58 *Review of Primary Medical Care Services to Remote Area Aboriginal Communities*, The Office of Aboriginal Health, Health Department of Western Australia, undated, p. 47.

59 *Review of Primary Medical Care Services to Remote Area Aboriginal Communities*, The Office of Aboriginal Health, Health Department of Western Australia, undated, p. 48.

60 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 7.

4.22 The HDWA advised the Committee that:

> *"Due to demography, unreliable or non-existent commercial transport, lack of appropriate alternative accommodation in towns and season problems such as flooding, the KHS has a high percentage of patients who can not be returned to their place of residence within short time frames, and therefore have longer stays in hospital and high PATS costs."*[61]

4.23 Medicare and Pharmaceutical benefits schemes are not easily accessed by Aboriginal communities in the Kimberley region. The lack of private doctors, specialists and pharmacists in the Kimberley region mean that Aboriginal communities are denied the benefit of a significant portion of total public health funding. Many Aboriginals in remote communities do not even possess Medicare cards. For the 1996/1997 financial year, it is estimated that the average Medicare expenditure in Halls Creek was $25.30 per person (compared with the expenditure in Double Bay, NSW, of $900 per person per year).[62]

4.24 There are minimal health services for pregnant women and mothers with young children in the Kimberley region. As one witness told the Committee:

> *"I think that the provision of services to women and children in the Kimberley is fairly fragmented. I think women are disadvantaged living in the Kimberley compared to other areas as far as choice, birth options, care for their children. As you probably know, the percentage of Aboriginal children who are low birth weight is higher than* [for children born to] *non-Aboriginal women, significantly higher. The sorts of services that we provide are the same as what would be provided in a metropolitan area in the main, or worse, and I think that there is a lot that can be done, and there has been a lot of evidence over a long time about programs that do work that have not been implemented. There is a big problem in the Kimberleys with difficulty for women accessing information that is appropriate to their needs, and the lack of use of appropriately trained Aboriginal health workers is really a great cause for concern in the Kimberleys."*[63]

---

61 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 25.

62 *Review of Primary Medical Care Services to Remote Area Aboriginal Communities*, The Office of Aboriginal Health, Health Department of Western Australia, undated, pp. 25-26.

63 Ms Isabelle Ellis, Transcript of Evidence, August 21 2000, p. 2.

4.25 There are no facilities for delivering babies in either Halls Creek or Fitzroy Crossing. Pregnant women from these towns and surrounding areas are referred to either Derby or Kununurra for the birth of their children.

4.26 Interestingly, immunisation of children is one area of health where the HDWA is providing a highly successful level of coverage in the Kimberley region. The high immunisation rates for Aboriginal children in the Kimberley region are in large part due to a recognition of the very high risk of a significant health crisis arising in the event of a measles or polio epidemic in remote Aboriginal communities.[64] Ensuring almost all children are immunised is one important health measure that can be successfully implemented in all Aboriginal communities in the Kimberley region at relatively minimal cost.

Lack of Suitably Trained Staff and Equipment

4.27 There is a chronic shortage of health staff "at the coal face" (that is, nurses and Aboriginal Health Workers) in the Kimberley region. The existing health staff perform their duties admirably, but under great stress and with limited resources.

4.28 Derby Regional Hospital has no permanent full-time surgeon on staff. Surgical services have been undertaken by a succession of short-term locums who are employed one at a time, and are expected to be on call 24 hours a day (as well as travel throughout the Kimberley region as required). This means that the Derby Regional Hospital can be without a surgeon for days at a time whilst the single surgeon on staff is occupied with duties in Broome or Kununurra.[65]

4.29 The Halls Creek District Hospital is licensed and funded for four beds, although seven beds are physically present in the hospital and up to 10 beds have been used at any one time (with three patients being placed on mattresses on the back verandah of the Hospital).[66] Halls Creek District Hospital is the second-busiest hospital of its size (that is, 10 beds or less) in Western Australia, with 2583 occasions of service per hospital bed for the 1998-1999 financial year.[67]

---

64 Ms Isabelle Ellis, Transcript of Evidence, August 21 2000, pp. 15-16.

65 Submission by Mr R. D. Spence, F.R.C.S., F.R.A.C.S., September 8 2000, p. 2.

66 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 20.

67 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, pp. 21-22.

4.30 It has been stated that many modern metropolitan general practices have better facilities than Halls Creek District Hospital.[68] Patients with fractures and minor trauma are transferred to other hospitals because of the lack of an operating theatre or a doctor trained in the use of anaesthetics.[69]

4.31 No blood is stored at Halls Creek District Hospital for emergency transfusion, despite the high likelihood of road trauma, violent assault and unplanned births.[70] There is also no autoclave at the hospital to sterilise surgical equipment.[71]

4.32 The ambulance service at Halls Creek is operated by volunteers, who receive almost no training, and on-call nursing staff from the hospital.[72]

4.33 There is presently no Computerized Tomography ("CT") Scanner in the Kimberley region. The use of such equipment is routine in the Perth metropolitan area. The absence of a CT Scanner poses difficulties when patients have suffered severe head injuries, strokes and acute neurological disorders, as well as those patients with various orthopaedic, thoracic and abdominal conditions.[73] Patients must be transferred to Perth, at considerable expense, to undergo a CT scan when it is required.

4.34 For a number of months this year, the Ultra Sound equipment at the Derby Regional Hospital has not been available to patients due to the absence of a technician skilled in the use of the equipment.[74]

4.35 There is only one Health Promotion Officer for the entire Kimberley region.[75]

4.36 The Australian Nursing Federation has identified the following problems with the operation of the remote area nursing posts located throughout the Kimberley region:

4.36.1 excessive call outs;

---

68 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 26.

69 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 27.

70 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 28.

71 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, pp. 28.

72 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 28.

73 Submission by Mr R. D. Spence, F.R.C.S., F.R.A.C.S., received July 17 2000, p. 1.

74 Submission by Mr R. D. Spence, F.R.C.S., F.R.A.C.S., received July 17 2000, p. 1.

75 Submission by the Australian Nursing Federation, Mr Mark Olson, State Secretary, July 28 2000, p. 7.

4.36.2 stress/burnout;

4.36.3 poor staff development;

4.36.4 personal safety concerns;

4.36.5 isolation; and

4.36.6 ineffective health care because of the inability of Remote Area Nurses to perform primary health care.[76]

4.37 When asked by the Committee to provide details as to what would be required to undertake high speed transmission of data such as x-rays and scans from the Kimberley region to specialists in the metropolitan area, the Minister for Health responded:

> *"The facilities required to undertake high speed transmission of data such as x-rays and scans from the Kimberley to specialists in the metropolitan area are a stand alone film digitiser and a personal computer equipped with the appropriate software to convert the image into digital for transmission.*
>
> *The Telehealth Program of the HDWA will arrange for the installation of a Tele-radiology network of the above equipment in Kununurra, Broome and Derby so that the transmission of digital images can be reported from these sites down to specialists in the metropolitan area. The equipment will be installed in time for the commencement of the new radiology contract for the Kimberley, due to commence in December 2000."*[77]

Turnover of Health Staff

4.38 Itinerant health staff combined with uncertain short-term project funding is a huge problem for the delivery of all health services in the Kimberley region. The lack of opportunity for professional development of health staff at all levels contributes to poor morale and the high turnover of nursing staff.[78] The lack of suitable equipment also encourages de-skilling of health workers and a desire to return to more professionally rewarding careers in the metropolitan area:

---

76 Submission by the Australian Nursing Federation, Mr Mark Olson, State Secretary, July 28 2000, p. 6.

77 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 18.

78 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 27.

> *"The extraordinary turnover of nursing staff at Halls Creek Hospital is a major impediment to the provision of quality care. The reasons for this high turnover are complex but relate mainly to the fact that nursing staff are each performing three to four times the amount of work as their colleagues in other Rural hospitals. Furthermore, professional satisfaction cannot be maintained in an environment of outdated equipment, lack of resources and without any prospect of meaningful professional development or training opportunities. Poor working conditions and accommodation and the frequent demands to do extra shifts further contribute to low morale."*[79]

4.39 The highest turnover in nursing staff within the KHS has been experienced in Halls Creek (271.9% in 1999), Wyndham (172.5% in 1999), and Remote Areas – East Kimberley (150% in 1999).[80]

4.40 With respect to the high turnover of health staff, particularly nursing staff, in the Kimberley region, the Minister for Health advised the Committee as follows:

> "[Human Resource Information System] *information indicates that the overall turnover of staff has not fluctuated significantly, averaging 51.88% for the five years from 1995 to 2000. In 1999/2000, the rate was 51.67%. A breakdown of these figures indicates that the turnover of permanent staff has decreased significantly from 35.7% in 1995/96 to 20% in 1999/2000, whereas the turnover of temporary staff has increased proportionally from 11.5% to 31.6%.*
>
> *Of those staff that have turned over (both permanent and temporary), the number of registered and enrolled nurses turning over has increased from around a third to over half of the total turnover. The turnover of miscellaneous workers has decreased over time, allied health and administrative staff represented under a quarter of staff turning over, and medical staff have remained at under 10% of total staff turnover. This is roughly in keeping with the percentage of the workforce that each occupation represents (ie: nurses represent nearly half the workforce, allied health and administrative represent approximately a quarter, and so on)."*[81]

---

79 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 31.

80 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 6.

81 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 8.

CHAPTER 5

THE IMPORTANCE OF ENVIRONMENTAL HEALTH TO THE MAINTENANCE OF PHYSICAL HEALTH

5.1 The process of wide consultation with stakeholders in the area of Aboriginal health as part of the State Government's recently announced Norhealth 2020 strategy has identified 10 key health issues as the critical targets of the plan:

5.1.1 maternal, foetal and child health;

5.1.2 diabetes and renal disease;

5.1.3 cardiovascular disease;

5.1.4 respiratory disease;

5.1.5 oral health;

5.1.6 injury and poisons;

5.1.7 mental health;

5.1.8 communicable diseases;

5.1.9 alcohol, tobacco and drug abuse; and

5.1.10 domestic violence.[82]

5.2 The Committee notes that these 10 areas where there is considerable sickness, disability and loss of life in the Aboriginal community are all *"... avoidable and preventable, as each of them largely reflects lifestyle and behaviour"*.[83]

5.3 In its submission to the Committee, the Aboriginal Affairs Department of Western Australia stated that:

> *"The continuing poor health status of Aboriginal people in the Kimberley has been well documented and there is considerable international and Australian research linking hospitalisation and*

[82] *Norhealth 2020: Moving Forward*, Health Department of Western Australia, April 2000, p. 2.

[83] *Norhealth 2020: Moving Forward*, Health Department of Western Australia, April 2000, p. 2.

other health costs to the conditions of the environment in which Aboriginal people live."[84]

5.4 The Committee is of the view that there must be significant improvements in environment health education, monitoring, and enforcement processes before there is likely to be any noticeable improvement in the standard of Aboriginal health in the Kimberley region.

A Change of Focus in the Provision of Health Services to Aboriginal Communities

5.5 A large number of documents outlining the poor standard of Aboriginal health in Australia have been prepared at both the State and Commonwealth level over the last 20 years. In the past 12 months, two significant additions to that collection of documents have been the report of the House of Representatives Standing Committee on Family and Community Affairs entitled *"Health is Life"*[85] which was tabled in the Commonwealth Parliament in May 2000, and the *Kimberley Regional Aboriginal Health Plan*[86] which was published in December 1999 and signed off by representatives of the Kimberley Aboriginal Medical Services Council, Inc., the HDWA (that is, the KHS and OAH of the HDWA), relevant Aboriginal and Torres Strait Islander Commission ("ATSIC") regional councils, the Commonwealth Department of Health and Aged Care, and the Aboriginal Affairs Department.

5.6 Over the years there have been a number of suggestions by various committees, agencies and organisations on how to improve the status of Aboriginal health in the Kimberley region. Many of these suggestions are along the following lines:

5.6.1 That fully equipped hospitals like those in the metropolitan area be built in every town in the Kimberley region.

5.6.2 That the number of health staff be significantly increased at all levels.

5.6.3 That nursing posts, all weather airfields, and sporting grounds and associated facilities be constructed at every remote community and out-station.

---

84 Submission by Mr Haydn Lowe, Chief Executive Officer, Aboriginal Affairs Department, August 11 2000, pp. 1-2.

85 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000.

86 *Kimberley Regional Aboriginal Health Plan*, by David Atkinson, Catherine Bridge and Dennis Gray, December 1999.

5.6.4 That doctors (GPs and specialists) be flown to each remote community on a weekly or monthly basis.

5.6.5 That a regular free public transport service operate from every remote community to the major towns.

5.7 Such expensive measures to improve Aboriginal health are unlikely to be pursued by either the State or Commonwealth governments in the foreseeable future. The Committee recognises that the sheer cost of relocating and maintaining a metropolitan-style level of health services in the Kimberley region is prohibitive for the State Government. The unfortunate economic reality is that it would be far more cost-effective and may also be beneficial solely in terms of physical health outcomes to relocate people currently living in remote communities to regional centres. However, this would clearly be culturally and politically inappropriate.

5.8 The House of Representatives Standing Committee on Family and Community Affairs recently noted that improvements in the areas of environmental health could have a greater impact on the general health and well-being of Aboriginal Australians than the same level of improvement in health services.[87]

5.9 The Committee also notes a recent article which suggests that the available evidence indicates that the health of Aboriginal people living in urban areas (the particular example given in the article is Brisbane) is, in most respects, as poor as the health of Aboriginals in remote communities and, in some cases, worse.[88] This tends to indicate that environmental and cultural factors are as important for the health of Aboriginal people, if not more important, than access to the full range of modern health services.

5.10 While undoubtedly health resources throughout the Kimberley region are stretched to the limit, and in a number of areas are grossly inadequate, the Committee believes that there are a number of measures that could be taken within the short term, involving relatively minimal increases to existing resources, which may bring dramatic improvements in Aboriginal health in the Kimberley region in the short term. These measures are set out later in this report in the Chapter entitled "Possible Solutions".

---

87 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, p. 14.

88 "Achieving Improved Health Outcomes for Urban Aboriginal People: Biomedical and Ethnomedical Models of Health", by Michele Ivanitz, *Australian Journal of Public Administration*, Vol. 59, No. 3, September 2000, p. 49.

5.11 The Committee is of the view that the health "dollar" could be better spent if jurisdictional and administrative issues were better managed between the three levels of government involved in the provision of health services in the Kimberley region. As Ms Maxine Middap, Shire President of the Shire of Wyndham-East Kimberley told the Committee:

> *"[T]he health services that we have up here now are not as good as they were 30 years ago. Do not ask me why, but I guess more money seems to be spent on administration and setting up various other bodies to run various other bits of health things. At the end of the day the dollar spends more of its time in an office than it does providing the health service."*[89]

5.12 The Committee adopts the following definition of "environmental health" as developed by the World Health Organisation:

> *"Environmental health comprises of those aspects of human health, including quality of life, that are determined by physical, chemical, biological, social and psychosocial factors in the environment. It also refers to the theory and practice of assessing, correcting, controlling and preventing those factors in the environment that can potentially affect adversely the health of present and future generations."*[90]

5.13 Environmental health is tied in with preventative health and education in attempting to confront at an early stage those factors that have the potential to lead to serious health problems, with the associated adverse economic consequences for the whole community.

5.14 The Committee agrees with the view expressed by the Shire Council of Halls Creek that Environmental Health and Primary Health (Community Health) problems in the Kimberley region are exponentially related to acute health care.[91]

5.15 Such adverse economic consequences for society as a whole as a result of poor environmental health are not merely confined to those associated with the provision of

---

[89] Ms Maxine Middap, Shire President, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 7.

[90] World Health Organisation ("WHO") draft definition of "environmental health" developed at a WHO consultation in Sofia, Bulgaria, 1993, cited in *An Ensemble of Definitions of Environmental Health*, US Department of Health and Human Services Environmental Health Policy Committee Risk Communication and Education Subcommittee, p. 4, at Internet site: http://www.health.gov/environment/DefinitionsofEnvHealth/ehdef2.htm

[91] Submission by the Shire of Halls Creek, Peter McConnell, Chief Executive Officer, August 1 2000, p. 2.

expensive acute medical services. The consequences also extend to the economic costs associated with poor performance in education, loss of employment options, and losses in work production due to the absence of workers on sick leave.

