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REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO EARLY INTERVENTION FOR CHILDREN WITH LEARNING DIFFICULTIES

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At Liverpool on Tuesday 20 August 2002

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The Committee met at 10.30 a.m.

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PRESENT

The Hon. Jan Burnswoods (Chair)

The Hon. Dr Arthur Chesterfield-Evans
The Hon. Ian West

VICTOR NOSSAR, Service Director for Community Paediatrics, South Western Sydney Area Health Service, Department of Community Paediatrics, South Western Sydney Area Health Service, sworn and examined:

CHAIR: You are appearing before us in your professional capacity?

Dr NOSSAR: I am.

CHAIR: You have received a summons and you know the terms of reference?

Dr NOSSAR: That is correct.

CHAIR: Would you like your submission included as part of your sworn evidence?

Dr NOSSAR: I am happy to do that.

CHAIR: We have prepared some questions to guide us, of which you have a copy. Would you like to make an opening statement or give us some background before we ask our questions?

Dr NOSSAR: The main thing I would like to state up front is that I have spent a considerable amount of time working with children who have a range of disabilities, including learning disabilities, particularly when I was director of a child development centre in Illawarra. I understand the dilemmas that families and children face. But one of the things I have come to understand over the years is that there is a silent pool of disability in this country and almost every western country in which I have worked that is far larger than the children with a structural problem, and it is the learning disability created by poverty, disadvantage and family structures. In some ways it is sadder because it is so much more amenable to treatment. We tend to lose that in the hurly-burly of clinical management. In fact, when I look at many of my clinical textbooks, they teach none of my colleagues about how to intervene successfully on the social basis but a lot on how to treat children with very real and difficult problems. I am not diminishing the problems that those children face, it is just that I am very keen for this Committee to get a sense that there is a broader more amenable group of children with learning disabilities that we fail to address at society's peril.

CHAIR: That is why we have asked our first question about the link between socioeconomic status [SES] and children's health outcomes and, obviously, in turn, the link between health outcomes and problems with learning and other problems.

Dr NOSSAR: I attached a number of papers that I will give to the Committee secretary. There is clear evidence across the world that socioeconomic status has a major and detrimental impact on children's health and development. I would probably refer to the Early Years study published in Canada as one of the seminal ones, which just aggregates that. But there are studies all over the place. The West Australian Child Health Survey again demonstrates very clearly the links between socioeconomic status and health, be that mental health or physical health. I have been involved in many studies as well, looking at the correlation between disadvantage and health outcomes. I would like to refer to an issue that has come to me over the years from the evidence: we have historically believed that the answer to this disadvantage is to provide more and better services. That is an important response that we need to provide anyway.

But it worries me that there is a growing body of evidence that says that when you have situations of iniquity or disadvantage and you provide good clinical intervention, even if it works on good randomised studies, you can have evidence of that inequity widening. In other words, you get a net improvement across the society, but when you look at it again some years down the path you find that the lowest and highest SES quintiles have diverged, not narrowed. That is for a whole range of reasons that are self-evident. The families who are most educated and most resourced are also the most able to take advantage of the information, and the families who are most vulnerable are least likely to hear the message to take advantage of it. That is now evidenced through studies on the use of folate to prevent spina bifida. We know that folic acid can reduce the rates of spina bifida. But if a young lady is not using contraception, the chances of her using folic acid two weeks into the pregnancy are virtually zero because she is not even planning on being pregnant.

There are studies that show that you get socioeconomic gradient divergence on that. There are also studies on SIDS prevention from a number of countries that show that when we have a very good intervention—lie your baby on its back—the families who heed the message first are the ones with the greatest resources and the least number of children. The mother who is smoking and may not have a partner, and who is still using Coca-Cola in the bottle is least likely to heed it, not for any reason but just because she has no capacity to even hear the message. The same applies to injury prevention. We see the same divergence in immunisation. The notion that if we had more and better services addressing this inequity is flawed right at the beginning. That is not to say that we do not need more and better services, because we do. I have worked with families who have those problems. But we also need to have a systematic way to address that inequity.

CHAIR: Is that partly to do with the way the services are delivered, making the professions, for instance, sensitive to those points that are obvious when you mentioned them, but may not be obvious otherwise?

Dr NOSSAR: All those things are good things to do anyway. The reason I am cautious about that is that there is very little evidence that defines this. My impression is that it is because a totally different kind of program is needed. When you look through the literature about programs that have redressed inequity they are few and they are not programs that you would pick first. That is where I am particularly impressed by the data around home visiting and early childhood education, such as the Perry preschool project. They are the only two studies I have seen that have shown that when you implement them at a population level, the more resources you have, the more links you have to support, the less benefit you gain. Whereas the more vulnerable you are, the greater the benefit for your child. That is counter to all the other clinical intervention.

The inherent nature of the clinical intervention is requiring someone to present looking for assistance selects out. It is not one or the other. We need to have clinical responses, but at the same time we need to make sure that we have programs that try to attenuate that inequity. There is a risk in inequity. There is evidence that the ginie coefficient, which is the international measure of economic equality, correlates with the distributions of literacy across the OECD. There is a lovely phrase in Mustard, a piece of work on that, which demonstrates that in other words the greater the inequity across the OECD countries the wider the gap in literacy across the country. It is not as simple as: Give them money and you have solved the problem. It is the inequity within the country and then the parents' capacity to use those resources.

The revealing factor for me—it is not just simply socioeconomic disadvantage in the West Australian Child Health Survey—is that the socioeconomic status, the family structure and family function that are all independently linked to adverse child outcomes, be they educational or physical. You need to address all three, maybe separately or maybe together. One of the articles I gave to the secretary of the Committee is a diagram with some background papers. It is a very revealing graph of the socioeconomic gradient, and I refer to the word "gradient" importantly because people tend to see it as being poor people's health and rich people's health. There is nothing in literature that suggests that it is a biphasic curve: it is a continuous gradient. In other words, you will be less healthy than the people who are better off than you and you will be healthier than the people who work for you, always. The importance of this graph is that this gradient always exists. These are standardised mortality ratios for the United Kingdom.

But the relevance is that introducing the National Health Service in 1947 in the United Kingdom did not break that gradient. I would argue that a national health service, which means there is no fee for service, which we know selects against people who have a disadvantage, would be the most equitable. You could argue about the quality, but it is still the most equitable service that exists. It did not address that gradient. In fact, it diverged. I do not think it diverged because of the National Health Service, I think it diverged because of political decisions in the United Kingdom. But it is important to recognise that it is a long straw to say that we will have more and better services and we will have less inequity. There is nothing to suggest that that is the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With the National Health Service?

Dr NOSSAR: With any kind of service-based approach.

CHAIR: Does that partly answer that second part of our first question? Would you say that child health inequality is on the rise in Australia?

Dr NOSSAR: I think there is evidence that it is.

CHAIR: And, presumably, in other, or OECD countries?

Dr NOSSAR: Absolutely. Probably the best source of reference for this is the Innocenti Research Centre in Florence, which has an excellent publication on inequity rise across OECD, the drivers for it and some excellent economic modelling on how to address it, none of which is what we do. But that does not matter, at least it is well published so that we can turn to that for information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you are comparing, and I think you are, universal services, or at least services that may fail the upper socioeconomic groups as opposed to more targeted services that are more expensive but they are more targeted, your total increase in welfare per dollar may be better with the universal services and the particularly targeted ones that reduce inequality but, in a sense, you still do not get as much quality per dollar, or whatever you want to measure. You talk about inequality and you referred to the National Health Service. I would have thought that the divergence in that would be greater if you did not have the services.

Dr NOSSAR: Absolutely true. I think it probably would be true.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Although it is true that most people are probably okay and, therefore, it is good to target the lower group, the increase in welfare at the top, in the upper 80 quintiles is not necessarily to be ignored. The total welfare of society has to be looked at. If you are looking at things like childhood intervention, and you mentioned home visiting and you talked about child care, if they were means tested that is a target at services. You would probably have to have some sort of home visiting that would catch people. Is there ever any relative cost benefit?

Dr NOSSAR: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is one thing to say that this is good. People do not want universal child care because it is too expensive, which I think is a problem. Would you elaborate on the difference between universal services and targeted services, and then which targeted services?

Dr NOSSAR: That is an important question because the assumption has been in the universal targeted, my break is in a different level. My break is between clinical care services and population level programs, which are not actually services responding to problems. There is good evidence in child health that targeted programs, such as home visiting, are less effective than population-delivered programs. You actually lose efficacy when you start targeting. That actually happens for a very obvious reason, because mothers start perceiving that Mrs Jones down the street did not get this, Mrs Franks up the road did not, but I did. We all know that this is a child abuse prevention program, so that tells me what the welfare thinks of me. In fact, I have seen this happen when we have a targeted program that falls of the efficacy scales because the family stops attending. There is good evidence to show that if you want home visiting to work you apply it to everyone, David Olds has written on this, and not to individuals who you believe to be at high risk.