5.16 The House of Representatives Standing Committee on Family and Community Affairs, as part of its recent inquiry into Aboriginal health in Australia, noted the nine healthy living practices identified by the Nganampa Health Council in South Australia during a 1987 environmental health review which are important in improving the health status of Aboriginals:

5.16.1 washing people;

5.16.2 washing clothes and bedding;

5.16.3 removing waste;

5.16.4 improving nutrition;

5.16.5 reducing crowding;

5.16.6 separating dogs and children;

5.16.7 controlling dust;

5.16.8 temperature control; and

5.16.9 reducing trauma.[92]

5.17 *The National Environmental Health Strategy 1999*[93], a collaborative effort between the Commonwealth and State health agencies and private environmental health stakeholder organisations, sets out the following “Charter of Entitlements and Responsibilities” for individuals and communities when it comes to environmental health:

*“**Entitlements***

Individuals and communities are entitled to live in a safe and healthy environment. This includes:

- *Safe and adequate supplies of water*

---

[92] *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, pp. 49-50.

[93] *The National Environmental Health Strategy 1999*, Publications Production Unit, Commonwealth Department of Health and Aged Care, Canberra, 1999.

- *Safe and nutritious food*
- *Safe and adequate sanitation*
- *Clean air*
- *Safe and sustainable shelter*
- *Urban and housing designs that promote environmental health*
- *Environmental management systems that protect environmental health*
- *Safe occupational environments and work practices*
- *Safe and adequate recreational facilities, including water*
- *Information about environmental health issues*
- *Being consulted on plans, decisions, and activities likely to affect both the environment and health, and to open and transparent decision making on these issues*

Responsibilities

Individuals and communities are responsible for:

- *Ensuring their own actions contribute to the protection of the environment in the interests of their own health and the health of others*
- *Participating in decision-making processes on matters likely to affect both the environment and health*
- *Ensuring its environmental health services are delivered to a high standard"*[94]

94 *The National Environmental Health Strategy 1999*, Publications Production Unit, Commonwealth Department of Health and Aged Care, Canberra, 1999, pp. 10-11.

CHAPTER 6

SOME OF THE MAJOR ENVIRONMENTAL HEALTH ISSUES FACING ABORIGINAL COMMUNITIES IN THE KIMBERLEY REGION

Nutrition and the Key Role of Community Stores in Remote Communities

6.1 The Committee notes the following excerpt from a recent report of the Halls Creek Failure to Thrive Committee:

> *"Childhood malnutrition is known to be associated with many health problems. Amongst these are reduced immunity, leading to an increase in infectious disease. There is a large body of literature which links malnutrition to behavioural disturbances, learning difficulties and poor educational achievement. Recent evidence suggests that perinatal deficiency of essential fatty acids and iron deficiency in infancy can permanently impair mental function through inhibition of normal brain development. Deficiency of other specific vitamins and trace elements is associated with a variety of cognitive and developmental deficits. There is good evidence from both local and overseas studies that perinatal and childhood malnutrition predisposes to a number of diseases in adult life, including ischaemic heart disease, non insulin-dependent diabetes and renal failure. Aboriginal children still die at rates three to four times that of non-aboriginal children. Extrapolation of information from studies in developing countries would suggest that more than half of the excess deaths in Aboriginal children are attributable to malnutrition."*[95]

6.2 The Committee acknowledges that there is clear evidence that the type of food consumed by a person has a very close correlation with the health outcomes for that person. The Committee believes that the State Government needs to take a more pro-active role in ensuring a basic level of nutrition amongst the children of the Kimberley region. In that respect, the Committee noted with interest the following statement of the Halls Creek Failure to Thrive Committee:

---

95 *Child Malnutrition in Halls Creek Shire: A Summary of Local Issues,* Halls Creek Failure to Thrive Committee, April 1999, p. 1, cited in *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 50.

> *"Internationally, much work has been done in evaluating strategies for the alleviation of child malnutrition. There is no simple solution which will suit every situation and it is important that planned interventions are implemented with the support and involvement of local people. The impact of didactic nutritional education as an isolated strategy is generally disappointing, especially when poverty or other environmental factors prevent people from putting into practice what they have learned. School-based supplementary feeding programs can improve attendance, behaviour and school achievement. International studies have shown this to be a cost-effective public health intervention. Regular worming programs and provision of essential nutrients such as iron and zinc have proved effective in a number of studies. Home visiting programs are highly effective but require significant resource allocation. Whilst such strategies may offer significant relief, it is only through substantial improvement in political, social, and environmental conditions that permanent solutions are likely to be found."*[96]

6.3 The high cost of fresh fruit and vegetables in the Kimberley region, ostensibly due to transport costs, is seen as a continuing obstacle to encouraging healthy eating patterns in Aboriginal communities:

> *"Surveys undertaken since the mid 1980s have found that the costs of an average family food basket are of the order of 60 to 80 per cent or more higher in a number of areas in the Kimberley than in Perth. While prices of goods have consistently been of the order of 15 to 25 per cent higher in Broome and Derby, they are 40 to 50 per cent or more higher in towns like Fitzroy Crossing and Halls Creek and 50 to 90 per cent higher (or worse) in Aboriginal community stores. This high cost encourages poor dietary patterns and contributes to poor nutrition and related diseases, particularly amongst infants, young children, and mothers."*[97]

6.4 The Committee is of the view that the managers of community stores have a crucial role to play in reducing the costs, and increasing the supply, of healthy food to

---

96 *Child Malnutrition in Halls Creek Shire: A Summary of Local Issues,* Halls Creek Failure to Thrive Committee, April 1999, p. 1, cited in *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 50.

97 *Kimberley Regional Aboriginal Health Plan*, by Dr David Atkinson, Ms Catherine Bridge, and Dr Dennis Gray, December 1999, p. 24.

Aboriginal communities. The Committee notes the following observations regarding the management of community stores in the Kimberley region:

> *"There are many reasons for the high cost of goods in community stores which can be partly explained by the fact that many stores are located in isolated areas ... . Other factors that influence prices relate to the management of stores. Aboriginal councils and other incorporated bodies own Aboriginal stores under various administrative and legal arrangements. The community councils directly own some, and profits move directly into community accounts, while others are commercial enterprises that are administratively and legally separate from the community.*
>
> *Problems associated with running Aboriginal community stores impact on the cost of goods. These problems include: difficulties in recruiting skilled and honest managers; inadequate management systems leading to poor financial accountability; high staff turnover creating inefficiencies and stability problems; poor relationships between communities and store managers; lack of community commitment and preparedness to take responsibility for the store's success; goods damaged in transit due to bad roads and inadequate packing; poor stock control; high transport costs; inadequate store security; inability to secure lower prices through volume purchasing; high levels of bad debt due to credit mismanagement; and dishonesty by managers and staff ... .*
>
> *Community stores are the biggest commercial enterprises in most isolated Aboriginal communities. Generally they are fixtures and enjoy a captive market. Their current and potential role is of significance to Aboriginal economic development and to future health. Store managers wield considerable power over the food supply of remote Aboriginal communities and can be important allies or enemies in efforts by Aboriginal communities and their health services to improve dietary intakes."*[98]

6.5 The Committee notes that the KHS Kimberley Public Health Unit presently has a limited role in promoting nutrition in Aboriginal community stores. The Unit conducts a number of programs in conjunction with the managers of community stores

---

98 *Kimberley Regional Aboriginal Health Plan*, by Dr David Atkinson, Ms Catherine Bridge, and Dr Dennis Gray, December 1999, pp. 24-25.

in order to influence stock selection and buying habits within communities. For instance, healthy food approval stickers on items and “shelf talkers” clearly identifying nutritious foods are used to encourage healthy eating practices.[99]

Employment

6.6 The Committee agrees with the statement contained in the *Kimberley Regional Aboriginal Health Plan* that worthwhile employment opportunities and a reasonable income would do more to improve Aboriginal health than most other initiatives.[100]

6.7 The poor health of Aboriginal people in the Kimberley region, particularly amongst children, has a significant adverse impact upon their education and employment options, and for the economy of the Kimberley region generally.

6.8 The establishment of Aboriginal communities away from towns and stations has reduced the employment options for Aboriginal people in the Kimberley region. The privatization of many government services has also significantly impacted on employment opportunities for Aboriginals. In towns like Halls Creek the Shire is generally the largest employer of Aboriginal people.

6.9 The Committee understands that recent attempts by the Shire of Halls Creek to improve employment opportunities for Aboriginal people in the district have included the submission of a tender for contracts with the Main Roads Department for work involving minor road maintenance, the erection of signs, and the collecting of rubbish along road verges. Such tenders are extremely competitive, and the Shires are required to put in a significant amount of effort in preparing an attractive submission.

6.10 Opportunities for employment of Aboriginal people in the lucrative mining industry in the Kimberley region is limited due to the requirement of mining companies to employ highly skilled staff with mining industry experience. Mining companies generally prefer to fly in skilled staff from the metropolitan area, rather than hire and train locally. Furthermore, the rigid “2 weeks on – 2 weeks off” rostering of workers in the mining industry does not sit comfortably with Aboriginal lifestyle and culture in the Kimberley region.

---

[99] Dr Stuart Garrow, Director, Kimberley Public Health Unit, Transcript of Evidence, August 22 2000, p. 10.

[100] *Kimberley Regional Aboriginal Health Plan*, by Dr David Atkinson, Ms Catherine Bridge, and Dr Dennis Gray, December 1999, p. 27.

Housing

6.11 By way of illustration of the standard of housing in Aboriginal communities in the Kimberley region, the Committee provides the following excerpt from a report prepared by Halls Creek Environmental Health Officer, Mr Ian Gladigau, following a building inspection at the Balgo Aboriginal community on July 19 2000:

> *"RE: ELDERLY PERSONS ACCOMODATION* [sic] *AT BALGO (WIRRIMANU) LOTS 22 & 23*
>
> *There are two units approximately 12m x 2.5m on piers 1m high. Each unit has a shower & toilet that are not functional. The stoves, cupboards & fittings have all been removed. The flooring is rotted & dangerous (holes in many areas), the flooring moves as you walk.*
>
> *All the windows are broken or missing.*
>
> *The walls are damp to touch and holed or damaged throughout.*
>
> *The septic systems are overflowing and the lines are blocked.*
>
> *The general condition of the building is a danger to health, and is beyond economical repair.*
>
> *The stench inside the building was enough to make me retch.*
>
> *There are 18 elderly people living in these 2 dwellings.*
>
> *According to the information given at the time of my visit (19th July 2000) there is no alternative accommodation available for these people.*
>
> *The premises are unfit for human habitation and urgently need replacement."*[101]

6.12 A recent review of health services in the remote communities in the Balgo region south of Halls Creek also noted the following:

> *"[T]he environmental health issues raised at community level relate to having liveable houses with adequate, functioning health hardware*

[101] Report by Mr Ian Gladigau, Environmental Health Officer, Halls Creek, undated, p. 1.

> *within the house, and reliable rubbish collection. Overflowing septic tanks and other effluent were noted during our consultation.*
>
> *Repairs and maintenance of housing (environmental health inside the house fence) is a community responsibility with all work in the region subcontracted to a group based in Fitzroy Crossing, which dispatches tradesmen as required. Lack of equipment to do the job locally and reliance on non-local resources results in an ongoing health problem.*
>
> *Rubbish collection is under community management with labour funded by CDEP, with the consequence that it is achieved intermittently. There is little evidence of reliable rubbish collection due to lack of operating equipment and ineffective labour management (CDEP), as well as inefficient or absent community administration. These issues are ongoing and cyclical to various degrees in most remote Aboriginal communities."*[102]

6.13 The problems of Aboriginal housing in Halls Creek extends not only to the remote Aboriginal communities, but also allegedly to the fringe camps around the town of Halls Creek, and to the town itself:

> *"[L]ocal data obtained by the Shire of Halls Creek shows that in 1999 one hundred percent of housing in the fringe camps surrounding the town did not meet health requirements to be fit for human habitation. Informal estimates suggest that over 90% of State Government public housing within the town boundaries is also unfit for human habitation or is well below standards which would normally be considered acceptable by the Australian community."*[103]

6.14 The Committee was advised by the former Principal Environmental Health Officer for the Shire of Halls Creek that many of the problems relating to the poor standard of housing in Aboriginal communities in the Kimberley region are caused by a lack of supervision and building inspections at the time of construction of the dwellings.[104]

6.15 Due to their legal incapacity to enforce health, safety, and building laws on Crown land (an issue which will be discussed in Chapter 7, below), the four local

---

102 *Review of Health Services in the Kutjungka Region of Western Australia*, by John Wakerman, John Tregenza, and Ilan Warchivker, Centre for Remote Health and Menzies School of Health Research, Alice Springs, October 1999, p. 25.

103 *Health Care in Halls Creek 2000: Third World Health in a First World Country*, by Dr Matthew Ritson, March 23 2000, p. 42.

104 Submission by Mr W.V. Atyeo, July 2000, p. 2.

governments in the Kimberley region have been compelled by necessity to enter into informal agreements with communities and with funding bodies such as ATSIC on the basis that it will be a condition of any ATSIC funding for the construction of new dwellings in Aboriginal communities that building licences must first be obtained by the builder from the relevant local government authority.[105]

Refuse Collection

6.16 The 1997 Environmental Health Needs Survey of Western Australia identified 19 Aboriginal communities in the Kimberley region which have:

(a) an inappropriate rubbish tip, with less than 12 months capacity;

(b) poor management of the rubbish tip; and/or

(c) problems with rubbish collection.[106]

6.17 Aboriginal communities in the eastern Kimberley reported in 1997 that rubbish is sometimes not collected due to management issues such as lack of a vehicle, lack of organisation, or lack of workers.[107]

6.18 In 1997 it was also reported that almost all Aboriginal communities in Western Australia had unfenced rubbish tips.[108] Such a situation aggravates other environmental health problems associated with vermin and dog control.

Dog Control

6.19 The extent of the problem of an over-population of dogs varies from community to community throughout the Kimberley region. The Committee understands that in some of the smaller and mid-size Aboriginal communities, that is, 50-200 people, the dog population has been known to outnumber the human population. As these dogs are not licensed with the local government, and carry no identification tags, it is often difficult to establish which dogs in a community are actually owned, and which dogs are wild.

---

105 Submission by Mr W.V. Atyeo, July 2000, pp. 2-3.

106 Submission by Mr Haydn Lowe, Chief Executive Officer, Aboriginal Affairs Department, August 11 2000, p. 6.

107 *Environmental Health Needs of Aboriginal Communities in Western Australia: The 1997 Survey and its Findings*, Environmental Health Needs Coordinating Committee, 1998, p. 7.

108 *Environmental Health Needs of Aboriginal Communities in Western Australia: The 1997 Survey and its Findings*, Environmental Health Needs Coordinating Committee, 1998, p. 7.

6.20 The health problems posed by large numbers of unhealthy dogs vary from biting injuries on humans, attacks on livestock, noise pollution from barking and fighting dogs, the spread of disease by dogs gaining access to rubbish, and the spread of diseases and parasites from dogs to humans such as intestinal worms. Associate Professor Peter Williamson of Murdoch University Veterinary School, who was closely involved in a dog health program conducted by the HDWA within the Shire of Derby-West Kimberley, has noted:

> *"A number of important zoonoses are contracted directly from the dogs. These include Sarcoptic mange, Hookworm (Ancylostoma), Roundworm (Toxocara) and Threadworm (Strongyloides). In addition, the dogs provide a reservoir for a number of important gastro-enteric organisms which cause severe diarrhoea, including such organisms that cause vibriosis, salmonellosis, treponemiasis and giardiasis. These diseases are in high prevalence in the communities, especially among the children."*[109]

6.21 In its submission to the Committee, the Western Australian Aboriginal Affairs Department noted the following findings of the 1997 Environmental Health Needs Survey of Western Australia:

> *"The number and health condition of community dogs has a direct impact on the health of community members. Dogs are associated with the spread of parasitic diseases such as ticks and scabies. State funded, but Shire administered dog programs, aim to minimise these health consequences by offering sterilisation, dipping and community education services. Within the Kimberley region 54 communities (36% or 1545 people) reported not having a dog program."*[110]

6.22 The Committee notes that recent medical research raises some doubt as to whether many of the diseases and parasites afflicting children once thought to have been attributed to close contact with dogs can, in fact, be transferred from dogs to humans. As Dr David Atkinson advised the Committee:

> *"I do not think the dogs have that big an impact on human health. A researcher named Bart Currie who used to work at Menzies, but who is now in Queensland has written extensively on this. We were led*

---

[109] "Health Secrets May Lie in Dogs", by Peter Williamson, *Murdoch News Article*, undated, at Internet site: http://wwwcomm.murdoch.edu.au/webster/A56.html

[110] Submission by Mr Haydn Lowe, Chief Executive Officer, Aboriginal Affairs Department, August 11 2000, p. 6.

somewhat down the garden path about the extent to which parasites transferred from dogs to humans. Some things do transfer; nonetheless, a number of parasites we thought did transfer, do not do so, one of which is giardia. It is a parasite that is common in dogs and in children. People thought they were the same because they look similar under the microscope. There is fairly good evidence they do not transfer; it is a slightly different species and we do not get sick with one or the other. The same goes for scabies. The mangy dogs have severe sarcoptes mange due to scabies and the consequential continual scratching. Apparently all that does for humans is cause a little bit of an itch, not a proper infestation. The bacterial bugs such as salmonella can be spread around. The dogs probably eat a fair amount of either food they are given or food they have stolen. Having large packs of dogs is not positive for health, so I am not in favour of them."[111]

6.23 The Committee adopts the view that, on the whole, large numbers of free roaming dogs within a small, densely populated, area can only be detrimental to the environmental, physical, and mental health of a community. As one submission to the Committee noted:

"There has been a lot of discussion as to whether dogs impact on human health or not. Do people get disease from dogs? Dogs do have the potential to transmit disease to humans (Zoonosis). I suspect that in desert areas the transmission if any is low.

So why do a program on dogs at all?

1. *Dogs barking all night keep people awake.*
2. *Dogs tip over rubbish bins.*
3. *Dogs bite people.*
4. *Dogs walk through septic overflows and then enter houses and jump on bedding.*
5. *Dog faeces can be found where the children play.*

[111] Dr David Atkinson, Director, Centre for Aboriginal Medical and Dental Health, Faculty of Medicine and Dentistry, University of Western Australia, Transcript of Evidence, September 11 2000, p. 9.

6. *Dogs eat nappies then lick children's faces.*

7. *Dogs take food from elderly people.*

8. *Dogs that are sick and starving are an animal welfare issue.*

All the above are common complaints and must have some impact on health."[112]

6.24 The Committee also expresses its concern at the recent appearance of some of the more potentially violent breeds of dog within Aboriginal communities in the Kimberley region, such as great danes, rottweillers, and pit bull terriers.

6.25 Some of the Aboriginal communities in the Kimberley region identified in the 1997 Environmental Health Needs Survey as having a priority need for a dog control program were:

6.25.1 Imintji, north of Fitzroy Crossing, with a population of 45 people.

6.25.2 Kupingarri, north of Fitzroy Crossing, with a population of 130 people.

6.25.3 Ngallagunda, north of Fitzroy Crossing, with a population of 80 people.

6.25.4 Karmulinunga, near Derby, with a population of 103 people.[113]

6.26 All four of the local governments in the Kimberley region told the Committee that they had not attempted to enforce the provisions of the *Dog Act 1976* in the Aboriginal communities within their districts. Quite apart from the legal issue of jurisdiction on Crown land (see the discussion in Chapter 7, below), the local governments also expressed the view that they would face practical difficulties enforcing dog control laws without the acceptance and support of the Aboriginal communities.

---

[112] Submission by Dr. Robert M. Irving B.V.Sc., October 26 2000, p. 3.

[113] *Environmental Health Needs of Aboriginal Communities in Western Australia: The 1997 Survey and its Findings*, Environmental Health Needs Coordinating Committee, 1998, p. 50.

CHAPTER 7

OVERLAPPING JURISDICTIONS IN THE AREA OF ENVIRONMENTAL HEALTH

> *"“Normalisation of Services” has been the catch cry of the nineties, however it appears that Aboriginal Communities are not treated normally. Every Government Agency appears to have a division, which addresses Aboriginal health issues, be it Infrastructure, Housing or Environmental Health conditions. In a “normal” situation the appropriate Local Authority would address the Environmental Health Issues with support when required by the appropriate Government Agency."*[114]

7.1 The *Indigenous Environmental Health Policy* of the Australian Institute of Environmental Health (the national professional body for environmental health workers), states that the implementation of environmental health services for Aboriginal communities is best served at the local government level.[115] The Committee agrees with this proposition.

7.2 At present, however, environmental health programs are developed and implemented in the Kimberley region by a variety of government agencies at the local, state and federal level. The House of Representatives Standing Committee on Family and Community Affairs found that the planning and delivery of health services for Aboriginal Australians *"... is characterised by a general lack of direction and poor coordination"*.[116]

7.3 One submission received by the Committee noted:

> *"There are also other Departments and Organisations which receive both Federal and State funding that do not adequately service the needs of Aboriginal people situated on these communities. Officers from the Departments and Organisations constantly displayed their ignorance and inability to effectively communicate with the people, or*

---

114 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 3.

115 *Indigenous Environmental Health Policy*, Policy No. 1, October 1994, Australian Institute of Environmental Health, pp. 1-2.

116 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, p. 1.

> *even to understand the local barriers to improvement. These people were often labelled as "seagulls" by the local people."*[117]

7.4 In its submission to the Committee, the Western Australian Aboriginal Affairs Department advised the Committee of recent attempts to centrally coordinate the various government agencies involved in Aboriginal environmental health:

> *"As the "environmental health" portfolio responsibility does not lie with any particular agency, a collaborative interagency approach has been adopted. The consolidation of this coordinated approach has been progressed through the Environmental Health Needs Coordinating Committee (EHNCC), a committee of those agencies recognised as having a key role in the delivery of environmental health related programs and services. The member agencies of the EHNCC are the AAD, ATSIC, Ministry of Housing (MOH), Health Department of Western Australia (HDWA), Commonwealth Department of Health and Aged Care, and the Western Australian Municipal Association.*
>
> *Some of the existing programs coordinated through the EHNCC and currently operating in the Kimberley region include:*
>
> - *The Remote Area Essential Services Program – MOH and ATSIC*
> - *Aboriginal Community Strategic Investment Program – MOH*
> - *Community Construction Program – MOH*
> - *Management Support Program – MOH*
> - *National Aboriginal Health Strategy – ATSIC*
> - *Aboriginal Environmental Health Workers – HDWA*
> - *Aboriginal Field Support Officers – HDWA*
> - *Aboriginal Community Power Procurement Process – Office of Energy, AAD, ATSIC*

---

117 Submission by Mr W.V. Atyeo, July 2000, p. 1.

- *Energy Efficiency Education Package – Office of Energy, Western Power, AAD. ATSIC, MOH*
- *Regularisation of Services to Town Based Communities – AAD, ATSIC, MOH*
- *Building the Capacity of Aboriginal Communities – AAD*
- *Healthy Homes – Healthy Families Program – HDWA*
- *Town Planning – AAD, ATSIC, Western Australian Planning Commission*

The above programs represent the concerted effort across-government to achieve long-term outcomes in Aboriginal health. However these programs target selected communities and address particular priority environmental health issues within these communities. Significant gaps still exist, particularly in the areas of regular environmental health surveillance, rubbish disposal, dust and dog control, housing, access to municipal services and deficiencies in community management."[118]

7.5 An important aspect of Aboriginal environmental health that remains poorly coordinated is the location and development of Aboriginal communities and out-stations throughout Western Australia, which has progressed without any formal interagency/intergovernmental planning policy. The recently gazetted Western Australian Planning Commission Statement of Planning Policy No. 13, entitled *Planning for Aboriginal Communities*, which is a recent, but incomplete, attempt to address this problem, notes that:

"Most Aboriginal communities have developed over time with the involvement of many different government agencies. ... The State Government has acknowledged that it has a responsibility to provide services to selected large, permanent Aboriginal communities and that the funding of infrastructure to smaller outstation communities is the responsibility of the Commonwealth."[119]

---

118 Submission by Mr Haydn Lowe, Chief Executive Officer, Aboriginal Affairs Department, August 11 2000, pp. 6-7.

119 "Planning for Aboriginal Communities", Western Australian Planning Commission Statement of Planning Policy No. 13, *Western Australian Government Gazette No. 167 Special*, Friday, August 11 2000, p. 4685.

7.6 The Western Australian Planning Commission states that it is of the opinion that local government, through its understanding of local issues, has an important role to play in improving the quality of life in Aboriginal communities.[120] However, all four local governments in the Kimberley region expressed to the Committee a reluctance to become too involved in environmental health issues on Aboriginal communities due to a number of jurisdictional uncertainties. The *Planning for Aboriginal Communities* policy notes this reluctance in the area of planning:

> *"Recognising the need to improve the standard of planning in Aboriginal communities, the AAD and ATSIC, have, since 1996 embarked on a joint project to develop layout plans for many communities throughout the State. In lieu of any formal framework for these plans, interim procedures have been developed which involve referral of these plans to local government for endorsement. A number of local governments have embraced the planning project and are taking a pro-active role in communities. Others have been hesitant to become involved because of uncertainty regarding the future role of local government in these communities."*[121]

7.7 A summary of each level of government's current activities in the area of environmental health in Aboriginal communities in the Kimberley region is set out below.

Commonwealth Government

7.8 Environmental health is not one of the areas covered by the Commonwealth's specific powers as listed in s.51 of the *Constitution* of the Commonwealth of Australia. Nevertheless, there are a number of Commonwealth Government agencies that are involved in the provision of environmental health services.

7.9 The House of Representatives Standing Committee on Family and Community Affairs recently described the Commonwealth Government as having a *"... broad policy and financial role ..."*[122] in the area of Aboriginal health generally.

7.10 The Commonwealth Department of Health and Aged Care ("CDHAC") develops national policy on environmental health matters.[123] A significant level of annual

---

[120] "Planning for Aboriginal Communities", Western Australian Planning Commission Statement of Planning Policy No. 13, *Western Australian Government Gazette No. 167 Special*, Friday, August 11 2000, p. 4686.

[121] "Planning for Aboriginal Communities", Western Australian Planning Commission Statement of Planning Policy No. 13, *Western Australian Government Gazette No. 167 Special*, Friday, August 11 2000, p. 4685.

funding in the general "health" area is provided to the State Government by CDHAC for allocation throughout Western Australia. CDHAC also provides funds direct to the State through agreements such as the Health Care Agreements and Public Health Outcome Funding Agreements.[124]

7.11 CDHAC has provided funds to a current project of the Commonwealth Department of Family and Children's Services to improve the storage, preparation and cooking of food in Aboriginal communities by way of more practically designed kitchens in Aboriginal houses.[125]

7.12 CDHAC also provides funds to a number of non-government organisations that provide state-wide health services, such as the RFDS, the WA Aboriginal Child Health Survey conducted by the TVW Telethon Institute for Child Health Research, and Enhanced Primary Care and mental health funds administered to local Divisions of General Practice by General Practice Divisions of WA.[126]

7.13 The Commonwealth Government also heavily subsidises private medical services and pharmaceuticals through the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme, as well as providing financial incentives to purchase private health insurance. However, as the House of Representatives Standing Committee on Family and Community Affairs recently noted, Aboriginals living in remote areas generally receive limited, if any, benefits from these arrangements.[127]

7.14 Of the funds administered by CDHAC direct to the Kimberley region, services funded by the Office of Aboriginal and Torres Strait Islander Health ("OATSIH") (for example, the Aboriginal Community Controlled Health Services and substance misuse services) amounts to $10,781,224 (including GST) annually.[128]

---

122 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, pp. 17-18.

123 *The National Environmental Health Strategy 1999*, Publications Production Unit, Commonwealth Department of Health and Aged Care, Canberra, 1999, p. 58.

124 Submission by the Commonwealth of Australia Department of Health and Aged Care, Ms Jan Lewis, Kimberley Regional Co-ordinator, July 21 2000, p. 2.

125 *enHealth News*, enHealth Council, Volume 1, Issue 1, May 2000, p. 4.

126 Submission by the Commonwealth of Australia Department of Health and Aged Care, Ms Jan Lewis, Kimberley Regional Co-ordinator, July 21 2000, p. 2.

127 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, pp. 17-18.

128 Submission by Commonwealth of Australia Department of Health and Aged Care, Ms Jan Lewis, Kimberley Regional Co-ordinator, July 21 2000, p. 2.

7.15 ATSIC is an independent statutory authority which not only assists in policy-making and in the provision of specialist advice to the Commonwealth Minister for Aboriginal and Torres Strait Islander Affairs, but also provides funding for various community development programs for Aboriginal people. Among the ATSIC programs offered to Aboriginal communities in the area of environmental health, are the Community Development Employment Projects ("CDEP") program (which aims to improve employment and economic prospects for Aboriginal people)[129], and the Community Housing and Infrastructure Program (which seeks to improve the living environment of Aboriginal people by providing housing and associated infrastructure).[130]

7.16 Environment Australia is the lead Commonwealth Government agency on general environmental matters.[131]

State Government

7.17 The State Government has responsibility for making laws concerning public health, as well as making laws empowering and directing local governments to undertake public health activities. The primary environmental health legislation enacted by the State Government is the *Health Act 1911* and the *Local Government Act 1995*.

7.18 The State Government views its responsibilities in the area of environmental health as follows:

7.18.1 Ensuring the equitable delivery of services across Western Australia's 144 local governments.

7.18.2 Introducing State regulations.

7.18.3 Providing advice to all Environmental Health Officers.

7.18.4 Coordinating responses to issues transcending local government boundaries.

7.18.5 Acting as a link between local and federal levels of government.[132]

---

129 *Community Development Employment Projects (CDEP)*, Fact Sheet, at Internet site: http://www.atsic.gov.au/programs/noticeboard/CDEP/Default.asp

130 *Community Housing and Infrastructure Program*, Fact Sheet, at Internet site: http://www.atsic.gov.au/programs/noticeboard/Community/Housing_and_Infrastructure/Default.asp

131 *The National Environmental Health Strategy 1999*, Publications Production Unit, Commonwealth Department of Health and Aged Care, Canberra, 1999, p. 58.

132 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 3.

7.19 The OAH of the HDWA funds various health programs across the State by purchasing "gap-closing" health services from a range of service providing organisations, but primarily from Aboriginal community controlled health services and other Aboriginal community organisations.[133]

7.20 In 1999/2000, combined funding from the State OAH and the Commonwealth OATSIH for health programs in the Kimberley region amounted to per capita expenditure of approximately $1,054 (compared to a combined per capita funding in the Metropolitan/South West area of $377).[134] The HDWA advised the Committee that:

> *"The distribution of State funding reflects a consideration of existing Commonwealth funding patterns. Historically the Kimberley was the only region to benefit from the Western Australian Government decision in the mid 1980s to assume responsibility for the previously Commonwealth Aboriginal Health program. Allocation of State resources has been mindful of the continuing levels of Commonwealth investment in the Kimberley. The State has however continued to target resources at needs that are specific to the Kimberley."*[135]

7.21 KHS Community Health staff located in Halls Creek, Fitzroy Crossing and Wyndham (with FTE funding for seven Community Health Nurses, two Child Health Nurses, one School Health Nurse, and eight Aboriginal Health Workers) provide the following services:

7.21.1 The delivery of health programs in early detection, disease prevention and health promotion.

7.21.2 Antenatal and post natal health promotion, education and support programs for families with children and preventative activities to optimise child development.

7.21.3 Health promotion, education and support for young people and preventative activities to optimise academic and social competence.

---

133 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 4.

134 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 33.

135 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 34.

7.21.4 Health services and information to target groups of people on specific health issues.[136]

7.22 The HDWA also provides funding ($817,000) to the Mercy Community Health Service to provide community health services in the Balgo, Mulan and Billiluna communities.[137]

7.23 The KHS Kimberley Public Health Unit provides services to the Kimberley region by monitoring communicable and non-communicable disease control, environmental health in both towns and Aboriginal communities, water surveillance, food surveillance, contaminated sites, waste disposal management, mosquito borne disease control, and general health promotion.[138] As well as essentially providing specialist consultative services, the Kimberley Public Health Unit also has a role in the training of Aboriginal Environmental Health Workers.

7.24 The Committee regards the Kimberley Public Health Unit as essential for the advancement of Aboriginal health issues. The Director of the Kimberley Public Health Unit has the most important role in the Kimberley region in ensuring that adequate environmental health standards are maintained.

7.25 One of the recommendations of the *Kimberley Regional Aboriginal Health Plan* was that the Kimberley Public Health Unit devolve its responsibility for the training and management of environmental health workers, and maintain only a consultancy role in the area of environmental health.[139]

7.26 Some of the specific programs conducted by the Kimberley Public Health Unit include:

7.26.1 Colilert water testing.

7.26.2 Inspection of at risk water treatment systems.

7.26.3 Meliodosis research and control program.

7.26.4 Monitor community chlorination and provide training.

---

136 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 8.