In fact, the predictive value of administering our targeting was very poor. There has been an excellent piece of work in Glasgow where they said: Okay, let's not target by individual characteristics, but by regions—the poorer regions versus the better-off regions. They showed that when you take the poorer regions you miss an appreciable portion—it is between 40 and 50 per cent of the people who are disadvantaged. You get benefit, but you can actually widen the inequity still. I think that you need universal services, but I think that we need to buy two different kinds of services. I refer to that in my papers. We need to buy population-delivered programs that cover everybody. They do not wait for you to have a problem to seek assistance. We also need care services. Two different buys. What worries me with our system is that we bought heavily into the care services, and nothing in the literature would indicate that they are ever going to address in equity.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: By "care services" you mean clinical service?

Dr NOSSAR: Not just medical clinical services, but any kind of service that responds to an individual's problems. They may be DOCS, they may be counselling, but they may not be medical services. They may be services that require a problem and seek assistance. That, I think, is an impediment to families with disadvantage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Showing cost effectiveness in things where you have not shown is the difficulty in getting any money from Treasury.

Dr NOSSAR: The beauty about this is that compared to any clinical service we find at the moment, this has a better cost-effectiveness evidence than has ever been produced for any of the clinical services.

~break/Sears

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There has been an excellent study, a Rand Corporation cost-benefit analysis study, *Investing in our Children*, which looked at the true costs including additional incomes that the kids got, the reduced gaol costs and counselling costs. It showed a 7:1 cost-benefit ratio. That did not take into account the additional social benefits and the reduced demands on healthcare. Just crude overestimating of the costs and underestimating of the benefits still produced a 7:1 cost benefit.

The Government Accounting Office in the United States was sold on it. Rand is not known for its love of populational interventions. That is something that is strong on home visiting. The Perry Preschool is not childcare, its program is parents engaged in child education, parents are engaged with a child between ages 3 and 5 in a care environment and also has home support. It has shown that a 27 year follow-up for a randomised controlled trial, the health benefits and educational gains for the children, and the lighter social gains, reduced our costs and provided better jobs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is randomised control?

Dr NOSSAR: Yes, and the same for home visiting. David Olds' randomised controlled studies, the 17-year follow-ups, nothing in my clinical engagement environment has ever got evidence like that.

CHAIR: Getting away from the dichotomy between universal and targeted, do you have any comment on a specialised targeted service within a universal program, such as specialised home visiting? In Families First's work on supported playgroups there is both targeting and more specialised targeting within a broader program.

Dr NOSSAR: There is benefit in its broader sense. However the evidence is not strong on that. The more you target, the less you see broad-scale populational benefits.

CHAIR: Basically because people are smart? Do they realise they are being picked out?

Dr NOSSAR: I think people are suspicious. I have been involved in a number of programs that set up good Families First interventions in the 1980s. As soon as we made it a service for mums with major problems—because we did not have enough resources in the 1980s—all the other mums dropped out. The mums left in the program effectively had been notified to DOCS and were there because they had to be. That is not the modelling environment that we envisaged when we started this.

CHAIR: Last week the Committee spoke with Graham Vimpani about some of these issues. We spoke about inequity and the worsening of health services. We went through some of the obvious matters including the effect of drug abuse on families. When you are talking about specific causes of poverty and disfunctionality, such as drug and alcohol abuse, is it possible to be more specifically targeted in the services you provide?

Dr NOSSAR: Yes, but that does not help government very much. I have been involved with Families First from its inception and I recognise the real dilemma about the number of dollars we have

and the desire to provide benefit for the children in New South Wales that we know is possible, from the evidence. The program I worked with and tried to draw lessons for was in Hawaii, call the Healthy Start Program. It asked: In the Hawaiian population is there any way of selecting out those who can get maximum benefit from a program? They found a number of indices which, if the family had those indices, they were more likely to gain than would the mainstream population. So they needed to have two of the 12 indices.

I cannot remember the whole 12, but, unfortunately, it has things like no phone, no car, no steady partner. We tend to focus on the higher-risk high-risk families, the drug abusing families, the families with mental illness, the families with violence. The evidence is weakest that we can do anything there, using home visiting or any program. We need to palliate and manage these problems as well as we can. I have not found any evidence that we can change these children's lives, nor has anyone presented it to me. Harriet McMillan has just completed a long study in Canada, which Graham and I referred to, on sustained home visiting for families that have been notified for abuse. She did not find the benefit that people had hoped to find.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean it did not work?

Dr NOSSAR: I do not know, I am not hedging, I have not seen her study. I have heard reports from her and Graham that the benefits were not what was expected.

CHAIR: It is a child protection issue rather than an early intervention issue.

Dr NOSSAR: I worry about it. I come from a clinical environment in which we believe early intervention was identifying a problem early, and intervening. The evidence would suggest that that is not the case, that is what I keep coming back to this population health versus clinical health outcomes. The evidence is that if you want a change population health measures you have to address the determinants about health, which is fundamentally social. Unfortunately it has health spin-offs. There is a vast industry doing things around health, of which I was part. I have never seen a program that reduces injury rates in a large, but David Olds' sustained home visiting does. It reduces mortality for kids at home just because the mother has become more receptive to all the messages.

The Hon. IAN WEST: The outcome from home visits is the essential ingredient in assessing the outcome for the family. You can have skewed figures for target, as opposed to universal, and the outcome of a home visit is not backed up by other resources. Theoretically it could be successful but it may be the home visits that were not properly implemented.

Dr NOSSAR: That is possible, and I would hope so. I live in hope that there must be something I can do for the high-risk families. My background is in working with children with major problems. I found a few studies that have shown that in families with substance abuse you get some gain for the children, but it is only tiny. At least there is some hope. There is also some hope that children living in families where there are mental health or developing disabilities that home-based support is of some advantage, but nowhere near on the scale you would find when providing sustained home visiting for the socially isolated. The mother who is sitting out there, but without the problems, could decompensate given more pressure and more disadvantage.

CHAIR: Do you have any knowledge of where Aboriginal people fit into those patterns?

Dr NOSSAR: That has addressed our minds, for two reasons. First, this area has the most innovative Aboriginal health programs in the State. There is a history of working in partnership with our community for quite a while. Again, I am guided by the evidence more than by intuition. Intuition is a good thing to start off with but there is an awful lot of clinical damage done by good intent. The evidence from a controlled study in Brisbane is that taking urban Aboriginal children and providing a nurse to do sustained home visiting for two years changes those children's health and developmental incomes. That is coming through continually.

Ken Armstrong is doing that work. I have talked to him about his protocols. We are still sceptical because it is the only study I have seen that addresses urban Aboriginal children. There is some work from Sandra Eades in Perth on urban Aboriginal children which suggests that it is likely to be a useful intervention. We set out to do a pilot here and we were told that urban Aboriginal mothers

would avoid our services, they will not accept them. Our pilot is drowned in acceptance. We have had two workers and over the year they have had a 100 per cent birth cohort pick-up. That absolutely amazes me!

Out of a birth cohort of 100-plus, two mothers said no. Mothers who have left our community to go back to western New South Wales still keep in touch with the workers. Our pilot is now trying desperately to find resources to make it a full-on two-year service. The other thing that struck me about the process was that we are aware that when you start home visiting it is not treatment, it is not educating the women, it is being there in the service modelling way. It is about being supportive. We are trying to find the protocols as quickly as possible. The evidence is that if we provide the service, and try to do clinical services in a home we attenuate the program's efficacy.

We are trying to be supportive of the women. Interestingly, these home visitors identified huge problems. The interim report for the program makes very interesting reading. I am talking about young, teenage mothers with multiple children, living in cars, looking for a home. The workers were finding their time heavily occupied by trying to rescue services for the young mothers. They were not able to provide home visiting on a sustained basis. We have set up a structure whereby the partner agencies have key contact people for the program, so that they can sort out Housing and DOCS issues rather than the workers themselves. It has been a fascinating process to watch unfold. Our DOCS partners and our Housing partners have come on board in huge way.

Housing has now discovered that this is one thing that they really want to do. Housing has liberated funds and resources and have identified more homes. Previously these young girls were on waiting lists. A young pregnant girl who already has three kids and no home is not helped by being on a waiting list. Major crisis help is needed. We have found that Housing is able to specifically generate resources for the young urban Aboriginal mothers. It has been interesting process.

Given the evidence of what Ken is doing, it is certainly the way that I would be investing. In the past I have developed clinical services in communities in the Northern Territory and at Nowra. None of them made much difference to the most disenfranchised; but these programs do. That is in line with the home visiting literature from the United States. When David Olds did his work he included studies from Elmira, New York, on poor black mums in Mississippi, and on Chicano families in Colorado, and it has been replicated in Bristol and in Ireland. I go with the evidence.

CHAIR: We will get more details from you about the Aboriginal program in particular.

Dr NOSSAR: I am fascinated by a small but significant body of literature that says that if you are a child in a non-Anglo-Saxon family your advantage is educational and healthwise it can override your socioeconomic status. Nobody has explored that very much other than me and a few other authors. I am not aware that people are following that actively. There are community groups that are overrepresented at universities and underrepresented at casualties and in mental health clinics whose kids develop do very well.

CHAIR: That has been talked about a lot lately in selective high schools.

Dr NOSSAR: As they acculturate they lose that socioeconomic advantage, and reflect wherever they are in their socioeconomic spectrum. That needs serious attention if there is something we can do about the way we raise our children that makes that advantage, that may well be something that can be started long before we wait for society to change.

The Hon. IAN WEST: Historians indicated that hundreds of years ago.