137 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 12.

138 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 17.

139 *Kimberley Regional Aboriginal Health Plan*, by David Atkinson, Catherine Bridge and Dennis Gray, December 1999, Recommendation 37, p. 88.

7.26.5 Assist implementation of the Food Safety program and modify its suitability for Aboriginal communities.

7.26.6 Pilot study of diarrhoeal disease amongst children admitted to Derby Regional Hospital.

7.26.7 Programs for Aboriginal Community Stores and facilitation of store workers short course training.

7.26.8 Monitor food outlet investigations conducted by local shires.

7.26.9 Implement "Tidy Towns" and communities initiatives including competition focussing on aspects of rubbish disposal, landscaping, etc.

7.26.10 Facilitate Community Dog Program.

7.26.11 Implement an Aboriginal environmental health home program. Increase knowledge in home ventilation.

7.26.12 Employ regional Aboriginal Environmental Health Workers and provide onsite training and support TAFE training.

7.26.13 Provide Environmental Health Officers to work closely with Aboriginal communities/agencies to ensure on-going health education, promotion and action plans are developed in support of environmental health issues. In particular, provide and support education strategies and conduct environmental health surveillance in areas of water supply, sewage disposal, housing standards, food hygiene, dog health and waste management.[140]

7.27 Additional programs conducted by the Kimberley Public Health Unit with relevance to preventative health education in Aboriginal communities include:

7.27.1 Comprehensive immunisation program in conjunction with Community Health Services.

7.27.2 Promoting safe sex and the prevention and treatment of sexually transmitted diseases.

7.27.3 Contribute to the Kimberley Child Health Sexual Abuse strategy.

7.27.4 Provide Hookworm/parasite treatment and education.

---

140 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, pp, 17-18.

7.27.5 Conduct "Eat Healthy Tucker" workshops and coordinate "FoodCent$" program.

7.27.6 Ensure Community Store Managers implement Best Practice Food guidelines.

7.27.7 Conduct annual Market Basket survey.

7.27.8 Provide store manager and Aboriginal Health Worker nutrition training.

7.27.9 Implement "Be Active the Kimberley Way" program.

7.27.10 Implement "Jabby Don't Smoke" campaign, including a school and community information package.

7.27.11 Survey Sales to Minors compliance, including Aboriginal Community Stores.

7.27.12 Coordinate "Respect Yourself" Kimberley campaign.[141]

7.28 Apart from the HDWA, the Aboriginal Affairs Department and the Department of Commerce and Trade are the most significant State Government agencies that provide funding for a number of short term environmental health and community development programs for Aboriginal communities in the Kimberley region. The Department of Commerce and Trade provides various grants and incentive schemes for community stores and funds various small business projects within Aboriginal communities.

Local Government

7.29 In addition to enforcing and implementing environmental health legislation enacted by the State Government, local governments have the power under the *Local Government Act 1995* (pursuant also to the provisions of the *Health Act 1911*[142] and the *Local Government (Miscellaneous Provisions) Act 1960*[143]), to develop local laws relating to environmental health issues, for example, public health and building construction, maintenance, and safety standards.[144]

7.30 Local governments are well placed to effectively implement environmental health programs. As *The National Environmental Health Strategy* states:

141 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, pp. 18-20.

142 See, for instance, s342 of the *Health Act 1911.*

143 See, for instance s433 of the *Local Government (Miscellaneous Provisions) Act 1960.*

144 Section 3.5, *Local Government Act 1995.*

> *"Through their environmental and health responsibilities, local governments have a unique capacity to improve the health of their communities. Research suggests that they spend a greater proportion of total outlays on pollution abatement and control (water treatment, household and other garbage disposal, sewerage, urban stormwater drainage, other environmental protection) than either State/Territory or Commonwaelth governments."*[145]

7.31 Under the *Health Act 1911* the Executive Director, Public Health, is empowered to direct both local governments and Environmental Health Officers in relation to the administration of the *Health Act 1911* and its regulations and local laws.[146]

7.32 However, the Shire of Halls Creek stated the following in its submission to the Committee:

> *"Council has a major responsibility to enforce the Health Act and Building Code of Australia but our powers are limited and the attempted co-ordination of numerous funding bodies, is in most cases, frustrating."*[147]

7.33 The Committee heard evidence that key environmental health enforcement provisions under the *Health Act 1911* and building legislation do not bind the Crown. The effect of this situation is that officers from one Crown agency, such as a local government, cannot legally enforce those particular provisions of the *Health Act 1911* against another Crown agency, such as the Aboriginal Lands Trust: *Atyeo v Aboriginal Lands Trust* CLS 1996 WASC 151 ("*Atyeo*").

7.34 In 1947 the Privy Council, in its decision in *Province of Bombay v Municipal Corporation of Bombay* [1947] AC 58, stated that a statute does not bind the Crown unless: (a) the statute itself expressly provides that it does; or (b) the statute would be unworkable if the Crown does not comply with it.

7.35 However, the strict rule developed by the Privy Council has since been modified in Australia by decisions of the High Court of Australia in *Bropho v Western Australia* (1990) 171 CLR 1 and in *Registrar of the Accident Compensation Tribunal v FCT* (1993) 178 CLR 145, in which it was held that the Privy Council's interpretation was merely a statutory presumption and not a hard and fast rule of statutory interpretation.

---

145 *The National Environmental Health Strategy 1999*, Publications Production Unit, Commonwealth Department of Health and Aged Care, Canberra, 1999, p. 58.

146 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 2.

147 Submission by the Shire of Halls Creek, Peter McConnell, Chief Executive Officer, August 1 2000, p. 2.

In the above cases, the High Court of Australia developed the approach that when a court examines a statute that is silent on the issue of whether it binds the Crown, the court should take into account other factors such as the subject matter of the legislation, the nature of the mischief to be addressed by the statute, the nature of the Crown instrumentality involved, and the nature of the activities of the Executive Government that would be affected if the Crown is bound by the statute.

7.36 It is noted by the Committee that Western Australian courts have, nevertheless, tended in recent times to apply the above mere "presumption" quite strictly: see *Atyeo*, and *Bridgetown/Greenbushes Friends of the Forest Inc v Department of Conservation and Land Management* (1997) 18 WAR 126.

7.37 The issue in dispute in *Atyeo* was whether a local authority, in this case the Shire of Halls Creek, could prosecute the Crown in right of the State of Western Australia through its instrumentality the Aboriginal Lands Trust, for a failure by the Aboriginal Lands Trust to provide apparatus for the treatment of sewage in a house provided by the Aboriginal Lands Trust and located at the Mardiwah Loop Aboriginal Community near Halls Creek, such a failure being contrary to s.99 of the *Health Act 1911.*

7.38 In the decision of the Western Australian Supreme Court (Templeman J sitting alone) in *Atyeo*, Templeman J stated:

> *"It is clear from Bropho, therefore, that if breach of a statute would result in criminal liability being visited on the Crown, that must be a powerful factor which reinforces the presumption against the Crown being bound."*[148]

7.39 Templeman J found in *Atyeo* that, given that the general administrative responsibility for the *Health Act 1911* was under the control of the Minister for Health[149] and that certain decisions of local governments under the *Health Act 1911* were subject to the possibility of appeal to the Minister for Health[150], in the absence of express words to the contrary it is unlikely that the State legislature intended to subject the Executive to the actions of a local authority where it was possible for the Minister for Health to override such actions in any event.[151]

7.40 Overall, Templeman J was not convinced that a finding that the *Health Act 1911* is not binding on the Aboriginal Lands Trust would so undermine the general effectiveness

---

148 *Atyeo v Aboriginal Lands Trust* CLS 1996 WASC 151 at 155.

149 *Health Act 1911*, s7.

150 *Health Act 1911*, s37.

151 *Atyeo v Aboriginal Lands Trust* CLS 1996 WASC 151 at 159.

of the *Health Act 1911* so as to lead to the conclusion that the Crown should be bound by it.[152]

7.41 With respect to building laws[153], the Crown in right of the State of Western Australia is also unaffected by statutory licensing, health and safety requirements so far as State Government buildings are concerned.[154] The Shire of Wyndham-East Kimberley advised the Committee that in recent years a large number of buildings had been constructed in both the towns and in Aboriginal communities within the Shire which had not complied with local building laws.[155] The Shire had been powerless to compel compliance with the law due to the fact that these buildings had been constructed by Crown instrumentalities, either Commonwealth or State, on Crown land.

7.42 Some of the Commonwealth Government agencies named by the Shire as having constructed buildings in Kununurra without regard to the Shire's building and parking laws were ATSIC and the Department of Social Security.[156] Recently, following the sale of a Commonwealth Government building in Kununurra to a private company, parking problems developed in the vicinity due to the Commonwealth Government's failure to observe local laws regarding the provision of adequate parking facilities when it constructed the building.[157]

7.43 Some of the State Government agencies named by the Shire as not complying with local building laws were the HDWA and the Education Department.[158] Other agencies, such as the Police Service, have proceeded with building construction with only minimal consultation with the Shire when it came to issues such as the provision of adequate parking facilities.[159] As one witness advised the Committee:

---

152 *Atyeo v Aboriginal Lands Trust* CLS 1996 WASC 151 at 160.

153 That is, those provisions of the *Health Act 1911*, the *Local Government (Miscellaneous Provisions) Act 1960*, and the *Local Government Act 1995*, and the regulations and local laws made under those Acts, which relate to the health, safety, construction, maintenance, and licensing of buildings.

154 *Local Government (Miscellaneous Provisions) Act 1960*, s373(3).

155 Mr Tony Brown, CEO, Shire of Wyndham-East Kimberley, and Mr Richard Brookes, Director Development Services, Transcript of Evidence, August 25 2000, pp. 13-15.

156 Ms Maxine Middap, Shire President, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 16.

157 Mr Richard Brookes, Director Development Services, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 16.

158 Mr Richard Brookes, Director Development Services, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 15.

159 Ms Maxine Middap, Shire President, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 16.

> *"Contract and Management Services who manage a lot of contracts* [on behalf of State Government agencies] *have a specific clause in their contract which says that the builder shall not submit the plans to the council for approval."*[160]

7.44 It was noted in the submission of the Shire of Wyndham-East Kimberley that there is currently in circulation a draft "Building Act" that includes the provision that the Crown will be bound by the Act.[161]

7.45 It is not clear whether the *Dog Act 1976* binds the Crown. Section 6 of the *Dog Act 1976* relevantly provides:

> *"**6**. Application*
>
> *(1) Subject to subsection (4), the provisions of this Act apply generally to all dogs, whether sterilized or unsterilized, and of whatever age.*
>
> ...
>
> *(4) The provisions of this Act, and of any regulation or local law which is made under this Act, do not apply to or in relation to a dog when it is working with a member of the Police Force on duty, and despite anything in any written law a member of the Police Force on duty is entitled to be accompanied, at all times and in all places, by a dog with which that member is working."*

7.46 Furthermore, s.9 of the *Dog Act 1976* states:

> *"**9**. Administrative responsibility*
>
> *It shall be the duty of a local government within its district to administer and enforce the provisions of this Act, and where in the opinion of the Governor the powers conferred by this Act on a local government should be extended to an area outside the district the Governor may by Order declare that for the purposes of this Act the area is to be regarded as being within the district and the provisions*

---

160 Mr Richard Brookes, Director Development Services, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 16.

161 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 3.

> *of this Act shall then apply as if in fact the area were within the district."*

7.47 The *Dog Act 1976* therefore purports to apply to "all dogs" (with the express exception of police dogs), and confers administrative responsibility for the statute on the local governments. However, the statute remains silent on the issue of whether the Crown is expressly bound by the statute and, therefore, whether local government officers have the statutory authority to enter upon, for instance, Aboriginal Lands Trust land to enforce the provisions of the *Dog Act 1976*. Those provisions of the *Dog Act 1976* expressly exempting dogs under the control of police officers do not help in clarifying the position of the Crown under that Act, as police officers are not properly to be regarded as "agents or servants" of the Crown: *Enever v The King* (1906) 3 CLR 969.

7.48 The general uncertainty caused by the fact that certain key public health enforcement provisions of acts such as the *Health Act 1911,* the *Local Government (Miscellaneous Provisions) Act 1960*, and the *Local Government Act 1995*, are not enforceable against the Crown, and by the fact that the status of other acts such as the *Dog Act 1976* are unclear on the issue, has to date resulted in hesitant, irregular, and inefficient supervision of environmental health standards in Aboriginal communities by local governments in the Kimberley region.

7.49 Councillor Lyn Page of the Shire of Broome advised the Committee that building inspections and work orders in Aboriginal communities do not produce any results due to the lack of power and authority of local government Environmental Health Officers in these areas.[162] The local governments must therefore rely on informal, non-legally enforceable service agreements with each Aboriginal community in order to introduce adequate standards in building construction projects on those communities.[163]

7.50 Under both the *Aboriginal Affairs Planning Authority Act 1972* and the *Aboriginal Communities Act 1979*, only persons authorized by an Aboriginal community may enter upon land within that community unless they fall within one of a few narrowly defined exempt classes of persons, such as members of parliament or a person "... *acting in pursuance of a duty imposed by law".*[164] Given the above stated uncertainty regarding the legal authority of a local government officer to carry out his/her

---

162 Ms Lyn Page, Councillor, Shire of Broome, Transcript of Evidence, August 21 2000, p. 5.

163 Ms Lyn Page, Councillor, Shire of Broome, Transcript of Evidence, August 21 2000, p. 6.

164 Section 31(1)(c), *Aboriginal Affairs Planning Authority Act 1972*. See also ss. 7(1)(a) and 13(2), *Aboriginal Communities Act 1979.*

statutory duties on State Government land, it is no wonder that local governments are reluctant to rely on such exemptions to gain access to Aboriginal communities.

7.51 Access to many Aboriginal communities in the Kimberley region for local government officers is therefore generally by way of a permit issued by the administrators of each Aboriginal community – the Committee understands that the protocol is usually for the local government to give four days notice of any proposed visit.

7.52 Further uncertainty about the applicability of local government regulatory powers within Aboriginal communities also tends to arise through the publication of vague policy documents such as the recently released *"Planning for Aboriginal Communities",*[165] which establishes a cooperative approach to planning decisions on Aboriginal communities through negotiation, rather than by way of a strict regulatory approach. Such policy documents ignore the fact that the key benefit of a strict regulatory approach is that all parties are well aware of their respective responsibilities, powers, and rights.

7.53 One of the recommendations made by the enHealth Council Indigenous Environmental Health 2nd National Workshop, held in Broome in May 1999, was that all Commonwealth and State legislation which impacts on environmental health standards in Aboriginal communities should bind the Crown.[166] Related recommendations were that all jurisdictions should commit to the upgrading of community stores in Aboriginal communities to satisfy National Food Safety Standards[167], and that nationally consistent standards for remote Aboriginal housing and infrastructure should be developed.[168]

7.54 However, even if local governments did have the express power to enforce environmental health laws in Aboriginal communities, it is clear that they currently would not have sufficient resources to provide an adequate monitoring service for all

---

165 "Planning for Aboriginal Communities", Western Australian Planning Commission Statement of Planning Policy No. 13, *Western Australian Government Gazette No. 167 Special*, Friday, August 11 2000, p. 4685.

166 *Indigenous Environmental Health: Report of the Second National Workshop, 20-21 May 1999, Broome, Western Australia*, enHealth Council Monographs, Indigenous Environmental Health Series No. 2, Commonwealth of Australia, 2000, p. x.

167 *Indigenous Environmental Health: Report of the Second National Workshop, 20-21 May 1999, Broome, Western Australia*, enHealth Council Monographs, Indigenous Environmental Health Series No. 2, Commonwealth of Australia, 2000, p. x.

168 *Indigenous Environmental Health: Report of the Second National Workshop, 20-21 May 1999, Broome, Western Australia*, enHealth Council Monographs, Indigenous Environmental Health Series No. 2, Commonwealth of Australia, 2000, p. x.

Aboriginal communities within their shire boundaries.[169] This situation is due to a lack of access by local governments to an appropriate portion of the existing level of Commonwealth and State government expenditure in the environmental health area, and also due to the fact that the local governments do not receive money from the Aboriginal communities themselves in the form of rates.[170]

Co-ordination of funding and localised supervision of environmental health programs

7.55 It has been recently reported that there is a considerable degree of distrust between some of the health service providers in the Kimberley region, which inhibits co-operation and a coherent centralised planning process.[171] As stated above, the Committee also observed first hand the high level of mistrust and suspicion between these bodies. Each of the funding and administrative bodies in the area of Aboriginal health has its own focus, and there is no formal process for cooperation or the sharing of information.

7.56 The House of Representatives Standing Committee on Family and Community Affairs found that whilst additional funding for environmental health issues in remote Aboriginal communities is urgently required, many of the problems in providing adequate environmental health services to these communities can be related to a lack of coordination between government authorities, local councils and local communities, as well as an inadequate focus on maintaining key services to an acceptable level.[172] Furthermore, the House of Representatives Standing Committee noted that many Commonwealth and State programs are commonly reviewed or revised every few years, meaning that service providers are constantly justifying existing expenditure, or putting forward submissions for a continuation of funding.[173]

7.57 The Committee acknowledges that involvement by Aboriginal community leaders in environmental health programs is critical for the success of such programs. The Committee is further of the view that a single level of government should be given primary and direct responsibility for the development, supervision and ongoing management of environmental health programs in Aboriginal communities in

---

169 Submission by Mr W.V. Atyeo, July 2000, p. 1.

170 Ms Lyn Page, Councillor, Shire of Broome, Transcript of Evidence, August 21 2000, pp. 9, 11-12.

171 *Kimberley Regional Aboriginal Health Plan*, by Dr David Atkinson, Ms Catherine Bridge, and Dr Dennis Gray, December 1999, p. 98.

172 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, p. 49.

173 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, p. 24.

conjunction with the community leaders. Such programs must also be on a long term basis (that is, at least three years in duration) with assured funding and continuity of program content over the life of the program.

7.58 The Committee agrees with the view of many of those who made submissions during the inquiry stressing that the success of any environmental health program depends upon continuity of commitment by a single responsible body, continuity of funding, continuity of appropriately experienced staff, continuity of physical presence in the Aboriginal communities, and continuity of commitment and involvement by those communities themselves.[174]

[174] Submission by Mr W.V. Atyeo, July 2000, p. 4.

CHAPTER 8

FUNDING AND TRAINING OF ENVIRONMENTAL HEALTH WORKERS

8.1 At present each of the local governments in the Kimberley region employs one or two Environmental Health Officers ("EHOs") to service their districts. However, these EHOs, subject to conditions imposed by alternative funding sources, if any, generally are occupied most of the time with duties in the towns within their shires.

8.2 The KHS Kimberley Public Health Unit employs a Regional EHO, based in Derby. The Unit supervises a number of Aboriginal Environmental Health Field Support Officers ("AEHFSOs") based in some Kimberley towns. These AEHFSOs provide direct advice and assistance to Aboriginal Environmental Health Workers ("AEHWs") based within Aboriginal communities and are required to cover large areas – for instance, the Kununurra-based AEHFSO has responsibility for areas within both the Shire of Wyndham-East Kimberley and the Shire of Halls Creek.[175]

8.3 The KHS Kimberley Public Health Unit also indirectly supervises AEHWs located in a number of Aboriginal communities (often part of the HDWA staff assigned to Community Health Nursing Posts).

8.4 The KHS Kimberley Public Health Unit directly employs four AEHWs (two based in Kununurra, one in Derby and one in Broome).[176] Further AEHWs funded by the HDWA are located in Aboriginal communities as follows:

8.4.1 Derby: One Full Time Equivalent ("FTE") funded by the OAH.

8.4.2 Halls Creek: One FTE funded by the OAH.

8.4.3 One Arm Point Aboriginal Community: One FTE.

8.4.4 Looma Aboriginal Community: One FTE.

8.4.5 Kupangarri Aboriginal Community: One FTE.

8.4.6 Fitzroy Valley: 17 FTEs (part of the "Family Futures" project, funded by CDEP payments and the OAH).

175 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 1.

176 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, p. 14.

8.4.7 Broome: Six FTEs (currently vacant, and to be funded as a top up on CDEP and managed by the Kimberley Public Health Unit).

8.4.8 Kununurra: One FTE managed by the Kimberley Public Health Unit.[177]

8.5 The HDWA also funds a number of AEHFSOs at the following locations:

8.5.1 Shire of Derby-West Kimberley: Two FTEs.

8.5.2 Fitzroy Valley: One FTE (part of the "Family Futures" project, funded by CDEP payments and the OAH).

8.5.3 Wyndham: Four FTEs.[178]

Environmental Health Officers

8.6 The Australian Institute of Environmental Health – Accreditation Registration Board accredits a Bachelor of Science Degree (Environmental Health) as the recognised academic qualification for professional practice as an EHO in Australia.[179] All Australian jurisdictions accept this accreditation.

8.7 EHOs have a comprehensive knowledge of the physical, biological and social sciences. Their duties include[180]:

8.7.1 Water quality management.

8.7.2 Illness prevention (including immunisation).

8.7.3 Food surveillance (including hygiene, handling, inspection, prevention, promotion, and overall surveillance).

8.7.4 Waste management (including sewage and recycling).

8.7.5 Healthy buildings, hairdressing and tattoo health standards.

8.7.6 Pest control (mosquito, dogs, feral cats, etc.).

8.7.7 Basic principles of urban and regional planning.

---

177 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, Attachment A, Term of Reference 3, p. 2.

178 Submission by the Health Department of Western Australia, Mr Alan Bansemer, Commissioner of Health, July 28 2000, Attachment A, Term of Reference 3, p. 2.

179 *What is an Environmental Health Officer?*, Australian Institute of Environmental Health, p. 1, at Internet site: http://www.aieh.org.au/body_employment.html

180 *What is an Environmental Health Officer?*, Australian Institute of Environmental Health, pp. 1-2, at Internet site: http://www.aieh.org.au/body_employment.html

8.7.8 Air quality management.

8.7.9 Noise control and other physical factors including radiation monitoring.

8.7.10 Potentially hazardous substances.

8.7.11 Contamination of food, land, etc.

8.7.12 Epidemiology and research.

8.7.13 Occupational health and safety applied environmental health law and management principles.

8.7.14 Environmental health education and promotion.

8.7.15 Environmental management.

8.7.16 Disaster management covering animal disposal, sewerage/septic, food following earthquakes, floods, etc.

8.7.17 Communicable diseases and vector control.

8.7.18 Recreation safety, cemetery controls.

8.7.19 All other aspects of preventative health at the local level.

8.8 Pursuant to s.27 of the *Health Act 1911*, local governments may employ an EHO, subject to approval of the officer's qualifications[181] and the issuing of directions to that officer by the Executive Director, Public Health. Furthermore, the Executive Director, Public Health, may require a particular local government, or more than one local government jointly,[182] to appoint an EHO, or may appoint the officer himself/herself in the event of the local government/s neglecting to do so.[183] The qualifications, powers and responsibilities of EHOs are set out within various provisions of the *Health Act 1911*.[184]

8.9 In the 1997 Environmental Health Needs Survey, 31% of Aboriginal communities throughout Western Australia reported having no on-site or visiting EHO.[185]

---

181 Section 28, *Health Act 1911*.

182 Section 30, *Health Act 1911*.

183 Section 29, *Health Act 1911*.

184 See, for example, ss. 27-31, 33, 246ZB, 246ZE.

185 *Environmental Health Needs of Aboriginal Communities in Western Australia: The 1997 Survey and its Findings*, Environmental Health Needs Coordinating Committee, 1998, p. 7.

8.10 EHOs are generally employed and funded by local governments. In the area of environmental health in Aboriginal communities, the local governments must generally rely on funding from other sources. Such funding is usually program specific and short-term. In the Kimberley region, all four local government authorities have either a current or proposed funding arrangement with the OAH, to employ wholly or partly an EHO dedicated to providing services to Aboriginal communities.[186] It is generally acknowledged, however, that problems can arise from the situation where a Perth based State Government agency makes decisions targeting where environmental health funding should be spent within the Kimberley shires.[187]

Aboriginal Environmental Health Workers

8.11 The Aboriginal Environmental Health Worker Training Program trains selected Aboriginal community members in the areas of home hygiene, dog health, sanitary plumbing, refuse control, and other vital components of environmental health.[188] Having on-site environmental health program staff within the Aboriginal communities means that there are significant cost savings in not having to transport people in to the communities to unblock drains, change tap washers, clean houses, and conduct dog control and dust suppression programs.

8.12 Many environmental health problems in Aboriginal communities are compounded by the lack of basic maintenance skills within the community, and the time and cost implications for essential repairs due to geographic isolation.[189] As well as providing basic maintenance services and general environmental health education and advice, on-site or visiting AEHWs can identify future maintenance requirements or environmental health risks, as well as any breaches of building and dog control legislation (which can then be communicated back to the town-based EHOs).

8.13 One submission received by the Committee described AEHWs as the “key” that unlocked many doors in Aboriginal communities for the local governments, and who proved a most valuable source of learning and understanding of Aboriginal culture.[190]

---

186 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 2.

187 Dr Stuart Garrow, Director, Kimberley Public Health Unit, HDWA, Transcript of Evidence, August 22 2000, p. 4.

188 Submission by Mr W.V. Atyeo, July 2000, p. 5.

189 *Environmental Health Needs of Aboriginal Communities in Western Australia: The 1997 Survey and its Findings*, Environmental Health Needs Coordinating Committee, 1998, p. 11.

190 Submission by Mr W.V. Atyeo, July 2000, p. 5.

8.14 In the 1997 Environmental Health Needs Survey, one quarter of Aboriginal communities throughout Western Australia reported having no AEHW either on-site or visiting.[191]

8.15 The State Government provides funding for the employment of AEHWs and AEHFSOs through the OAH by way of contracts to service providers.[192] In the Kimberley, the OAH has AEHW and AEHFSO contracts with local governments, the KHS Kimberley Public Health Unit and with various Aboriginal communities.[193] Some Aboriginal communities, however, use the CDEP scheme to employ AEHWs.[194] This situation is to be contrasted with the position of Aboriginal Health Workers within Aboriginal communities, who receive a normal wage from the HDWA rather than simply relying on CDEP schemes.[195]

8.16 At Fitzroy Crossing, the Nindilingarri Cultural Health Service is an incorporated body providing health programs to Aboriginal families in approximately 10 of the 35 Aboriginal communities in the Fitzroy Valley.[196] Amongst the programs it provides are Environmental Health, Sexual Health, Family Futures, Alcohol and Drugs, and Health Promotion.[197] These programs have been funded by either the State Government through the OAH or the KHS, or the Commonwealth Government through OATSIH.[198]

8.17 The Family Futures program has resulted in the training of 25 AEHWs based in the Aboriginal communities, and three Health Promotions officers who have focussed on the development of video, music and other health promotional materials throughout the Fitzroy Valley.[199] The Nindilingarri Cultural Health Service has also provided first aid training which has resulted in 40 people being issued with First Aid Certificates in the Fitzroy Valley.[200]

8.18 The State Government, through the OAH, entered into a contract to fund the community controlled Derby Aboriginal Health Service ("DAHS") to provide a

---

191 *Environmental Health Needs of Aboriginal Communities in Western Australia: The 1997 Survey and its Findings*, Environmental Health Needs Coordinating Committee, 1998, p. 7.

192 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, pp. 2-3.

193 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 3.

194 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 2.

195 Mr Ian Smith, Manager KHS, HDWA, Transcript of Evidence, August 25 2000, p. 5.

196 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 6.

197 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 5.

198 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 6.

199 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 6.

200 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 6.

comprehensive environmental health program to Aboriginal communities in the Derby-West Kimberley Shire. The contract was initially for the period September 1999 to June 2000. However, the OAH announced on May 19 2000 that the contract was terminated, apparently due to confusion over the Aboriginal communities to be serviced by DAHS and the lack of progress reports or evidence that the program had "worked".[201]

8.19 The Committee notes that the Commonwealth Department of Health and Aged Care has recently provided a grant to the HDWA to produce video resources to promote the roles and responsibilities of AEHWs.[202]

8.20 There was general agreement amongst witnesses, and in the submissions to the Committee, that the most effective training programs for AEHWs are those that are conducted as close as possible to the relevant Aboriginal community. Community-based AEHW training courses have a higher completion rate, act to increase the standing of AEHWs in their communities, and enable the communities to see first-hand the benefits of increased environmental health standards.[203]

8.21 The Shire of Halls Creek was of the view that the training, education and supervision of AEHWs is undertaken on an *ad hoc* basis with no follow up or support.[204] The Committee was informed that few people from the Halls Creek area had actually completed the three year TAFE Aboriginal Environmental Health Worker Training Program course. The course was seen by some Aboriginal people as lacking practical training, and as being too theoretical, consisting of two years basic training with a further year of specialist training in areas such as dog control.

8.22 *The National Environmental Health Strategy 1999* identified a number of problems relating to the training and employment of AEHWs:

8.22.1 Greater support is required from local government and other agencies.

8.22.2 AEHWs do not have defined career paths after completing their training.

8.22.3 Communities do not recognise the expertise of AEHWs, which makes it difficult for AEHWs to have their recommendations implemented.

---

201 Attachment to the submission of Kimberley Aboriginal Medical Services Council, Inc., July 31 2000, prepared by Derby Aboriginal Health Service, August 2 2000, pp. 1-2.

202 *enHealth News*, enHealth Council, Volume 1, Issue 1, May 2000, p. 4.

203 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 3.

204 Submission by the Shire of Halls Creek, Peter McConnell, Chief Executive Officer, August 1 2000, p. 2.

8.22.4 AEHWs have difficulty achieving recognition for their expertise and qualifications from workers in other fields.

8.22.5 AEHW training programs are conducted in Western Australia, the Northern Territory and Queensland. However, there is no standard competency level, and little portability of the qualification between the regions.

8.22.6 There is little ongoing professional development once the formal AEHW training program has been completed.

8.22.7 There is no basic environmental health training for Aboriginal Health Workers, who may be able to assist with the work of AEHWs and EHOs in the smaller Aboriginal communities.

8.22.8 AEHW training needs to be recognised as prior learning for admission to other areas of study, especially undergraduate environmental health training.

8.22.9 AEHWs based in remote Aboriginal communities need greater support in order to encourage their acceptance within their communities.[205]

8.23 The Committee is of the view that many of the above problems could be solved by providing standard training, qualifications, and a clear job description for AEHWs, and by making AEHWs part of a single environmental health management and enforcement structure based within local governments.

8.24 In 1996, the EHOs from all of the four local governments in the Kimberley region met with the KHS Kimberley Public Health Unit in Broome to discuss the best method of managing AEHWs and AEHFSOs in the Kimberley region. The Shire of Wyndham-East Kimberley notes:

> *"It was decided and agreed by all parties that the organisations best placed to take on the responsibility of addressing Environmental Health in the region was the Local Government Authority. A submission was put to the Health Department, however, that appears to have been buried."*[206]

8.25 The HDWA is opposed to the employment of AEHWs and AEHFSOs under a single employing authority. The reason given for this position, is that the HDWA prefers to

---

205 *The National Environmental Health Strategy 1999*, Publications Production Unit, Commonwealth Department of Health and Aged Care, Canberra, 1999, p. 30.

206 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 1.

maintain a flexible approach to its arrangements for the provision of environmental health services, thereby *"... seeking the best fit for local needs"*.[207] The State Government recently announced that it had established "Regional Environmental Health Networks" across the State, creating partnerships with public health units, local governments, Aboriginal communities and service providers.[208] The Minister for Health advised the Committee that:

> *"The intention of networking arrangements in environmental health is that all AEHWs and* [AEH]*FSOs employed through OAH contracts in the Kimberley have the support and assistance of relevant agencies, including local government, no matter who their particular employer may be. This approach optimises both local access to AEHW services for Aboriginal communities and technical and other support from agencies such as local government."*[209]

8.26 The State Government has also adopted the view that there would be no advantage in providing enabling legislation to define the responsibilities and regulate the standards of AEHWs.[210]

8.27 The House of Representatives Standing Committee on Family and Community Affairs recently concluded that a more appropriate role for AEHWs needs to be developed, based on improving their skills, remuneration and status within their communities.[211] It was suggested that it may be more appropriate for AEHWs to work within the health sector rather than for local governments in order to improve the career structure of environmental health workers as well as creating a more positive link in people's minds between their work and health outcomes.[212]

8.28 From the perspective of the HDWA, not all of the shires in the Kimberley region have shown a high level of interest in taking a more active role in supporting AEHWs in the Aboriginal communities of the Kimberley region.[213] As such, the HDWA is of the view that AEHWs based in Aboriginal communities generally feel more comfortable working for the HDWA than for the shires.[214] The Committee accepts that this may be the situation with respect to some communities and shires at present. However, the Committee is of the view that the HDWA does not have the resources to effectively supervise the work of AEHWs on a regular basis in Aboriginal communities, and that such supervision should be undertaken by the level of government which has the

---

207 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 3.