Dr NOSSAR: That is the healthy migrant effect. But that is not true for these children. There has been some elegant work in the United States that has shown that they overrepresented educationally and underrepresented in the mental health problems. The determinants of those advantages are the number of children in the family—the more children in the family, the better the outcome. That is exactly opposite to all the other Anglo studies; up to five then it levels off. From a study of Vietnamese families in America, on a mix of rich and educated, it seems that the more westernised the families are in their orientation the more they reflect their mainstream progress rates. As they acculturate they lose that advantage. There are lessons in that I would like to see explored.

CHAIR: The Committee has raised some of those matters in its disability inquiry. The reasons for underrepresentation of non-English speaking background people in disability services seem to be both a mix of the strong community and other factors, but also the lack of knowledge to access services.

Dr NOSSAR: I do not underestimate that. I come from a refugee family and I learnt to speak English when I went to school. I did not have any English when I started school. My mum did not speak English until I was about 12. I understand fully the difficulties in getting access to resources and services.

CHAIR: I turn now to general practitioners, partly because I am sure you have some knowledge and opinions on that subject. A number of people have raised the failure, which is a harsh word, of general practitioners to identify or refer children with at least the potential for learning difficulties. If the child is very young perhaps "learning difficulties" is the wrong phrase. Do you think that is the case? Do you have any ideas about what can be done about that?

~break/Mendra

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Do you have any ideas about what can be done about that?

Dr NOSSAR: This is probably the question I have least opinion on.

CHAIR: No-one has an opinion on it.

Dr NOSSAR: There is a reason for that. Since my active involvement in the child development clinic, which was before I went overseas to try to develop private health care services, I have not been actively involved with the clinicians. I am trying to build up population interventions. What I am aware of is that there are two trends that are under way from my experience and also from what I am reading in the literature. One is that we tend to medical-ise problems. We are trying to find medical labels or definitions for problems. I think that is fraught with risk because I am not sure that all of those problems are medical. If you just put a label on it and find a gene that is associated with it, I am not sure that you actually solve many of those problems. A good example of that is the recent announcement that there is a gene associated with an increased likelihood of having a violent delinquent if exposed to childhood trauma.

If one-third of the population has an aberrant monoamine oxidase [MAO] gene, that gene is very unhelpful because it does not tell you—if one-third of the population has it and you are screening for this MAO gene, you have one-third of the population—about the children who have a normal MAO gene and who, when they are beaten and abused, end up being violent delinquents. Its predictive capacity is really very poor. We are trying to find medical names for things whereas in reality what we are describing with genes and much of our biochemistry is the means by which the environment or insult is translated into the adverse outcome, whether it is criminality or violence. I do not underestimate it: children who have the aberrant MAO gene represent 80 per cent of the kids who turn out with those bad outcomes. It is a very good predictor but it is not a disease problem. It is the means by which that abnormal environment exists. I thanked God when I read the reviews about the people who have been doing the study saying that there is no value in screening for this gene. The value is still in reducing abuse to children. I thought, "Thank God there are some sensible geneticists."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that the research is sound, though?

Dr NOSSAR: Oh yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could it not be that the families who are poor or something have this gene?

Dr NOSSAR: No, I think it is very sound.

CHAIR: The effects are through each generation.

Dr NOSSAR: What it is saying is that one of the neurochemical genes is one of the genes that has a variability of expression, and that is no surprise. Those who have less and less expression are at a greater risk, but that does not preclude you from having the normal genes and still being abused and still having a violent outcome. There are still 20 per cent of children who are have violent outcomes who have normal expression of that gene. Much as I am interested in the clinical side of this and much as it is very nice to have this documentation, it is not to be taken in place of the need to intervene on a social level. I think the other part of the difficulty that GPs face—and I know this myself from having worked with families—is the desire for things not to be wrong with the child, particularly if it is a young child.

A number of times I have had children come to my clinics where the GP and the parents have all spent a long time hoping that there will be nothing wrong. Sometimes there was autism or other serious developmental underlays, and it is a totally understandable desire. Parents want to see the best they can for their child. I think that GPs have a limited exposure to training in this and I think they are expected to do everything for everybody around medicine. I also believe that they are confronted by parents and their own innate desire not to find something wrong with the child. It has been well-recognised when you do hearing screening of children that a significant proportion of children who are deaf pass the tests because the nurses and parents want them not to be deaf.

CHAIR: Is that likely to happen with the newly announced universal screening?

Dr NOSSAR: No. That screening is a much more concrete in terms of its testing. It is an automated process. They are looking at brain potentials. It is interesting that you raise that because we are about to launch a major investment into hearing. I have been one of the advocates of this in this area. We have been piloting some very interesting examples around this part of Sydney and I think it is long overdue. It is not long overdue because there has been a lack of effort: there just has not been the technology that we could rely on. There is no point generating data on hundreds and hundreds of children with no problems. There is a study which I think should ring bells in people's minds. It is out there and it is a very good study. It looked at the children who are deaf and hard of hearing and followed up with their vocabulary at five years of age and with what were the factors that affected that vocabulary.

The age of detection is important. The earlier they detect the child, the better their gain for vocabulary. Age of detection accounts for about 11 per cent or 12 per cent of the variables. The family within which you are growing up and the degree of engagement accounts for 57 per cent of the variants. That is not saying we should not screening; we should definitely screen. But if we have an untold million-dollar program that is going to roll out and we still have family involvement being the dominant factor about how well you do, we will spend a lot of money to know why these children are not going well. My argument is, yes, you should screen, but for the screening to work you need to have a capacity to help those families to respond. That is why I again come back to home visiting because that is the only program that I have shown that helps parents to engage with existing services normally.

What I have found, as has David Olds, and what has been shown by the Irish, the British and our own little pilot in Campbelltown, which we have documented and published, was that families who are vulnerable and who are historically underutilising medical services—because they do not use them, do not know them and therefore probably do not trust them—suddenly start using existing services more appropriately. They use GPs rather than the emergency department clinics for routine care and they start going to screening. I have seen this myself in programs.

CHAIR: In relation to your pilot about screening for hearing difficulties, are other services there? I guess one awful thing is to be a parent, to be faced with the news that the child has a serious hearing disability, but then have nowhere to go, particularly in those early years that are well before school entry.

Dr NOSSAR: I am not actually actively involved in the State's roll out, but the criterion for me would be not just the technology of the screening, which is what I have seen most of the public reading material about, but the issue of when a child goes home and needs a second follow-up test which will require our nurses again to have a very high coverage rate. If you are dealing with a

condition that affects somewhere between three and five per thousand births, it does not take many missed children to have missed most of the children who are deaf. If you have poor compliance and follow-up, you can actually lose the children who are deaf. You need a robust system that follows up virtually 100 per cent of the birth cohort, which includes the nurses doing this follow-up who are supposed to be doing early childhood and who are now doing Families First.

You cannot lose them, because if you lose them you start to run the risk of making the system not cost effective. Then you need the Australian Hearing Services which I am assured will do the diagnostics in a timely fashion. I know that the service is flooded at the moment but I think the effect is probably worse without screening. They are caveats, not reasons not to do it. One of the things I have learnt since being a clinician and moving into building up population intervention programming is that if you do not build a system that addresses these issues, it does not work. You could have all the goodwill in the world and all the best clinicians in the world and all the best technology, but if you do not address things systematically, which means that you address each of the determinants in a fashion, it will fail. An engineer can tell you that as well as any program manager or any general can tell you that. Clinicians are yet to discover and build a system to provide total coverage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are what are called instant implementation assumptions.

Dr NOSSAR: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They get at the end of the bed, they give the orders, and they assume 100 per cent compliance and correct implementation.

Dr NOSSAR: I will tell you an anecdote about that. When I was working in Papua New-Guinea in the kids ward, I had ordered antibiotics for the children and different medications. I was amazed at this nurse who had longer shifts than I did—"NIW". Those were the initials on the medication chart and she was there on every shift. There were two or three children that I saw, and she was there, day after day. I thought that I had to meet this woman because she was working harder than I was, and I was on 24 hours on-call, seven days a week.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not in ward?

Dr NOSSAR: "NIW" meant "not in ward" and it was actually that the nurses were recording that the drugs were not available. That meant that the child had gone days without getting medication. I asked, "What do you mean that you were just writing down that the treatment is not in the ward?" The child was in the ward, but the drugs were not in the ward. I have learned not to make assumptions. I do not make assumptions. I am obsessive about systems.

The Hon. IAN WEST: So you can have all these home visits, but it is absolutely a waste of time if they are not done properly.

Dr NOSSAR: No, home visits are interesting. There is more risk with clinical interventions because clinical interventions require you to do something. You have to give a patient some information or a drug or therapy and you walk away and they are supposed to be doing it. Home visiting is different because it is a relationship. You are not giving them tasks or work to do while you are away. You and there regularly, frequently, and it is amazing.

CHAIR: That is the point, is it not? I think it was Graham Vimpani last week who said that home visits are fantastic but one-off home visits are likely to achieve absolutely nothing.

Dr NOSSAR: The evidence is that for 18 months to two years it is a sustainable resource.

CHAIR: And how frequent is that?

Dr NOSSAR: Frequent early and infrequently later on, so that is weekly and then monthly.

CHAIR: So the total number of visits for the first two years might add up to what?