208 *2000-01 Budget Statements*, Vol. 2, Budget Paper No. 2, May 11 2000, p. 681.

209 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 4.

qualified environmental health staff "on the ground" and is the closest to the Aboriginal communities, that is, the local governments.

Commonwealth Funding of Local Governments for the Provision of Environmental health services

8.29 The Commonwealth Government, based on recommendations made by the Western Australian Local Government Grants Commission ("LGGC") to the State Government, provides untied general purpose funding to all local governments in Western Australia. In calculating the funding to be provided to a particular local government, the expenditure requirements of that local government in eight broad expenditure categories is taken into consideration by the LGGC.[215] One of those expenditure categories is "education, health and welfare".

8.30 The assessed Education, Health and Welfare Expenditure Requirements for each of the four local governments in the Kimberley region over the past five financial years is set out in the table below[216]:

---

210 Submission by the Minister for Health, Hon John Day, BSc, BDSc, MLA, August 30 2000, p. 16.

211 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, p. 58.

212 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, p. 58.

213 Dr Stuart Garrow, Director, Kimberley Public Health Unit, Transcript of Evidence, August 22 2000, p. 19.

214 Dr Stuart Garrow, Director, Kimberley Public Health Unit, Transcript of Evidence, August 22 2000, p. 20.

215 Letter from the Western Australian Local Government Grants Commission, Mr Christopher Berry, Manager, August 23 2000, p. 1.

216 Letter from the Western Australian Local Government Grants Commission, Mr Christopher Berry, Manager, August 23 2000, pp. 1-2.

COUNCIL	**TOTAL ASSESSED EXPENDITURE ON EDUCATION, HEALTH AND WELFARE ($)**				
	1996-97	**1997-98**	**1998-99**	**1999-00**	**2000-01**
Broome	370,537	217,079	301,757	327,570	358,760
Derby-West Kimberley	374,639	240,902	309,650	288,385	354,942
Halls Creek	156,923	131,944	163,859	166,240	191,642
Wyndham-East Kimberley	328,512	196,934	252,978	258,435	300,992
Kimberley Total	**1,230,611**	**786,860**	**1,028,245**	**1,040,629**	**1,206,335**
STATE TOTAL	**26,482,225**	**20,732,146**	**25,121,041**	**25,265,506**	**29,599,600**

8.31 It should be noted that, as the LGGC has insufficient funds to meet the full assessed requirements as set out above, the local governments generally receive funding from the LGGC for only 50-60% of the assessed need in any year.[217]

8.32 Apart from a component for education, health and welfare, annual LGGC grants to the local governments in the Kimberley region also include a component to recognise the costs incurred for the provision of environmental health services to remote Aboriginal communities (which is based on the number of EHO full time equivalents required to meet *Health Act 1911* obligations).[218] Once again, due to insufficient funds, only 50-60% of the assessed funding need is actually provided to the local governments. The

217 Letter from the Western Australian Local Government Grants Commission, Mr Christopher Berry, Manager, August 23 2000, p. 1.

218 Letter from the Western Australian Local Government Grants Commission, Mr Christopher Berry, Manager, August 23 2000, p. 2.

assessed Aboriginal Environmental Health allowance for each of the four Kimberley local governments over the last 5 financial years is set out in the table below:[219]

COUNCIL	**ABORIGINAL ENVIRONMENTAL HEALTH ALLOWANCE ($)**				
	1996	**1997**	**1998**	**1999**	**2000**
Broome	38,340	38,340	38,340	58,656	58,656
Derby-West Kimberley	93,372	93,372	93,372	117,312	117,312
Halls Creek	67,291	67,291	67,291	78,396	78,396
Wyndham-East Kimberley	43,035	43,035	43,035	84,600	84,600
Kimberley Total	**242,037**	**242,037**	**242,037**	**338,964**	**338,964**

8.33 The Committee is very concerned by the fact that it is the LGGC's stated intention to discontinue the Aboriginal Environmental Health allowance in its 2004/2005 determinations.[220]

Shire of Broome – Provision of Environmental Health Services to Aboriginal Communities

8.34 The Shire of Broome currently employs two EHOs, with plans for a third. They are all funded by the Shire.[221]

8.35 The Shire of Broome has only recently taken upon itself the responsibility of providing environmental health services to Aboriginal communities within its district. The Shire has begun entering into service agreements with each Aboriginal

---

219 Letter from the Western Australian Local Government Grants Commission, Mr Christopher Berry, Manager, August 23 2000, p. 2.

220 Letter from the Western Australian Local Government Grants Commission, Mr Christopher Berry, Manager, August 23 2000, p. 2.

221 Ms Lyn Page, Councillor, Shire of Broome, Transcript of Evidence, August 21 2000, p. 3.

community, along with other relevant service providing agencies such as ATSIC, the HDWA, and the Aboriginal Affairs Department, which set out the services to be performed by the Shire's EHOs.[222]

Shire of Derby-West Kimberley – Provision of Environmental Health Services to Aboriginal Communities

8.36 The Shire of Derby-West Kimberley currently employs one full-time Environmental Health Officer/Building Surveyor for Aboriginal Communities ("EHO/BS-AC"), and two full-time AEHFSOs to work solely within Aboriginal communities. The two latter positions are fully funded by the HDWA, whilst the EHO/BS-AC position is funded partly by the HDWA (approximately $90,000 annually) and partly by the Shire (approximately $10,000 plus $17,000 in kind annually).[223] These three officers work as a team (known as the "Aboriginal Environmental Health Services Team"), which implements environmental health programs in all of the 54 Aboriginal communities within the Shire, conducts community education sessions, and liaises and provides on-going support for a number of community-based AEHWs funded by the HDWA.[224]

8.37 The Shire advised the Committee of its frustration at the inability of Aboriginal communities to retain trained AEHWs. The Shire believes that this problem could be addressed by improving the career structure for AEHWs and by ensuring a closer connection between the work that AEHWs do and the programs initiated in the Aboriginal communities by the Shire's Aboriginal Environmental Health Services Team.[225] The Shire is presently attempting to lift the profile of environmental health workers in communities:

> *"We have also prepared a community awareness presentation for the community councils. That is discussing and giving councils information on what we actually do and the services that we can provide to the Aboriginal community. I think at this stage, early in Aboriginal environmental health there are a lot of communities out there and councils that actually do not realise our role, what we do*

---

222 Ms Lyn Page, Councillor, Shire of Broome, Transcript of Evidence, August 21 2000, p. 6.

223 Submission by Mr Kim Nolan, Principal Environmental Health Officer/Building Surveyor, Shire of Derby-West Kimberley, July 28 2000, pp. 2-4.

224 Submission by Mr Kim Nolan, Principal Environmental Health Officer/Building Surveyor, Shire of Derby-West Kimberley, July 28 2000, p. 2.

225 Mr Kim Nolan, Principal Environmental Health Officer/Building Surveyor, Shire of Derby-West Kimberley, Transcript of Evidence, August 22 2000, p. 3.

and what we can do for them. Through this, we also hope to build the profile of an environmental health worker.”[226]

8.38 Two of the programs conducted by the Shire of Derby-West Kimberley's Aboriginal Environmental Health Services Team which particularly impressed the Committee were its Dog Health Program and its School Education Program.

> *“The Dog Health Program was initiated in 1995. Since it's conception the Aboriginal people have been able to see the benefits the program provides to the health of their dogs. This has provided an excellent avenue in establishing working relationships with these communities whilst reducing the incidence of zoonotic disease in the people. Injections are provided for community dogs in aiding parasite control and reducing the incidence of zoonotic disease. Injections are also administered for dog birth control and euthanasia (if requested by owners).”*[227]

8.39 The School Education Program involves the presentation of a computer-based animated slide-show called “Beat the Germs”, that aims to educate children on issues of personal hygiene and ways of protecting themselves against disease.[228] Children are also shown a series of digital pictures of environmental health dangers that exist in their communities.[229]

8.40 The Shire of Derby-West Kimberley has expressed dissatisfaction at the fact that the EHO/BS-AC position has only been funded by the HDWA on a year by year basis over the past two years. The Shire stresses that continuity of staff and programs is an essential ingredient in liaising and working successfully with Aboriginal communities on environmental health issues.[230]

8.41 Since being advised of the HDWA's decision to reduce funding for the EHO/BS-AC position in future years, the Shire has approached a number of government agencies and organisations to secure future funding:

---

226 Mr Nicholas Alford, Environmental Health Officer/Building Surveyor (Aboriginal Communities), Shire of Derby-West Kimberley, Transcript of Evidence, August 22 2000, p. 6.

227 Submission by Mr Kim Nolan, Principal Environmental Health Officer/Building Surveyor, Shire of Derby-West Kimberley, July 28 2000, p. 2.

228 Submission by Mr Kim Nolan, Principal Environmental Health Officer/Building Surveyor, Shire of Derby-West Kimberley, July 28 2000, p. 3.

229 Mr Nicholas Alford, Environmental Health Officer/Building Surveyor (Aboriginal Communities), Shire of Derby-West Kimberley, Transcript of Evidence, August 22 2000, p. 6.

230 Submission by Mr Kim Nolan, Principal Environmental Health Officer/Building Surveyor, Shire of Derby-West Kimberley, July 28 2000, p. 3.

> *"Since being advised of the HDWA's position in regard to future funding, exhaustive efforts have been made by the Shire to secure sustainable ongoing funding to ensure that future of the above EHO/BS position and thus the continuity of this Shire's services delivery to Aboriginal communities. Numerous government departments (including Aboriginal Affairs Department) have been approached to consider a partnership arrangement to contribute financially to an ongoing long-term basis toward the position, therefore injecting some continuity and sustainability into the programme rather than the present situation whereby the 'rug could be pulled out from under' at any time.*
>
> *The current funding situation limits the Shire's ability to provide service delivery 'year-round' to remote communities. Regional flooding of the Kimberley during the wet season cuts off access by road to some communities for up to 5-6 months. The tropical conditions during 'the wet' provide a favourable environment for the occurrence and proliferation of infectious disease and dramatically upset the continuity and momentum of numerous environmental health programs including the Dog Health Program, environmental health surveillance and school and community education."* [231]

Shire of Halls Creek - Provision of Environmental Health Services to Aboriginal Communities

8.42 Loss of key staff and the restrictions inherent in short term funding for environmental health programs, which itself further encourages the rapid turnover in appropriately qualified health staff which is endemic to the Kimberley region, have posed significant obstacles for environmental health programs in Aboriginal communities in the Halls Creek area:

> *"A continual change to staff within the region has not allowed for the production and implementation of an "Environmental and Community Health Plan", in particular for Halls Creek. An effort was made and a lot of ground work done some four years ago, however with the continual turnover of staff from all agencies the*

---

231 Submission by Mr Kim Nolan, Principal Environmental Health Officer/Building Surveyor, Shire of Derby-West Kimberley, July 28 2000, p. 4.

good work has all been lost. The people of the area have therefore suffered accordingly."[232]

8.43 The Committee was advised that local governments generally plan their programs five years in advance. However, difficulties arise when they receive funding from the HDWA for an EHO on the basis of a 12 month contract only.

Shire of Wyndham-East Kimberley – Provision of Environmental Health Services to Aboriginal Communities

8.44 The Shire of Wyndham-East Kimberley receives no funding from the HDWA for its two existing EHOs.[233]

8.45 The OAH of the HDWA provided funding to the Shire of Wyndham-East Kimberley for an AEHW from 1994 to 1997, at the end of which funding was withdrawn and the AEHW was re-deployed to KHS Community Health.[234] The Shire of Wyndham-East Kimberley notes that since the funding for the AEHW was withdrawn, the Shire has had limited resources to carry out any monitoring or assessment of environmental conditions in Aboriginal communities.[235] The Shire stated the following in its submission:

"The Council is concerned that the funding provided by the Office of Aboriginal Health is not constant and cannot be guaranteed. This makes it difficult for the Council to plan a long-term strategic approach to providing suitable services."[236]

8.46 A number of Aboriginal communities within the Shire have either resident or visiting AEHWs, employed by the KHS Kimberley Public Health Unit and under CDEP schemes. However, there is presently little interaction between these AEHWs and the Shire's EHOs. Although Shire EHOs visit the largest Aboriginal communities of Kalumburu and Oombulgurri, they rarely visit the other 68 Aboriginal communities located in the Shire.[237]

---

232 Submission by the Shire of Halls Creek, Peter McConnell, Chief Executive Officer, August 1 2000, p. 2.

233 Mr Tony Brown, Chief Executive Officer, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 4.

234 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 1.

235 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 1.

236 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 2.

237 Mr Richard Brookes, Director Development Services, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 9.

8.47 The Shire of Wyndham-East Kimberley notes that the environmental health conditions in the Aboriginal communities within the Shire have deteriorated significantly since 1997.[238] During the time that the Shire did employ an AEHW, the Shire noted an increased level of cooperation between the Shire and the Aboriginal communities. The Shire believes that this was due to the AEHW's constant contact with both community leaders and the Shire's EHOs, who provided ongoing advice and assistance in addressing important health issues.[239] One of the successful programs carried out by the Shire of Wyndham-East Kimberley's AEHW was the Dog Health Program:

> *'The Council instigated a "dog health program" which provided an avenue for the Council's Environmental Health Worker to go to communities and provide a tangible service. This program opened the door for the community to discuss its environmental health issues with the Officer when he was carrying out the program. It also built up a level of trust in that the Environmental Health Worker actually did something on the community that the community could see had tangible benefits. Since the Environmental Health Worker has been re-deployed in the Kimberley Public Health Unit the "dog health program" has fallen by the wayside.'*[240]

8.48 The Shire of Wyndham-East Kimberley advised the Committee that the OAH had offered in June of this year to provide funding to the Shire of approximately $170,000 over a two year period (that is, to 2002) to employ an EHO/Aboriginal Communities to address declining environmental health standards in the Aboriginal communities in the Shire.[241]

8.49 The Committee was advised by the Shire that it believed it could be effective in addressing most environmental health issues within the Shire if it received long-term funding for two EHOs dedicated solely to working within Aboriginal communities in conjunction with the Shire's two existing EHOs, as well as with the various community-based HDWA and CDEP-funded AEHWs and the KHS Kimberley Public Health Unit funded and controlled AEHFSOs.[242]

---

238 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 2.

239 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 1.

240 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, pp. 2-3.

241 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 2; and Mr Richard Brookes, Director Development Services, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 4.

242 Mr Richard Brookes, Director Development Services, Shire of Wyndham-East Kimberley, Transcript of Evidence, August 25 2000, p. 5.

8.50 The Shire of Wyndham-East Kimberley expressed a desire to directly employ and supervise all AEHFSOs and AEHWs operating within its Shire boundaries.[243] It is felt that such an arrangement would foster a good working relationship between local governments and Aboriginal communities and give greater support to AEHWs within the communities, who would then have greater access to professional development and a structured career path within local government, which is also one of the major employers of Aboriginal people in the Kimberley region.

8.51 The Committee believes that this aspect of professional standing and a career path is very important. Many of the witnesses who appeared before the Committee stated that trained AEHWs did not seem to last long in the communities, as they had found it difficult to gain respect and support from the community for their qualifications and their work.[244]

8.52 Another advantage of having Shire staff based within the Aboriginal communities is constant supervision of building standards. Building projects on Aboriginal communities can be monitored by AEHWs to ascertain whether Council building licences have been issued and that building laws are being complied with. The Shire of Wyndham-East Kimberley stated that with regular contact with Council staff, building contractors undertaking construction work on remote Aboriginal communities are more likely to “do the right thing”.[245]

---

243 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 2.

244 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 2.

245 Submission of the Shire of Wyndham-East Kimberley, August 25 2000, p. 3.

CHAPTER 9

POSSIBLE SOLUTIONS

Greater Community Involvement in Environmental Health

9.1 The Committee has been left in no doubt that further State Government spending is required to address all aspects of the continuing poor health standard of Aboriginal people in the Kimberley region. However, the Committee also holds the view that any increase in Aboriginal health funding without a significant re-assessment of the current structures for health service delivery and the focus of current health programs, will achieve minimal, if any, improvements in Aboriginal health.