Dr NOSSAR: I have no protocols; I do not have them with me. They are actually protocols but I base it on the studies of what works. Everybody is keen to save money and I understand why—I have to manage a service too—but my concern is that if I implement a program which does not deliver the outcomes, such as $117 million of Families First money in the community, and we do not change child health, to me that is unacceptable.

The Hon. IAN WEST: Is there any point where you could water down the home visits, or is there a point at which watering down the home visits becomes ineffectual?

Dr NOSSAR: That is a great question. I am trying to get somebody to study it. Nobody in the world is doing a very good study yet on this.

The Hon. IAN WEST: In terms of defining a home, you had the local district nurses or a maternal child centre.

CHAIR: They were the former baby health centres.

Dr NOSSAR: It is actually going where the mother lives with the baby.

The Hon. IAN WEST: I am actually thinking of cost.

Dr NOSSAR: I know. Do not worry I am thinking about cost, too. Can I tell you why for me I think it is important? If you do not have efficacy, the cost equation is meaningless because it is cheaper, but we have what we had in the past—the rich get healthier and the poor have problems.

The Hon. IAN WEST: So you are saying that setting up a baby health centre is nowhere near as effective as home visits.

Dr NOSSAR: I am.

CHAIR: And they may be a way of working out whether nine home visits in the first two years of life is perfect but once you get below eight visits—

Dr NOSSAR: I would love to do this study. Nobody has published anything on this, but I am sure that somebody has done it. It is such an obvious question.

CHAIR: But the basic question is that if it is not done properly—

Dr NOSSAR: You do not get the results.

CHAIR:—it is a waste of time and money.

Dr NOSSAR: Yes. What I have seen from the pilots we have been doing is that it needs to be the same person and it needs to be done early in the piece and frequently enough. That does not mean everybody: There are mothers who are clearly doing well on social support whom you may see infrequently. We used to vary visits according to the pilots in Campbelltown.

The Hon. IAN WEST: It appears that that is a fundamental issue in terms of the cost effectiveness in determining a measure for preventive measures. If we do not have a study on that—

Dr NOSSAR: There are some studies. Even if you have intensive visiting and even if you have intensive Perry preschool, it is cost effective. That is what I have kept saying to you. Even if we compare it back, it is even better. It is cost effective as it stands, which is really quite frightening and part of that equation is also the lack of efficacy of the other interventions. You can run a massive community education project on injury reduction or suicide prevention without any evidence of efficacy.

The Hon. IAN WEST: Do you think you are going to convince an actuary on that?

Dr NOSSAR: What you mean? That there is no evidence of efficacy?

The Hon. IAN WEST: No, an actuary.

Dr NOSSAR: Yes, I understand, but of which?

The Hon. IAN WEST: Of cost effectiveness.

Dr NOSSAR: Well, Rand is convinced and so is the United States Government's accounting office.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that with suicide prevention, there is no proof of efficacy.

Dr NOSSAR: There is not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not even longitudinal studies?

Dr NOSSAR: No, not in the programs that we are running. I will give you a classic example. Child abuse prevention is a big issue. We are doing lots and lots of child abuse prevention programs. There was a study published in the 1990s by the McMaster University, which was an analysis of the abuse prevention programs, but there was no evidence of effect that had been shown at any stage. They are not saying that they do not work, it is just that nobody has shown that they work yet, except for home visiting which has been shown at a population level to reduce abuse. I actually came to home visiting not by virtue of all the other interventions but as a child abuse prevention strategy because I have done all sorts of things. I have educated mothers and I have tried to program support factors in the home, and yet the review in the McMaster review, which is probably the gold standard review at the moment, there is no evidence of effect in all the things that we want to do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So basically it is only a gut feeling.

Dr NOSSAR: Of course. In fact I am amazed how often people still defend what we really know works over even randomised control studies. People are actually suspicious and say, "That is that the medical thing, the randomised control studies" whereas randomised control studies are a pretty powerful thing to ignore. If I am buying a car and I have a choice between one that the NRMA says will run and one about which a dealer says "Trust me", guess which one I would buy?

CHAIR: Let us get onto Families First. We have several questions and we start off by saying how much support there is for it. It is almost a universally supported and popular program, at least in terms of its aims and its potential, but the matter of inadequate resources has been raised by a number of people. I guess what we want you to tell us is, particularly given the work that Families First has done in this area, what the main barriers to its effective implementation are?

~break Kirchner follows

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Dr NOSSAR: The issue you have identified about resourcing to sustain home visiting is a very real issue for the Government. Do not underestimate the political problems. I have worked with both political parties at Federal and State levels. I have not found one group that is not accepting of the evidence and not committed to it, but seriously confronted by how much it will cost. Do not underestimate that in the slightest. Resourcing is certainly an issue, but, having tried to implement it now for three or four years, one of the issues that is a sleeper that government really has to come to grips with his how resilient rescue cultures are. I support GrahamVimpani in his analysis, and Fraser Mustard came up with exactly the same analysis. People who have been trained at university and postgraduate levels to help people know that their help is important. Even in the face of the evidence they know it is important. The number of times I have presented the evidence to staff who say: All that is fine, but that is not what I do, is incredible.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It sounds like a cardiac surgeon.

Dr NOSSAR: It is like an awful lot of clinical services. It is not limited to medical services; it is limited to any helping profession. You actually build into people's desire that they have to help. The idea that these mothers out there who you will visit regularly who do not need help—in fact, you will not even educate them—is counterintuitive to many helping professionals.

CHAIR: Does this come back to your example about the teenage Aboriginal mother with the three kids in the car and people wanting to help across the spectrum instead of sticking to their brief, which is home visiting?

Dr NOSSAR: Yes. It is interesting for us. The teaching has been trying to get the visitors who visit to be a shoulder to cry on, an ear to listen to their problems and not a rescuer. We have miles of rescuers in all of our departments. We can happily roll them out.

CHAIR: What is the best professional template for a home visit?

Dr NOSSAR: David Olds used nurses. If you go to his program there is a rigid training process for what you do. Education is a dirty word. You are not going to teach these mothers how to parent; you are going to be there regularly. There is a program of information you give them and things you do, but it is steering the person away from even hinting—

CHAIR: Why should they be nurses, given what you are saying?

Dr NOSSAR: I fully agree with you. As a pragmatist and a manager of services I have a costing in my office for how much it would cost to do 85,000 visits a year or 85,000 children from nurses out to nurse assistants. The issue is that it has to be somebody who can be held accountable in a sense that you basically help train and support them. We have run a pilot with volunteers in Campbelltown for 50 mums, and it worked. Scaling that up to 85,000 people for volunteers will not work because of the number of volunteers you would need. It is not impossible. I worry about the professionals' arrogance that says that volunteers are nowhere near as good as nurses. The Community Mothers Evaluation in Ireland compared nurses against volunteers and got the same outcome. I am not sceptical about that. Well-organised, well-managed quality services could do it. My concern is that we underestimate how much resources you need to run a well-organised, well-managed volunteer service, and getting people to volunteer is not easy, as we are finding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Let us assume volunteers. No-one wants to put any money into the facilitation and training of volunteers.

Dr NOSSAR: Quite possibly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does what you call holding them accountable mean being able to insure it?

Dr NOSSAR: Our pilot in Campbelltown had very close management. Those volunteers did a great job.

CHAIR: You mean public liability?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Insure, not ensure?

Dr NOSSAR: That is an additional issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But is that what you were frightened of?

Dr NOSSAR: No. I am trying to get people to be accountable in the sense that they are there every day. This is not an also-ran service. It sounds to me awfully similar to the debate I present when I am working in any third-world developing country, trying to get clinicians, workers and health workers at primary health care services are not our poor relation. They are doing something that we cannot do. What a home visiting service can do is something that we cannot do no matter how much money Health or DOCS invest.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not advocating that your home visiting be done by Health at all?

Dr NOSSAR: It could be.

CHAIR: Your preference is nurses?

Dr NOSSAR: At the moment.

CHAIR: What is the advantage of nurses over nurses aides?

Dr NOSSAR: Only because David Olds is doing it using nurses. Being ultimately conservative, I am quite prepared to go with what the randomised control study shows. But, being a pragmatist, I am prepared to stretch the point and say, okay, nurse assistants will cost the $26,000 a year plus on costs versus the cost of a registered nurse level six. It is significantly different.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you said that you would combine two studies, one using nurses and the Irish one.

Dr NOSSAR: Using the Irish one I would be happy to go with volunteers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you could get them.

Dr NOSSAR: Yes. The point is that we have tried that. For several years running we are seeing only 700 families a year through volunteer programs.

CHAIR: They must be an awful lot of nurses who would be absolutely hopeless home visitors?

Dr NOSSAR: Yes, it is not automatic.

CHAIR: Probably a lot of volunteers would be hopeless, as well.

Dr NOSSAR: Yes.

CHAIR: You would have to screen and so forth.

Dr NOSSAR: We have a training program, and that is exactly right. It needs to be seen as a home visiting service. This is not a poor baby health service, this is a totally different kind of service with a different orientation and different training needs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We might be better off to set up a TAFE course for middle-aged people with some of experience?

Dr NOSSAR: Possibly.

CHAIR: A certificate in home visiting?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. People with life experience. When I say people of middle age, I am not being ageist. I mean people with credibility who are brought up to do whatever.

Dr NOSSAR: I know. I would be open to any suggestions. When we first did our pilot with volunteers in Campbelltown the first intake of our volunteers was young TAFE graduates who had never had a child but who were looking for work experience. As much as we welcomed the—they went through the training—nothing in my review of literature of people who had worked with mothers at home said that young 18 and 19-year-olds would be the women who would change these women's lives. Fortunately, as work came up they dropped out of our program and the middle-aged women

who were older and who had kids came into our program and it worked fine. You have to have life experience to have cred with a mother.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would think so. I would have thought that there was a bigger pool of volunteers there to staff it.

Dr NOSSAR: You would have to test that very carefully if you rolled that out because you have moved away from where the evidence is. Not because it could not work or it should not work, I think it probably would. I am the kind of person who says the you have to tie dollars to make sure that in five years time you can say "abandon it".

CHAIR: What about social workers? You say that the studies were all guided by having nurses in them. I accept that. If we are talking about volunteer workers, nurse assistants or whatever another pool would be, possibly, social workers. You do not look enthusiastic

Dr NOSSAR: Not at all. It is not a question of professional groups. It is an impression of where their profession is going. Within the last year I was asked to give a talk at the Social Welfare Conference at the University of New South Wales. There was this room full of social workers, people who are supposed to be far less clinical than I am. Everybody in the room thought that clinical social work was the place to go. All the social workers I work with these days are into helping the family through a whole range of interventions, which is back to being one of those rescuers I mentioned.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Finding discharge beds?

Dr NOSSAR: I would worry about that because of all people, they should be the ones seeing the social context, not a paediatrician. I do not mind any professional group, as long as we can unlock them from where they have been trained.

CHAIR: Which may come back to the suggestion of Hon. Dr Arthur Chesterfield-Evans that you may need a TAFE course in a certificate of home visiting, for example, which may be on top of or part of another qualification.

Dr NOSSAR: Resourcing is an issue. There is a very real risk, as happens everywhere, that the Government will finally weaken and feel that these resources are better used to enhance and co-ordinate our existing services. You hear that for Sure Start already. When I look at the Pathways program in Victoria, it is better co-ordination and has more enhanced services. There is no evidence that that produces outcomes. In fact, I asked Naomi Eisenstart when she was here whether she was reading something that I had not read about co-ordinated services. She said, "No, but we are hoping that this will make a difference."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When they find an anecdote of disco-ordinated services then that will fill the gap.

Dr NOSSAR: Co-ordinated services are important. We should provide better co-ordinated services. I have worked with families with disabilities where they have to wend their way through a multiplicity of agencies, carry files and repeat their histories. That is rubbish! That needs to happen. That is a different buy. Better care is a different buy for better health.

The Hon. IAN WEST: In terms of co-ordination, would you see rolling this out at the regional, local, focus level?

Dr NOSSAR: Families First?

The Hon. IAN WEST: No, home visiting.

Dr NOSSAR: I think you have to, in a practical way. But I am pragmatic enough to know that you have to have State control of this process because the Thousand Flowers solution that England is resorting to, Sure Start tells me that programs in every community are different.

CHAIR: Our secretary and I are smiling because we had a very quick meeting with Naomi Eisenstart two weeks ago, just before she was rushing off to catch a plane. We are very interested to hear how Sure Start is going.

Dr NOSSAR: I think it is good. I am glad there is £1.5 billion, but I am worried about what they are spending it on.

The Hon. IAN WEST: I did not explain myself properly. I was not really thinking of the Maoist philosophy, I was seeking more along the lines of local supervision and ensuring that ownership of the roll-out is locally focused. If you are talking about home visits and an individual person delivering those home visits will feel some ownership, even though they are resourced. I am visualising a resource centre-type person who will access all these services. If they do not remain locally centred I visualise effective access will diminish.

Dr NOSSAR: David Olds said that. You have to respond to the families needs and where they are at, which means local. You have to understand the locality and the people.

The Hon. IAN WEST: The management of it, even though, obviously, funding would be at the State level, how do you maintain that localised, family focus? How many families do you think one person can resource?

Dr NOSSAR: The evidence is between 20 and 25. One professional visitor can do 20 to 25 families from the studies that I have seen. They are the figures we are working on at the moment. I use 25 when I do the numbers.

CHAIR: That is 25 mothers of children below what?

Dr NOSSAR: That is virtually taking in families when children are born and up to two years of age. But that is not possible at the moment. I have 12,000 in south-western Sydney, which is more than Tasmania and almost as big as South Australia. The number of staff out here is smaller than some of the urban hospitals.

CHAIR: That is the heart of the question. If you have 12,000 how does the management of Families First, home visiting and so on in this area fulfil the local and community-based criteria?

The Hon. IAN WEST: I can understand 20 to 25 in Liverpool, but I cannot understand it at Comboyne or Coonamble, for example. Geographically those figures do not gel. What about the Department of Education and Training? Is there any way that it can link in?

Dr NOSSAR: I think it is. The Schools Community Sectors program, which we were one of the pilots for, has shown the capacity to build up the local community much more.

CHAIR: And Families First has now taken that over?

Dr NOSSAR: I did not go to Coonamble, but I was aware that the pilot was being established. It has to try to focus not just on service delivery as in: You've got a problem, can we help you? You have to engage the community in the job. The architect for our schools community centre is to make the community more child friendly. In Curran there is an effort to actively engage and enrol families who may not yet be aware of our schools. We find that mothers who participate in early child play groups, it is part of that Perry preschool being brought to reality.

~break/Sears

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We are finding the mothers come along and get engaged in the program. We did a pilot in Curran where the mothers with the best advocates for that process. They present to parliamentary groups, not to doctors and the co-ordinator. The mothers have a voice and allow themselves to be heard and they go off and get jobs, which is wonderful.

CHAIR: The Committee visited one group at Coonamble and in an earlier inquiry on education we visited Redfern. Are there any more barriers, apart from the shortage of nurses and dollars?

Dr NOSSAR: The staff, yes.

CHAIR: You said that the Government has a tendency towards people in the field moving back.

Dr NOSSAR: If we end up, after the $117 million, with a better resourced, better co-ordinated way than before, that would be desirable. But it will not reflect itself in any of the health outcomes that I would care to put my name against. I would love to, but there is nothing in the literature that says that that is the case.

The Hon. IAN WEST: Will it be a failure?

Dr NOSSAR: No, it will be good. We will have better care, but it will not improve injury rates, suicide rates, cot death rates, smoking mother rates, or breast-feeding rates.

CHAIR: What do we have to do to achieve that?

Dr NOSSAR: Sustained home visiting for two years.

CHAIR: How many more millions would you need in your area?

Dr NOSSAR: I have done a statewide calculation, not local.

CHAIR: That is even more useful.

Dr NOSSAR: I have the figures and can provide them. For 85,000 children to be visited on a 1:25 ratio, and it would have to be varied according to the population, it is in the order of $200-250 million. We had to spend $3 billion on intensive care, on casualties and a range of clinical services—I have not seen the demand for more money reduced—without even a blink. That was with no evidence of efficacy or change.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will the Liverpool Hospital study on intensive care units continue or have they stopped?

Dr NOSSAR: They are continuing. Microeffectiveness and how much health we buy is a question I ask in my work with other governments: How much health do you buy for the money you are spending? I have been working for the Australian Government in China. In 1985 China embarked on a program investing much more resources into training clinicians, getting better quality care services. Their hospitals for the rich are good, on a par with everywhere. Since 1985 the infant mortality rate stopped improving. Their rates of TB are stating to increase. Their immunisation rates are starting to fall. They have better care but people are in worse health. They are appalled that they are spending billions and not seeing the gains they saw beforehand.

The Hon. IAN WEST: The barefoot doctors?

Dr NOSSAR: Those doctors were salaried to try to make sure every kid was immunised and everyone was seen.

The Hon. IAN WEST: In the brand-new wards there are no patients?

Dr NOSSAR: There are, they very rich patients. When I go to villages in rural China I can clearly see the doctor's house; it is the biggest house in the village. It is now fee-for-service and there is a multiplicity of treatments. Efficacy is not a problem, as long as they get their injection. They cannot bill for preventative care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is like us.

Dr NOSSAR: That is exactly right.

CHAIR: What would happen to Families First if it were transferred to DOCS, as has been announced is the intention? Would it be a problem?

Dr NOSSAR: I cannot predict that. I think it is a problem, but not because of DOCS. If you transfer Families First to a service agency you run the risk of it being suborned into enhancing some more care.

CHAIR: It would be just as problematic if it were in Health or Education?

Dr NOSSAR: Yes. I have spoken to Garth Raymond about this dilemma. Education has a population brief, it is meant to provide education for a whole population. My concern about Education is that it is so locked into schools and teaching that this would have to be a whole new agency. That is not where Education is at. In many of our fora, Education people are well and truly committed but not active participants. They have enough on their plate trying to make schools work. You would have to build a new agency within Education.

I work with the World Bank on early child development programs and the literature on that is not new. There has been a 27-year controlled follow-up; it has been around for a quarter of a century. Why is it not being used? It is not being used because the lead agent is Education; and education in a Government hierarchy is not one of the top pecking orders, it is not big bucks, it is not high prestige. The reality is that, yes, the message has been known to educational theorists for a long time. The reason that the Government is talking about it now is because professors of medicine and paediatrics are talking about it.