9.2 The Committee is of the view that the primary focus of Aboriginal health programs in the Kimberley region should be on community-based education and preventative health services, based upon a foundation of AEHWs and Aboriginal Health Workers located within the Aboriginal communities. If basic environmental health standards can be effectively implemented and maintained within the Aboriginal communities, then the Committee is sure that the reliance of Aboriginal communities upon acute hospital care in centres such as Derby, Darwin and Perth, with the attendant high transport and social costs, will be significantly reduced. The Committee sees the potential health, social, and economic benefits for both the Aboriginal communities and for the State generally in such a community-based environmental health program as enormous.

9.3 The Committee is of the view that Aboriginal communities themselves must become more involved in the provision of basic health services to their populations. In particular, the communities must become involved in greater public health and environmental health education.

9.4 The Committee endorses the Nindilingarri "health vision statement" with regards to the importance of training and general education within Aboriginal communities:

> *"TRAINING*
>
> *The old model of holding onto information and treating people needs to be dismantled. In place we want to be educating all Aboriginal people in self-responsibility so that as many skills as possible will be available locally in remote communities. First Aid training would be available to all Aboriginal Organisations Employees and*

> *Communities. Training of Aboriginal Health Workers should be ongoing, one AHW for every 10 families would be good, and 1 to 5 would be better. Our Doctors and Nurses will be supporting AHWs to do the health care in their own communities.*
>
> *GENERAL EDUCATION*
>
> *Nindilingarri would actively support all general health education in communities, encouraging people's interaction and responsibility for their own health by developing local based culturally appropriate health awareness material."*[246]

9.5 The Committee notes that the Rumbalara Football Netball Club in Shepparton, Victoria, has developed an innovative "Healthy Lifestyle Program" for the local Koori community:

> *"Rumbalara Football Netball Club is a Koori sporting organisation which not only provides sporting, recreational and social opportunities for its members but also addresses the spiritual, emotional and physical well being of its players and community members. It currently has a total of ten teams, in both netball and football, competing in local leagues. It is also the avenue for the delivery of a Healthy Lifestyle Program which encompasses strategies in the areas of diet, substance abuse, youth suicide, cultural activities, men's health, exercise and gambling.*
>
> …
>
> *The club is unique in Victoria (and possibly all of Australia) in its use of the organisational infrastructure of a football and netball club as the main avenue of delivery for its broad range of health promotion initiatives."*[247]

9.6 The Committee is of the view that such innovative methods of health education should be implemented in the Kimberley region at the community level. As it is generally the case in many parts of the Kimberley region that the Aboriginal population is

---

[246] *Nindilingarri Health Vision for the Fitzroy Valley Aboriginal People,* Appendix 4 of *Draft Final Report to the Kimberley Aboriginal Health Plan Steering Committee*, by Dr David Atkinson, Ms Catherine Bridge, and Dr Dennis Gray, 1999, p. 155

[247] *Rumbalara Healthy Lifestyle Program – Koori Community Initiative Shepparton Victoria*, by Paul Briggs, 5th National Rural Health Conference Paper, Adelaide, March 14-17 1999. At Internet site: http://www.ruralhealth.org.au/fifthconf/briggs.htm

significantly younger than the non-Aboriginal population, such public health programs directed at the youth of Aboriginal communities will have the potential to bring long term advantages to those communities.

9.7 Public health education in a social, community-based, setting should be conducted on a regular basis by staff on the ground in the Aboriginal communities who receive regular supervision and assistance. The Committee is of the view that effective environmental health and public education programs cannot be conducted by State Government officials who fly in and fly out for short periods at irregular intervals in order to monitor *ad hoc* short-term projects.

9.8 The Committee is of the view that the local governments would be the most suitable agencies to carry out environmental health programs in Aboriginal communities. The Committee believes that the State Government should be encouraging a closer working relationship between Aboriginal communities and local governments.

RECOMMENDATION 1

The Committee recommends that the primary focus of State Government spending in the area of Aboriginal health be on the provision of basic community-based health programs, public health education, and environmental health programs.

Focussing the Confused Array of Agencies and Groups Providing Environmental Health Services to Aboriginal Communities

9.9 The Committee notes that the symbol of the inter-agency Environmental Health Needs Coordinating Committee is three pairs of circulating arrows indicating:

> *"... Regional, State and National levels of government sharing information, improving coordination, and working together with Aboriginal people to achieve improvements in environmental health conditions in Aboriginal communities."*[248]

9.10 The Committee saw little evidence of effective communication and information sharing between the three levels of government during the course of its inquiry.

9.11 The Committee is of the view that the provision of environmental health services to Aboriginal communities in the Kimberley region needs to be better structured and simplified.

---

248 *Environmental Health Needs of Aboriginal Communities in Western Australia: The 1997 Survey and its Findings*, Environmental Health Needs Coordinating Committee, 1998, p. ii.

RECOMMENDATION 2

The Committee recommends that the *Health Act 1911*, the *Local Government (Miscellaneous Provisions) Act 1960*, and the *Local Government Act 1995* be amended so as to vest in local governments the primary responsibility for the development, implementation, and enforcement of environmental health programs and standards in Aboriginal communities.

RECOMMENDATION 3

The Committee recommends that the Health Department of Western Australia, through the Executive Director, Public Health, and the regional public health units, have responsibility for monitoring and evaluating the effectiveness of the environmental health programs of the local governments. The Committee further recommends that the regional public health units continue to provide consultative services and expert advice, as well as managing the implementation of State-wide public health programs, that is, immunisation, infectious diseases, and the monitoring of Aboriginal community store content and prices in order to promote healthy stores.

Environmental Health Officers and Aboriginal Environmental Health Workers

9.12 The number of EHOs, AEHWs, and AEHFSOs needs to be increased throughout the Kimberley region.

9.13 The base salary of community-based environmental health workers could be met under the various CDEP programs presently operated by the Commonwealth Government through ATSIC throughout the Kimberley region. The CDEP, or "work for the dole", scheme has the potential to become a valuable basis for improving environmental health conditions in Aboriginal communities:

> *"The largest employment initiative in the Kimberley has been the Community Development Employment Program (CDEP). This program began in the mid 1980s when Aboriginal people agreed to became the first group who had to work for the dole. This has been consistently supported by many Aboriginal people as better than the alternative of 'sit down money' and has been productive in many settings, where options for more usual employment are very limited. CDEP is available to Aboriginal and Torres Strait Islander communities or distinct groups of Aboriginal and Torres Strait*

Islander people within a community. This Scheme enables unemployed Aboriginal and Torres Strait Islander people to undertake work on activities chosen by the community or organisation. The Scheme is intended to facilitate community development and to be community and participant led."[249]

9.14 The CDEP objective is:

> *"To provide work for unemployed Indigenous persons in community-managed activities which assist the individual in acquiring skills which benefit the community, develop business enterprises and/or lead to unsubsidised employment."*[250]

9.15 The House of Representatives Standing Committee on Family and Community Affairs recently summarised the CDEP scheme as follows:

> *"The CDEP was introduced to assist in the development of communities through work programs so that they could have greater economic, social and cultural strength. The scheme involves individuals in the community pooling their social security benefits, with some additional funding from the Government, so that those resources could be directed to fund particular programs for the benefit of the whole community.*
>
> *The scheme attempts to provide at least some form of employment and training in these communities, focussing on community development projects and giving the participants some form of workforce participation.*
>
> *In recent years the CDEP has been responsible for some two-thirds of the jobs created for Indigenous Australians*
>
> *…*

---

[249] *Kimberley Regional Aboriginal Health Plan*, by Dr David Atkinson, Ms Catherine Bridge, and Dr Dennis Gray, December 1999, p. 28.

[250] *ATSIC Programs*, at Internet site: http://www.atsic.gov.au/programs/noticeboard/CDEP/Default.asp

The CDEP has been successful in providing many participants with work preparation and other training. However, expectations of the scheme's ability to achieve any real increase in employment for many remote communities have to be tempered by the limited local labour market.

In many remote communities the prospect of other mainstream employment is limited, although the health services have played a key role in generating employment in these communities.

In the past the CDEP has often been used as a mechanism to supplement environmental health programs, such as garbage collection. While this is generally a result of community desires it often means that funding for such a program is not provided by the relevant authority. On the other hand some communities have been able to turn such endeavours into a viable business by bidding for other services." [251]

9.16 For the CDEP programs to become beneficial to Aboriginal communities in the long term, the Committee believes that they should not be simply used like the metropolitan area "work for the dole" schemes. Employment opportunities are minimal in the Kimberley region for unskilled workers, and so the CDEP programs in the Kimberley region should instead be directed towards providing recipients with more meaningful full-time employment and training in the area of environmental health management, with suitable top up amounts being provided by local governments to those CDEP recipients who achieve defined work goals.

9.17 Ideally, the Committee would like to see Aboriginal communities themselves take on an active day-to-day involvement in the environmental health programs conducted in their communities through specially devised CDEP schemes, topped up with an appropriate contribution from the local governments. Responsibility for supervision of such CDEP scheme participants would therefore be given to the local governments.

9.18 For the effective use of CDEP programs to improve environmental health in the Kimberley region, the Committee acknowledges that there will need to be cooperation between the Commonwealth, State and local governments in developing appropriate arrangements for the application of CDEP funds.

---

251 *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, Parliament of the Commonwealth of Australia, Canberra, May 2000, pp. 78-79.

RECOMMENDATION 4

The Committee recommends that local governments have sole responsibility for the employment and supervision of all Environmental Health Officers, Aboriginal Environmental Health Field Support Officers, and Aboriginal Environmental Health Workers, operating within their shires.

RECOMMENDATION 5

The Committee recommends that formal and consistent training courses be developed for the professional qualifications of "Aboriginal Environmental Health Worker" and "Aboriginal Environmental Health Field Support Officer" within Western Australia. The Committee further recommends that standard Job Description Forms be developed for these positions, and that a career structure be put in place allowing for the advancement of persons who hold these positions within local governments throughout the State.

9.19 Each of the four local governments in the Kimberley region should, in addition to its normal complement of town-based EHOs, have one or two positions established for Environmental Health Officer/Aboriginal Communities with the duties of visiting each and every Aboriginal community within their Shire at least once each year. These positions should be permanent positions, or at the very least on a three year contract basis.

RECOMMENDATION 6

The Committee recommends that each of the four local governments in the Kimberley region be funded by the State Government to employ at least one Environmental Health Officer/Aboriginal Communities on a full-time permanent basis.

9.20 Each of the four local governments in the Kimberley region should employ, possibly on a CDEP scheme topped up with an amount funded by the local government, enough AEHWs to ensure that each Aboriginal community within their district is visited at least 3-4 times over the course of each year. All Aboriginal communities with a usual population in excess of 150 persons should have an AEHW permanently based in that community.

RECOMMENDATION 7

The Committee recommends that the State Government provide sufficient funding to each of the four local governments in the Kimberley region to ensure that enough Aboriginal Environmental Health Workers are employed to provide a permanent full-time presence in each of the larger Aboriginal communities in the Kimberley region, and to provide a regular visiting service to all Aboriginal communities in the Kimberley region.

Elimination of Short Term Funding and Projects When Attempting to Deal with Long Term Environmental Health Problems

9.21 The Committee has formed the view that the practice of State and Commonwealth agencies providing funding for short term projects (that is, of less than 12 months duration) to combat chronic, long term, environmental health problems has "gotten out of hand", and may, in fact, have contributed to the decline in Aboriginal health standards in the Kimberley region over the last 10 years or so.

9.22 During the course of the inquiry, both KHS staff[252], and the local governments[253] expressed their great frustration at the lack of long-term funding for environmental and public health programs in the Kimberley region.

RECOMMENDATION 8

The Committee recommends that environmental health programs for Aboriginal communities no longer be funded by way of short term grants issued at the discretion of the Office of Aboriginal Health of the Health Department of Western Australia.

RECOMMENDATION 9

The Committee recommends that all State Government funding for environmental health programs in Aboriginal communities be by way of recurrent three year funding made to local governments and to the regional public health units. These recurrent payments should be recorded as ongoing programs in the annual Budget Papers, tabled in Parliament each year.

---

[252] See Dr Stuart Garrow, Director, Kimberley Public Health Unit, Transcript of Evidence, August 22 2000, p. 9, and Mr Ian Smith, Manager KHS, Transcript of Evidence, August 22 2000, p. 9.

[253] Mr Nicholas Alford, Environmental Health Officer/Building Surveyor (Aboriginal Communities), Shire of Derby-West Kimberley, Transcript of Evidence, August 22 2000, p. 4.

RECOMMENDATION 10

The Committee recommends that recurrent funding by the State Government to local governments for environmental health programs in Aboriginal communities be made available to the local governments to spend on environmental health projects in Aboriginal communities within their shires as they see fit (that is, such funding is not to be conditional on the funding being spent in any particular community or on any particular project), subject only to the regular assessment of the effectiveness of each local government's program by the Executive Director, Public Health and the regional public health units of the Health Department of Western Australia.

Dog Control

9.23 Under s.9 of the *Dog Act 1976*, local governments are given administrative responsibility for enforcing the provisions of that Act within their district (and even beyond the boundaries of their district, upon the issuing of an order by the Governor).

9.24 The power of local government officers to enforce the provisions of the *Dog Act 1976* within Aboriginal communities located on Crown land needs to be expressly clarified within the legislation.

RECOMMENDATION 11

The Committee recommends that the *Dog Act 1976* be amended so as to expressly provide that that Act binds the Crown.

9.25 Practical, long-term, dog control programs are a necessity for all Aboriginal communities in the Kimberley region.

9.26 Since the Shire of Derby-West Kimberley commenced its dog health program in 1994, the number of dogs across the 54 Aboriginal communities within the Shire has halved from approximately 1400 to 700, and the incidence of health issues requiring treatment has dropped 25 to 30 percent.[254] The Shire's dog health program involves euthanasia, contraceptive injections and treatment for mange and other disorders. The program is currently performed by two AEHFSOs, and its success is totally dependent upon their enthusiasm and initiative. As the Committee was told, if for any reason

[254] Mr Kenneth O'Donnell, Aboriginal Environmental Health Field Support Officer, Shire of Derby-West Kimberley, Transcript of Evidence, August 22 2000, pp. 11-13.

they were to cease to be a part of the dog health program tomorrow, the program would collapse.[255]

9.27 Dr Roberet M. Irving B.V.Sc. conducts a very successful dog control program in Aboriginal communities in central eastern Western Australia on behalf of the Ngaanyatjarraku Shire.[256] Dr Irving also conducts dog programs in South Australia and the Northern Territory. These programs have been successful due to the presence of people within each of the communities visited who are prepared to assist during periodic visits by the veterinarian, and who are prepared to continue parts of the program in the absence of the veterinarian:

> *"The role of a veterinary surgeon in dog health programs is to oversee the management of the program and to perform any tasks that are only able to be done by a veterinarian. Any program is very reliant on competent people in each community who can conduct parts of the program on an ongoing basis in the absence of day to day veterinary attendance."*[257]

9.28 Dr Irving further stressed to the Committee that:

> *"The key to all programs is REGULAR TREATMENTS. One off programs have no long term effects. When the numbers are at an acceptable level other possibilities include desexing programs, two? Dogs per house, collars/ID tags, etc."*[258]

9.29 The details of Dr Irving's dog programs are set out as follows:

> *"The programs I run are divided into 4 parts:*
>
> *(a) Parasite Control.*
>
> *All dogs which are to be kept are given an oral bait laced with a potent parasiticide to control internal parasites (worms) and most importantly external parasites (Scabies Mange). The response to this drug in most dogs is spectacular after several months. Any dog with severe mange usually will regrow a full coat of fur. This eliminates those hairless dogs that are common in the communities. It also*

---

255 Mr Kim Nolan, Principal Environmental Health Officer/Building Surveyor, Shire of Derby-West Kimberley, Transcript of Evidence, August 22 2000, p. 14.

256 Submission by Dr Robert M. Irving, B.V.Sc., undated, p. 1.

257 Submission by Dr Robert M. Irving, B.V.Sc., undated, p. 2.

258 Submission by Dr Robert M. Irving, B.V.Sc., undated, p. 1.

makes the dogs healthier looking which in turn is appreciated by the owner. (I have been asked to do many communities by word of mouth. People passing through a treated community will immediately notice the dogs are healthier looking and want the same for their own community!).

(b) Contraceptive Injections.