My big concern is that if you put it into Education it not be relegated to the backwater. I think education is critically important and makes a major difference to child outcomes. I have provided the Committee with a number of papers that show that an extra year of preschool education results in that young person earning additional dollars for the rest of their lives. If the child's father is illiterate, the child will earn so much more than his father could read. Education is critical.

CHAIR: If our education department was to become more focused on the education of younger children and expand its preschool program so that there was a bit of a turning away from an undue focus on the HSC and more concentration on younger children, would some of the problems be overcome?

Dr NOSSAR: I think they are two different tasks. They still have to focus on job preparation, the HSC and young people's problems. But there should be an early childhood arm of early education. I have wrestled with the politics of this; it may be a good idea to have other Ministers having accountability for its efficacy or input. I am worried about giving it to anyone of our partner agencies. I have been a practising doctor in Australia for more than 25 years. I cannot count how many co-ordination pilot's we have launched in this State. Which ever agency gets the lead, the rest walk away. A classic example is child protection.

Everyone was responsible for child protection and because that was not working well it was given to DOCS. Now the dilemma of DOCS is that other agencies refer abused children to it, and then walk away. They are trying to get people to re-engage—it is not an Education program. Can you convince Health that the money it is spending is not delivering unless the early childhood department does its work? Health would not believe that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that there should be a department of child development, for everyone from baby health centres to isolated youth?

Dr NOSSAR: I agree with that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you mention that in your submission?

Dr NOSSAR: No. I advocated against fiddling.

CHAIR: You said to build on Families First, build a structure out of that.

Dr NOSSAR: Yes, I was not opposing what Graham was recommending. When I read questions 59 and 60, they referred to micromanagement of issues. Should we be looking at reorganisation and better co-ordinated services? For me that was a high-risk strategy; we should be building on Families First. I strongly support what Graham was talking about, that was a micromanagement tactical issue. Should we reshuffle the deck chairs a bit better? No. I think with Families First you have a government-run structure which is central, essentially endorsed, so build on that. The stewardship of the Cabinet Office is not to be underestimated. It has probably produced better results than the formula everyone was happy to quote, that is Sure Start.

CHAIR: Cabinet Office would normally see itself, and be seen, as an appropriate place to get something started. Otherwise you would end up with a Cabinet Office replacing all the Ministers and departments.

Dr NOSSAR: I fully agree. I work closely with Cabinet and it has voiced that opinion to me. One of the papers I gave the Committee was a report from the United Kingdom House of Commons. When it reviewed population health in the United Kingdom it clearly said that population health was not well served by being in the Ministry of Health. Despite all the rhetoric and lip service it may well have been better to take population health out of Health, set it up as a Cabinet level department with smaller staff but with a different focus and bring in other players. That caused horror in the United Kingdom Ministry of Health. The House of Commons committee came back with a recommendation that for the next three years it would remain with Health and that will be reviewed. It is a great report.

The Hon. IAN WEST: Another pilot?

Dr NOSSAR: My concern about pilots is, when I discovered home visiting literature I asked the question, like everyone else: Does it apply to Australia? Should we do a pilot with 50 families? We were one of the first in Australia to do that, and keep it localised. Lo and behold, three years later there are 300 pilots around Australia. My plea is to stop piloting and start building a system. People love pilots because they are controlled. Systems require skills that clinicians do not have.

CHAIR: Beverly Duffy and I had the opportunity to talk to Naomi Eisenstart about Sure Start. One point she made was the importance of the personality, the character, of the individual. She referred to a junior Minister who originally chaired a Cabinet subcommittee and then moved. Other people then came in and it seemed that it was important to take note of the commencement and other qualities of the individuals involved at the top.

Dr NOSSAR: Always. We make a mistake to underestimate the importance of driving individuals, because obsessive people like to think that the system will do it all, but it does not. Treasury and finance are far too important to be left to anyone. Government always looks for people who will make it work. If this is seen as central core business for governments to make that happen, just because we cannot afford our society not to have children who are functional members of society, we make sure we put players there who will make it happen. I have never seen a government put in a weak and effective Minister of finance or treasury, because that would be a disaster. It tells us a lot about how relevant Ministers are.

CHAIR: It does. That leads to the second point that Naomi made: The direct involvement of the Chancellor and Treasury people was crucially important in getting money for Sure Start in the first place and being confident that the money would continue. It was not a problem that would flare up and flare away again.

Dr NOSSAR: I found Treasury and the Cabinet Office to be stronger allies for Families First in this State. It understands the importance and cost benefits.

CHAIR: Gabrielle Kibble made a similar point yesterday referring to child protection. She said that the presence of Premier's Department and Treasury on the working party she chairs, which

looked into DOCS systems, was of crucial importance to get it committed to funding and ongoing government involvement.

Dr NOSSAR: Whether it is DOCS or not has been relegated to whether DOCS is doing its job well or not. It is not a reflection on DOCS, it is about the function. The staff in DOCS are just as committed to Families First as we are, they are great partners. We have a memorandum of understanding with DOCS which is now in its second five-year slot, they help us fund pilots. When I developed the Cottage Community Care Project at Campbelltown as a pilot for home visiting, the local DOCS regional director gave me funds to do that. He had his staff on the management group, and that is excellent. We have a functional partnership. It is not about DOCS doing its job, it is a different cultural ethos. That is important in terms of the role of early childhood in our country.

CHAIR: This afternoon the Committee is visiting the Macarthur Child Protection Committee, meeting the working party of the Cottage Family Care Centre. In a sense where Families First is located in the end is not as important as the support and commitment it has from government.

Dr NOSSAR: Yes. If it ends up being a nice ministry on the edges, and there is no resources and no attention, that is very dangerous. The National Education and Employment Forum recently published an important report. It identified the same thing that I identified in other OECD countries, and I did not realise it was so strong in Australia, that between 650,000 and 750,000 Australian children live in homes were neither parent works. Many issues are not purely social, this is about the Australia that is going to take care of me when I am old and grey. That is enormously important.

We know that these kids' outcomes are dependent on how they are raised. The evidence is profound on that. Yet, we are quite happy to continue to bring in bandaid services for which we have no evidence of efficacy. We do not want to invest in what is really going to make a difference. We have spent a huge amount on hospital services and, yes, we need to. But it worries me that we are worried about $250 million when we have to spend $3 billion.

~break/Mendra

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CHAIR: Some people would say that the answer is to find jobs for all those people rather than put the money into Families First.

Dr NOSSAR: Yes, I fully agree with you, except that the thing that amazed me was the evidence from Perry preschool and David Olds. Guess whose kids were more likely to get jobs, even kids from disadvantaged families? In a control study, which I have to go back to—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The ones that are at home.

Dr NOSSAR: The other thing that we found was that the volunteers who did this got jobs. We had women who were employed and the biggest discovery when we were running our volunteer pilots were that women who had been locked into unemployment suddenly started finishing their education and getting jobs. In fact I was tempted when I was running short of funds for a while to float the idea of putting my hand up for one of those CentreLink contracts. We had a better run there than many of the employment agencies.

CHAIR: Some people would say that that would not be hard.

The Hon. IAN WEST: So it should be the case with the private education system.

Dr NOSSAR: Heaven knows. I do not think that this is a trite situation. I would argue very strongly that it is not important where it is, but the critical point is what it does and how importantly we resource it. I do not mind Treasury and Cabinet still continuing to play an oversight role. Maybe there is a whole new kind of way of working that we need to discover.

The Hon. IAN WEST: Your $250 million is a yearly thing, and Families First is running at $117 million over five years?

Dr NOSSAR: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it is not comprehensive.

Dr NOSSAR: At the moment, can I tell you what we are setting up with Families First? One of my objectives has been to improve the system. At the moment we are, in south-west Sydney, one of the only places in this State where we are getting a complete capture of the birth cohort. We are now actually in a timely fashion able to send a fax to the nurse in the local community saying, "In your area last night were born these babies to these ladies. You need to contact them." My staff are not judged by occasions of service but by how much of the birth cohort they have seen within two weeks of delivery. They have to contact the mother and do an assessment of her level of need because we do not have a sustainable home visiting program at the moment now that enables us to find the mothers who are most vulnerable and try to link them in with the volunteers and what we do have.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is numbers of service but in a different way?

Dr NOSSAR: Yes. It is a totally different part of the message. People are used to being busy. When we started an early data collection system here—which is not available anywhere else in the State, a computerised early childhood data system which we have been running for a long time—we found that, no, they do not do it on computer. It is just recorded on paper and it is scanned in every day and goes back to their records. That is actually useful for them and it has shaped their practice, but the data it has given me is priceless because we now see the typical profile of a woman who is using our early childhood services in south-west Sydney. It is not profiling the woman who is going to have the most problems, which is not a surprise. Statewide that is known and it came to be known because we have good clear data of that. We have fiddled with the hours of service, and nothing changes. The reality is that our services are designed for a different clientele across the State.

CHAIR: We were obviously somewhat confused about that, but getting back to Graham Vimpani's suggestion about a department of early childhood services which may grow out of Families First's existing structure, you are broadly supportive of that?

Dr NOSSAR: Yes. I strongly support that.

CHAIR: Although you have a reservation about its lack of clout in the political sense?

Dr NOSSAR: I know that that is how it is structured and that is how the environment has based it, yet you can have a strong individual. But ultimately, it depends on how it is valued.

CHAIR: Could you, as someone who knows about home visiting, and the people you are dealing with in terms of Families First find yourselves working for a department of early childhood? Would that be a huge culture shock and create all kinds of problems?

Dr NOSSAR: For me, no. It would be for many people, but not for me.

CHAIR: Is that in itself a problem—not for you, but for many people who would work there?

Dr NOSSAR: I think the biggest issue is the one that has been highlighted in my presentation and that is the issue of population health versus clinical care. We have resourced hugely care services, whether they our own doctor's services, social work services or counselling services. We have put huge resources into that and we have underestimated and undervalued population programming. That is exactly the dilemma and that is why I gave you the information on the House of Commons committee report. It is not about health; it is about population health and the picture of it. It is not serviceable by service providers in their current training. The issue would not be about where you are housed. You are right that many of them will not want to, and that is fine because there is enough care work to do, but we really do need to understand that there is a totally different program that we need to build in order to achieve efficacy.

CHAIR: The concept of the nurse, say, could encompass nurses working in all of these different sorts of areas, including being employed by a department of early childhood. In fact, if that is

where they were happy, that would be where they would be, and if they wanted to go into the traditional care area, that could also be where they would be.

Dr NOSSAR: You may be able to label it, I do not know, but overtly make it a population program so that it is not about centres and buildings. Its measure is not occasions of service, but the national figures, such as the State's child breastfeeding rates are falling or smoking rates are rising. They would be that department's problems.

CHAIR: You would not have a structure or something akin to community health centres or early childhood centres—your bricks and mortar types?

Dr NOSSAR: I would worry. People tend to draw a dichotomy between a hospital and community services. I am trying to make it clear that the dichotomy is not the reality. Community services that are doing rescue work in the community are in the rescue camp and you need to have a group whose job is to improve the health of people in Australia.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if you have the Department of Health and the Department of Illness and Pathology, and the Department of Illness and Pathology is renamed, you could end up with the Department of Ill Health.

Dr NOSSAR: That would be resisted enormously. One of the groups that has attacked this is a group by the name of the National Bureau of Economic Research which did a review of survival rates or mortality decreases in the United States. What that showed was that before 1940 was when you got the most length of life increases in the United States—and this is the US, which is the home of technology—and that was in young kids and young children. In 1940 to the 1960s when you got antibiotics, you still got some survival improvement thereby you are still talking about an average of a year added, not five years, and modern medicine made some gains of about a year and a half for older people. That is it. That is in my submission. That is a very different picture to what you are being sold by the technologists. If you want to buy health, it is not going to come from investing in more technology.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You need a suite of systems to sort it out?

Dr NOSSAR: We actually have a suite of systems. What we now have it is the second order problem about how families function in a society which is very individualistic and hugely inequitable.

CHAIR: We have one major area that we have not taken up with you but we obviously have to get on to Macarthur. Given your specific role in community paediatrics and given the multiple inquiries we are doing, can you make some comments about the interaction between early intervention and issues we have been talking about, prevention and the child protection issues? You have already said quite a bit.

Dr NOSSAR: We have a very strong relationship with DOCS. I have found that they are confronted by an unenviable task. I think the issue of early intervention needs to be unpacked from being early identification of abuse, which has not been shown to make much difference to the rates of abuse at all. I would refer you again to McMaster University's review on child abuse prevention programs. Early identification can reduce mortality and that is a significant outcome. In other words, if you leave a child in an abusive environment long enough, the rates of the number of children who get killed or severely damaged increases. But home visiting is one of the only studies I have found that shows that you can reduce child abuse rates on a large scale. For me, I would worry about a program that can do so much for so many different things, but the trouble is you cannot walk away from randomised control studies. If I was going to be buying child abuse prevention, it is going to be in a totally social context.

The interesting thing about David Olds' work was that they actually excluded families that we historically focus on, the very high-risk families, such as families with mental illness, the families with drug addiction and with domestic violence, and still demonstrated reductions in abuse. What that tells me is that while the high-risk families we focus on are very important because they have higher rates of abuse, they are a very small number, and the vast bulk of abuse is happening in families who

are isolated and who are not in the same category. They are much more amenable to treatment; at least, that is what David Olds' work shows. I guess that what I am trying to say is that early intervention is a totally different ball game to where we have been in the past, which has been the earlier and earlier identification of abuse. When you do that, and when you label mums as being potential early abusers, I have not seen any mums who put their hand up or open their doors the second time.

In fact, one of the nettles grasped when we did our pilot in Campbelltown was to take away the label of child abuse prevention. This was not a child abuse prevention program. This was a program to help the mother because, again, if you had somebody who rocked up to your door and said, "I am here to help you—to prevent you from abusing your child", I would hope that you would shut the door. It is an insult. It is skin off. I am very much concerned that if we have a system that is hugely overloaded—and this remark is in reference to the DOCS issue—I am not sure that increasing the number of things that we notify for makes good management sense. If I had a system which is not coping by tripling the potential referral base, I am not sure that that will enhance the capacity to identify the kids who are vulnerable and who are going to do badly. If anything, my business sense tells me that that will make it harder. Yet we have a system that is driven by more and more bases for identification.

Last Friday the *British Medical Journal* published a review for England saying that they are about to consider the idea of domestic violence screening. They are recommending against domestic violence screening in the United Kingdom, and why? It is an important problem and it should be examined at the clinical level. There is no evidence of any program which has shown that if you identify a woman who is in a domestic violence situation you can change her outcomes, short of a legal sanction. At the moment, having an intervention where you identify people and are not giving them any changed outcomes is probably unethical. They have opted for that in the UK or recommended that. It is a very good review and I recommend reading it. That is not arguing for or against the issue. That is trying to get a sense that a population program has to be of value and should not be done just because it is the right thing to do. If you add it into a system that is already overloaded, you just make it harder to detect the families that have problems.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you are being consistent, you should argue that the rescue model that DOCS is using is the wrong model anyway.

Dr NOSSAR: I remember that many years ago I sat in on a DOCS senior executive group that invited me to comment more or less on future planning. I asked the question—and then I sort of got the impression that I was the wrong one in the room—"What is the objective of DOCS? When do you know that you have reached your end point?" It was like a strange question. It was doing good things, was what the point was.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The end point would be that they will never reach the end point because you will never get rid of child abuse entirely.

Dr NOSSAR: That is what I said.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And anything DOCS do will lessen it.

Dr NOSSAR: That is what I said. There are two different propositions vying. There is one about reducing abuse rates, which is what Families First should be and what home visiting can be, and there is another one about managing. In fact, the reason I think it is important to specify them is because there are some families who are going to kill their kids and you will never know about them. They will continue to turn up because there is no warning and out of the blue they will kill their child. So is the objective averting all death? That is not going to happen. Is it improving children's outcomes? There is nothing in the literature that suggests that children who have been detected, other than not being dead—which is not a bad outcome—have better outcomes. Those children still have mental health scores which are terrible and they still have life outcomes that are terrible. If that is the outcome we are after, we really do need to focus again on what we are doing. I am not saying that we should abandon DOCS or child protection. I guess I am trying to put the proposition, "Let us be clear

about what we are doing and let us be clear that what we want to achieve" so that it makes the job doable for those workers.

The Hon. IAN WEST: But it is impossible to measure if you have not got indicators or objectives.

Dr NOSSAR: Yes. It makes me sound terribly obsessive, but I guess that my desire would be that it is not a question of resources, although there is a resource issue. My worry would be that if you do not have your systems set up so that you can achieve something, you can triple your quantity of resources and still not have any desirable outcomes.

CHAIR: When you say that there is not much point detecting if you cannot improve outcomes, are you talking there about children where abuse or neglect is detected and they stay with their families, or are you talking about them moving into out-of-home care?

Dr NOSSAR: I am not even thinking about that. I am trying to say, "What is it that improves this child's outcome? What is the evidence that says that we can improve the child's outcome?" That evidence is frightfully thin, by the way, despite what everybody says. In fact it is interesting that I had an argument from one of the randomised control studies of a group. It was probably not the best method. Consensus is what they are aiming towards, and it worries me enormously when I hear professionals talking about consensus. I am not being sarcastic because it is a very risky way of dealing with the world.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We all agree: We are all fine chaps?

Dr NOSSAR: That is right. I have seen that in many instances. There is an issue about the sudden infant death syndrome [SIDS] prevention. We were talking about laying babies on their backs to reduce SIDS or cot death rates. Why do you think that parents laid their babies on their tummies in the first place? No culture in which I have worked in the world lays their babies on their tummies, except for ours. We taught them to do that. I came from a generation which was telling parents that by laying their babies on their tummy, you reduced the aspiration rates and all sorts of other good things happened such as the babies slept better. As a matter of fact, in intensive care units, they used to put little premature babies on their tummies and their apnoea rates went down and their oxygenation rates improved, so it must be better. So we extrapolate from a clinical situation to the population level that what is true for the premmie kills babies at the population level. I have never seen any clinical service put up its hand and say, "Sorry for the last 2,000 or 3,000 children who died in Australia. It was the wrong advice." Nobody is going to do that. Do you understand what I am saying?

CHAIR: Yes.

Dr NOSSAR: It is a clinical intervention. There are some very good papers on defining that you have to be very cautious about population level advice as opposed to clinical level advice.