These last 3-4 months and are given to breeding female dogs that people wish to keep. It is a simple method to reduce the puppy explosion that occurs. Reducing the numbers of pups coming into the community has a dramatic effect on the total population after a period of time. Less dogs on heat also reduces the male dog aggression/fighting/barking that is a common occurrence.

(c) Desexing.

This is not a major part of my programs at this stage. When a community has its dog numbers under control then it can be a useful aid in population control. To desex lots of dogs is very time consuming, has some post operative risk, and as many dogs do not live for very long in these communities it may well be a waste of resources. However, in the future this may become a bigger part of the program. Unless most female dogs are done, those not desexed can still breed a lot of pups!

(d) Euthanasia

This is a very effective way of reducing numbers rapidly and those communities that have accepted euthanasia as part of their program quickly get their dog population under control. I have found that most people want to only have healthy dogs and will have sick and unwanted dogs removed. The dogs are humanely destroyed using an injection, and the body removed immediately to avoid further distress. Only the owner can make the decision to have any dog euthanased. (At one community the dog population was reduced from 170 to 68 in 2 hours. The people were desperate to solve the problem of too many dogs, and as unpleasant as the exercise was, a huge impact was made

in a short time. Of course the next visits involved only a few euthanasias as the dog population was at an acceptable level.)"[259]

9.30 An excerpt from Dr Irving's September 1999 report following a visit to the Warburton Aboriginal Community, in the central-east of Western Australia, which has a human population of approximately 544 people[260], states:

> *"Dogs euthanased* *99*
>
> *Contraceptive injections to breeding females* *15*
>
> *Remaining population ivomec parasiticide* *130*
>
> *Dog numbers in this community were far in excess of what could be considered satisfactory. However, the acceptance of humane euthanasia enabled me to substantially reduce the numbers. Most of the dogs put down were big male dogs and breeding females. The impact of a reduction of this size will be immediate as there is more food available for each dog, less fighting and noise, and fewer pups being born.*
>
> *…*
>
> *Lower dog numbers also markedly reduces the number of euthanasias at subsequent visits and this is desirable as destroying large numbers of dogs is stressful to community members.*
>
> *Remaining dogs are mange free and body weights in most cases are acceptable."*[261]

9.31 On a follow-up visit to Warburton Aboriginal community in August 2000, 31 dogs were euthanased, three dogs received contraceptive injections, and only a few required ivomec treatment for mange.[262] Approximately 70 dogs remained at Warburton after that visit.

9.32 Dogs play an important role in Aboriginal communities. It has been suggested that as there is a strong cultural and spiritual connection between Aboriginal communities

---

259 Submission by Dr. Robert M. Irving B.V.Sc., October 26 2000, pp. 2-3.

260 *Environmental Health Needs of Aboriginal Communities in Western Australia: The 1997 Survey and its Findings*, Environmental Health Needs Coordinating Committee, 1998, p. 10.

261 Submission by Dr Robert M. Irving, B.V.Sc., undated, p. 3.

262 Submission by Dr Robert M. Irving, B.V.Sc., undated, p. 8.

and their dogs, that demonstrable improvements in the health and appearance of the dogs in a community may facilitate community involvement in wider health programs and disease prevention measures for the humans in the community.[263]

RECOMMENDATION 12

The Committee recommends that a dog control program be established in each Aboriginal community in the Kimberley region, and that these programs be administered by the local governments.

9.33 Pursuant to Section 53 of the *Dog Act 1976*, the Minister for Local Government may recommend to the Governor that certain dangerous breeds of dog should be subject to regulations that may require:

9.33.1 the sterilization of any such dog;

9.33.2 that if any such dog is found in a certain area, it is to be destroyed;

9.33.3 that any such dog is to be kept chained or confined;

9.33.4 that any such dog is to be marked for identification; or

9.33.5 the imposition of conditions, restrictions or limitations upon the keeping and control of any such dog.

9.34 The Committee is of the view that regulations should be put in place in order to prevent the more potentially dangerous breeds of dog from appearing in Aboriginal communities in the Kimberley region. A particular problem of allowing such potentially dangerous breeds of dog in Aboriginal communities is the likelihood of these breeds mating with wild dogs and producing an even more dangerous offspring.

9.35 Breeds such as pit bull terriers, rottweillers, dobermans, and great danes, should not be allowed to be kept at such communities, unless precautions such as desexing of the dogs is undertaken.

RECOMMENDATION 13

The Committee recommends that the Minister for Local Government consider recommending to the Governor that regulations be made, pursuant to Section 53 of the *Dog Act 1976*, which will prohibit the keeping of the more potentially dangerous breeds of dog in Aboriginal communities in the Kimberley region unless they have been desexed.

---

263 "Health Secrets May Lie in Dogs", by Peter Williamson, *Murdoch News Article*, undated, at Internet site: http://wwwcomm.murdoch.edu.au/webster/A56.html

Local Government health and safety inspections

9.36 The Committee is of the view that local government health inspectors should have the power to enter upon Crown land and premises in order to enforce the key health, safety and building standards provisions of the *Health Act 1911*, the *Local Government (Miscellaneous Provisions) Act 1960*, and the *Local Government Act 1995*, and the regulations and local laws made under those Acts. This power can only be obtained if these Acts are amended so that their key health and safety provisions bind the Crown.

9.37 Once safeguards are in place to ensure that housing is built to an acceptable standard on Aboriginal communities, the key in terms of environmental health is then to keep these houses clean and free of contaminants. This goal could be attained through a long term program of environmental health education in the communities.

RECOMMENDATION 14

The Committee recommends that those provisions of the *Health Act 1911*, the *Local Government (Miscellaneous Provisions) Act 1960*, and the *Local Government Act 1995* which relate to the health and safety requirements and standards for the construction and maintenance of buildings in Western Australia, and which currently do not bind the Crown, be amended so as to expressly bind the Crown.

RECOMMENDATION 15

The Committee recommends that any future building legislation enacted by the State Government contain a provision which expressly states that that legislation binds the Crown.

School Breakfast Programs

9.38 School-based supplementary feeding programs (that is, the provision of snacks, breakfasts or lunches to students) have been implemented in a number of communities in the United States and Canada, as well as in South Africa, Jamaica and Peru. In 1999, an average of 7.3 million children participated every day in the United States' School Breakfast Program, and that average had grown to 7.5 million as at the early

months of 2000 (with 6.3 million of those participating children receiving their meals free or at a reduced price).[264]

9.39 The cost of the United States' School Breakfast Program for 1999 was US$1.35 billion, or approximately US$185 per child.[265] Although the scientific evidence is limited and equivocal, the overwhelming anecdotal evidence from teachers, students and parents has been that school breakfast programs improve the cognitive abilities of children as well as providing social benefits such as fewer classroom disruptions, reductions in discipline referrals, improved attendance and increased in-class participation.[266]

> *"Research in less-developed countries has also upheld the long-term benefits of school breakfast programs on cognitive performance. Children participating in a breakfast program at a farm school in South Africa demonstrated improvements in short-term memory tasks, class participation and positive peer interaction (Richter, Rose and Griesel, 1997). A randomized trial on the effects of a school breakfast program in Jamaica revealed that students receiving a full breakfast over the school year demonstrated improvements in attendance and nutritional status compared to those receiving a placebo (Powell et al., 1998). Younger children participating in the study also demonstrated improvements in their mathematical ability. Another study conducted in Jamaica reported higher attendance rates and mathematical ability among students receiving breakfast (Simeon, 1998). Peruvian students receiving breakfast over a one month period demonstrated improvements in attendance and vocabulary (Pollitt, Jacoby and Cueto, 1996)."*[267]

> *"[I]n many instances, the benefits of school breakfast programs extend well beyond improvements in the cognitive abilities of children. Although the research is by no means conclusive, reported improvements in classroom behaviour, school attendance, tardiness and readiness to learn point to an important social dividend of school*

---

264 *School Breakfast Program – Fact Sheet*, U.S Department of Agriculture Child Nutrition Programs, September 5 2000, p. 3 at Internet site: http://www.fns.usda.gov/cnd/Breakfast/AboutBFast/faqs.htm.

265 *School Breakfast Program – Fact Sheet*, U.S Department of Agriculture Child Nutrition Programs, September 5 2000, p. 3 at Internet site: http://www.fns.usda.gov/cnd/Breakfast/AboutBFast/faqs.htm.

266 *Feeding the Body, Feeding the Mind: An Overview of School-based Nutrition Programs in Canada*, Brian Hyndman, M.H.Sc, February 7 2000, p. 6, at Internet site: http://breakfast4learning.com/litreview.htm.

267 *Feeding the Body, Feeding the Mind: An Overview of School-based Nutrition Programs in Canada*, Brian Hyndman, M.H.Sc, February 7 2000, p. 5, at Internet site: http://breakfast4learning.com/litreview.htm.

> *feeding programs that should not be overlooked. By fostering a school environment that is more conducive to learning, breakfast programs benefit the entire student body, not just malnourished, disadvantaged participants."*[268]

9.40 The United States' School Breakfast Program operates by way of the United States' Federal Government reimbursing schools on a monthly basis for each approved breakfast provided. To be approved, the breakfast must contain all of the following items:

- ½ pint of fluid milk;
- ½ cup of fruit or vegetable, or
- ½ cup of fruit juice or vegetable juice;

AND

One of the following options:

- 1 serving of whole grain or enriched bread/bread alternate *and* 1 ounce meat/meat alternate.

OR

- 2 serving bread/bread alternate.

OR

- 2 one-ounce servings of meat/meat alternate.[269]

9.41 The meal provided does not have to be as formal as the United States' model. The Committee heard evidence that positive results in child health could be obtained by the provision of simple snacks, such as a tub of yoghurt, a boiled egg, or a peanut butter sandwich.[270]

9.42 The Committee notes that its next report will deal with the issue of dental health in the Kimberley region, and that positive health results could be obtained by the combining

---

268 *Feeding the Body, Feeding the Mind: An Overview of School-based Nutrition Programs in Canada*, Brian Hyndman, M.H.Sc, February 7 2000, pp. 5-6, at Internet site: http://breakfast4learning.com/litreview.htm

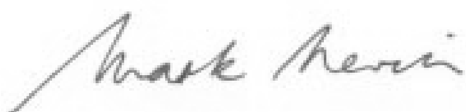
269 *School Breakfast Program*, program information sheet, Nutrition Program Management Unit, Nutrition Services Division, California Department of Education, p. 2, at Internet site: http://www.cde.ca.gov/cyfsbranch/cnfddiv/snp/breakfas.htm

270 Dr Matthew Ritson, Medical Practitioner, Transcript of Evidence, September 13 2000, p. 5.

of a school breakfast program with a school teeth-brushing and dental education program.

RECOMMENDATION 16

The Committee recommends that the State Government, through cooperation between the Health Department and the Ministry of Education, examine the feasibility of introducing a school breakfast program for children of Aboriginal communities in the Kimberley region.



HON MARK NEVILL MLC
CHAIRMAN

Date: November 14 2000

APPENDIX A: TRAVEL ITINERARY

Monday, August 21 2000

Broome (public hearings)

Tuesday, August 22 2000

Derby (public hearings)

Wednesday, August 23 2000

Halls Creek

Thursday, August 24 2000

Fitzroy Crossing

Friday, August 25 2000

Kununurra (public hearings)

APPENDIX B: WITNESSES AND SUBMISSIONS

Witnesses who appeared before the Committee at Public Hearings held in the Kimberley

Date	Witness
21/08/00	**Broome Shire** Mrs Lyn Page, Councillor Ms Elsta Foy, Councillor/Health Worker
	Kimberley Aboriginal Medical Services Mr Kevin Cox, Special Projects Officer Mr Arnold Hunter, Chairperson Dr Richard Murray, Medical Director Mr Henry Councillor, Director
	Mrs Isabelle Ellis, Lecturer, School of Nursing, Notre Dame University
	Kimberley Health Service Mr Ian Smith, Acting General Manager Dr Mark Dawson, Senior Medical Officer, Broome District Hospital
22/08/00	**Shire of Derby/West Kimberley** Mr Kim Nolan – Principal Environmental Health Officer/Building Surveyor Mr Nicholas Alford – Environmental Health Officer – Aboriginal Communities Mr Ken O'Donnell – Environmental Health Field Support Officer – Aboriginal Communities
	Kimberley Health Service Mr Ian Smith, Acting General Manager Dr Stuart Garrow, Director of Kimberley Public Health Unit Mrs Iris Prowse, Co-ordinating Officer, Environmental health, Kimberley Public Health Unit

	Mrs Judy Turton
25/08/00	**Shire of Wyndam East Kimberley** Tony Brown, Chief Executive Officer Richard Brookes, Director Development Services Maxine Middap, Shire President
	Maxine Middap, Shire President
	Mr Howard Young
	Kimberley Health Service Mr Ian Smith, Acting General Manager Dr Donal Watters, Senior Medical Officer, Kununurra District Hospital

People with whom the Committee met in the Kimberley

Date	Witness
23/08/00	Mr Peter McConnell, Chief Executive Officer, Shire of Halls Creek
	Ms Josephine Farrer, President, Shire of Halls Creek
	Ms Vanessa Elliott, Community Development Officer, Shire of Halls Creek
	Ms Heather D'Antoine, Health Service Manager, Kimberley Health Service
	Mrs Evelyn McAdam, Administrator, Yura Yungi Medical Service, Halls Creek
	Ms Maria Chan, Dentist, Fitzroy Crossing/Halls Creek
24/08/00	Mr Damon Innus
	Ms Joy Motter, Community Nurse, Fitzroy Valley Health Service

Witnesses who appeared before the Committee at Public Hearings held in Perth

Date	Witness
11/09/00	Dr David Atkinson, Director Centre for Aboriginal Medical and Dental Health Faculty of Medicine and Dentistry, UWA
11/09/00	Mr David Neesham, Director Perth Dental Hospital and Community Dental Mr Clory Carrello, Purchasing Manager Health Department of WA
11/09/00	Ms Tracey Pratt, A/Manager Health Equity Advancement & Purchasing Officer of Aboriginal Health Health Department of WA Mr Wayne Jolley, Senior Policy Officer Environmental Health Services Health Department of WA
11/09/00	Mr Mark Olson, State Secretary Ms Belinda Burke, Senior Industrial Officer Australian Nursing Federation
13/09/00	Dr Matthew Ritson, Medical Practitioner Dunsborough Medical Centre

Written Submissions Received

Date	Name
13/07/00	Dr Matthew Ritson
18/07/00	Mr Bill Atyeo, Principal Environmental Health Officer, Building Surveyor, Murchison Regional Health Scheme
21/07/00	Ms Jan Lewis, Kimberley Regional Co-ordinator, Commonwealth of Australia Department of Health and Aged Care
28/07/00	Mr Alan Bansemer, Commissioner of Health, Health Department of Western Australia
28/07/00	Ms Judy Turton
28/07/00	Mr David Irvine & Ms Maree Gaffney
30/07/00	Mr Kim Nolan, Principal Environmental Health Officer/Building Surveyor, Shire of Derby/West Kimberley
Undated	Kimberley Aboriginal Medical Services Council, Inc.
28/07/00	Mr Mark Olson, State Secretary, Australian Nursing Federation
01/08/00	Mr Peter McConnell, Chief Executive Officer, Shire of Halls Creek
11/08/00	Mr Haydn Lowe, Chief Executive Officer, Aboriginal Affairs Department
25/08/00	Shire of Wyndham/East Kimberley
30/08/00	Dr Richard Smith, Medical Scientist, Miln Walker and Associates Pty Ltd
30/08/00	Ms Cheryl Grant
04/09/00	Laurie Park and Julie Cook, Beagle Bay Store
08/09/00	Dr R D Spence
18/09/00	Steve & Julie Dignan, Store Managers, Wirrimanu Community Store
Undated	Bevan G Spackman JP, Chief Excutive Officer, Tuckerbox Stores
09/10/00	Mr Heath Nelson, Project Manager, Aboriginal Community Stores Schemes, Office of Aboriginal Economic Development, Commerce and Trade
Undated	Mr David King, Propietor, Rusty's Foodland Derby

APPENDIX C: SITES VISITED BY THE COMMITTEE

During the course of its inquiry into the expenditure of public financial resources on the provision of health services in the Kimberley region of Western Australia, the Committee undertook the following site visits:

- Derby Regional Hospital;
- Derby nurses' accommodation;
- Numbala Nunga Nursing Home, Derby;
- Halls Creek Hospital; and
- Halls Creek Community Health.