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CHAIR: But that does not help the DOCS worker faced with the choice. There is a notification, they have to visit the family.

Dr NOSSAR: No. I am talking about their management and the policy sector. Evidence-based policy has to be careful.

CHAIR: I asked a question about whether you draw a distinction between children staying with their families or children moving into out-of-home care. The evidence that is around about outcomes from out-of-home care is pretty clear.

Dr NOSSAR: Actually, it is not. The evidence is strongly the other way. Control studies yes.

CHAIR: Stronger in favour of children staying with their families?

Dr NOSSAR: It depends hugely on the families. A recent study looked at the outcomes for children whom they have been trying restitution as opposed to permanent fostering out or adoption. Those kids who were permanently fostered out did better than those they were trying to reinstate with their families on a whole range of measures.

CHAIR: But you also have to check whether it is relative or kinship care, et cetera?

Dr NOSSAR: I am not even trying to second-guess that because there are people who have an expertise about this who should produce good, clear evidence about policy. I am not relying on what we feel or believe or hope. I see an awful lot of individual experiences generated into system-wide changes, and that is dangerous.

The Hon. IAN WEST: Could you clarify those figures for me? Was it 85,000? Where did you get that from?

Dr NOSSAR: The State birth cohort is 85,000 children born in the State.

CHAIR: And 12,000 for south-western Sydney?

Dr NOSSAR: Yes. It is about 85,000 for the State.

CHAIR: You would not make any specific comments about the child protection area in terms of the mechanics of it or what you see?

Dr NOSSAR: No, I would not try to. I would plead for more clarity of purpose, more reliance on the evidence. I worry about good intent. I recently read a paper that says good intent is not enough, and I think that is true. Good intent can be good outcomes and you can have devastating outcomes. People cannot put their hand up and say, "I thought it was good." My concern would be that early intervention should be more focused on what works. As I said, early intervention is different from child abuse prevention. We talk in the language as if they are one in the same, but the evidence would suggest that they are not.

CHAIR: What should come out of our inquiry into early intervention for kids with learning difficulties? We keep finding ourselves talking about early intervention in a global way and not just limiting it to kids. As you say, poverty is a major problem.

Dr NOSSAR: This community has to understand the critical importance of early childhood development. We hear a lot about it, but people still relegate it to being one of those things you do if you have space, time and resource.

CHAIR: How do we change that?

Dr NOSSAR: The economists are starting to understand it. What worries me is that all the helpers cannot. Economists understand it because it makes a better buy to have some demand-side interventions as well as the supply side. We do lots on the supply side: more therapists and more workers, and we are trying to do more. We are doing remarkably well on demand control. Rationing is the only thing we do, and that is not very good.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that early intervention is the wrong name, because it suggests rescue when you are saying population health is the only way to go?

Dr NOSSAR: Yes.

CHAIR: We were actually given an inquiry that was much more specific. We have given ourselves the opportunity to sometimes be highly specific about learning difficulties that can have fairly clear labels put on them. Sometimes those labels may not be appropriate. But if you are talking about specific groups of children then early intervention is not such a bad phrase.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Doing DOCS at the same time tended to slant our thinking. We are kind of doubling up.

Dr NOSSAR: One of the hand-outs I have given you is a review that a colleague and I did of looking through the literature of what works to improve child health development. That applies if there is a learning disability. There are all those broad social interventions rather than—

CHAIR: Breast-feeding, smoking, et cetera.

Dr NOSSAR: We have given you some of the references that are attached to that. If you come out of this inquiry getting government to understand that ensuring programs that work need investment just because they are the better buy, in a sense it is the better buy that is more important than the worth of them. Lots of things have worth, but these things work.

CHAIR: We will have to make the Treasurer the Minister for early childhood.

Dr NOSSAR: I would be much more comfortable with that.

The Hon. IAN WEST: Let us assume for the moment that I am Michael Egan and I say to you, "I have swallowed that point of view. I am convinced that is the correct way to go." But you are putting to me I need to go the whole way because if I go halfway it is not good enough. The figures that you are quoting are roughly 10 per cent of what is needed. Family's First is, rather, putting in 10 per cent of what you say is needed, that is $250 million.

Dr NOSSAR: That is the top end.

The Hon. IAN WEST: But you also say to me, "Don't put half in. If you don't put the lot in, it won't work." I have got to stage one, I am at the starting barrier. I accept that prevention is better. But unless I go the whole hog it will not work.

Dr NOSSAR: I would argue that it is probably less likely than that. I would be prepared, first, to establish a system that does not exist. We are really using Families First money to build the system to make that possible. Second, I would support the idea even if you wanted to go half the way. I have never found a treasurer or an accountant who is not happy to lock in a five-year valuation with an option to close because if you did not do that you would have yet one more program added to your bill with that end expectancy. My concern is yes, by all means, go halfway but then almost lock in a five-year evaluation that you follow up. There are enough outcomes on home visiting within the first two years to tell you that you are on track, so you should start to see mothers' breast-feeding rates improving and a whole range of things. Micro measures do not need to change for kids. But you build that right up front, not as an option that you bid out to academics later on. This is the contingency: you get the money then in five years you are expected to demonstrate this.

CHAIR: Sure Start has done that and Families First—

Dr NOSSAR: Sure Start talks that, but when you talk to them it has not started. I asked how you could possibly have a program that is rolling out across these centres that says you have to prove that smoking rates go down when they do not even require the communities to engage with the mothers antenatally. They said this is not an accountability measure, this is the measure to indicate to communities that they should look at getting involved with mums. That worries me as a program because that means that some will pick it up, some will not and some will do what they want. It comes back to your question about how you roll it out. I do not mind if people do things slightly differently in their different areas, just so long as they are all accountable to the same set of outcome measures, which is reduced SIDS rates, reduced mothers smoking rates and improved breast-feeding rates. If they can deliver those outcome measures doing something slightly differently, I don't have a problem. We have had the same experience here. People have said: Let's all do it differently in each of our parts of south-western Sydney, and we have let them do it differently. But I have said, "As long as the measure is going to be the proportionate birth cohort that you see within two weeks." We are already seeing huge variations.

The Hon. IAN WEST: Have you given us your concept of the measure?

Dr NOSSAR: Which measure?

The Hon. IAN WEST: That you are talking about now?

Dr NOSSAR: Within two weeks of delivery?

The Hon. IAN WEST: You said as long as the measures are consistent.

Dr NOSSAR: The outcome measures, yes. Within the Families First project there is a set of outcomes that are derivable. It is in the material from Families First.

CHAIR: The other way of doing it is to close down all of the programs that do not work and divert the money to prevention.

Dr NOSSAR: I have been around politics long enough to know that you do not do that. What you do is deliver something that works and then review it in five years.

CHAIR: Where do not have to nibble away at existing non-efficacious programs?

Dr NOSSAR: Nothing in my experience tells me that that is possible. DOCS is replete with programs that it has given pilots to, not because they have had to but because the Government wanted to. It is both political sides. You can never touch them again because they linger on regardless of efficacy, what happens to them or even when the community wants to close them down.

CHAIR: There are things, for instance, that have not had their funding changed for 17 years, and that is largely for that sort of reason.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Lots of pilots get killed, even if they seem to work.

Dr NOSSAR: I could find lots of examples of things that are happening and you would ask me why. The reason is that 10 years ago they got funding and it stays there. They put up a submission every year.

CHAIR: The political answer to your question is that you cannot kill of anything quickly.

Dr NOSSAR: No. What you do is develop something better and then, as people's interest wanes, you can readdress that. My concern is that we spent billions down the tail end and that is the inverse relationship to where the efficacy is. That worries me enormously.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No-one looks at the quality.

Dr NOSSAR: No, they do not very much. But it is not just that, it is just the capacity to make a change. One that will come up in this State and this country is obesity. We know that childhood obesity is growing. Diabetes is coming up as a consequence of that, type II. Nothing in literature suggests that running clinics for obese kids will ever address obesity rates. It is the food we eat. It is the exercise. It is the balance between input and output. That is a social force thing. There has been an elegant study in the United States where they got a whole school to shut off their TV. I do not know how they did it, but they did. The parents have to agree, the kids had to agree and everyone agreed. At the end of the month they could demonstrate obesity rates falling in that community.

CHAIR: Is that because the TV was off, so they had to run around instead?

Dr NOSSAR: That, and it is what you see on TV. They probably had to play. I have no idea. To me there is a published intervention that works, yet I see all the emphasis on obesity clinics and that is a classic example of where we will get this attention. It will be around obesity and diabetes. Population interventions require population interventions. No amount of pretending that clinicians give more money will change that.

CHAIR: That is a medicalisation of something that is not, in its origins, a medical problem.

Dr NOSSAR: In the last two months the *British Medical Journal* had this elegant editorial that talked about medicalisation of life problems. It is a very real risk. It makes a nice trite basket to put things into. We might even pretend that we have a treatment we can fund.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We can criminalise them, that is the other alternative.

Dr NOSSAR: Neither of them work. That is why we have the billions down this end.

CHAIR: Thank you for a most stimulating morning. You gave fantastic evidence. Given that we have covered so much ground, we may need to get back to you. Our secretary may want to talk to you more about the nature of this new department.

(The witness withdrew.)

(The Committee concluded at 12.26 p.m.)