HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Indigenous health

HOBART

Monday, 9 February 1998

OFFICIAL HANSARD REPORT

CANBERRA

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE AND FAMILY AND COMMUNITY AFFAIRS

Members

Mr Forrest (Chair)

Mr Quick (Deputy Chair)

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

Matters referred for inquiry into and report on:

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

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

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

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

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

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

WITNESSES

LYPKA, Ms Barbara, Acting Director, Corporate Strategy Division, Department of Community and Health Services, GPO Box 125B, Hobart, Tasmania 101

REID, Ms Debra Ann, Policy Officer, Aboriginal Health, Health Advancement, Health and Wellbeing Outcomes Unit, Department of Community and Health Services, GPO Box 125B, Hobart, Tasmania 101

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Present

Mr Forrest (Chair)

Ms Ellis	Mr Allan Morris
Mr Jenkins	Mr Quick

The committee met at 11.05 a.m.

Mr Forrest took the chair.

CHAIR—This is the second day of public hearings on the committee's inquiry into indigenous health. We commenced our inquiry last week in Canberra. This inquiry was referred by the Minister for Health and Family Services, Dr Michael Wooldridge with the support of the Minister for Aboriginal and Torres Strait Islander Affairs, Senator Hon. John Herron in June last year. The committee is looking at the improved coordination, planning and delivery of indigenous health services against the background of past structures for the delivery of health services to indigenous populations.

The committee is somewhat frustrated, like many others, that there have been countless inquiries of all sorts yet we still have this dreadful and shameful situation where there has been little improvement in Aboriginal health. The committee is resolved, in a very bipartisan way, to make some progress on this matter. Today's hearing in Hobart follows a full day in Canberra on Friday, where we had an opportunity to talk at the Canberra based end of things.

For my own part and that of the other members, it would be very useful at this very early stage for us to get a good handle on what direction we might take. One thing we certainly want to do is look at the grassroots end of things—look at the way that things operate on the ground—look for good models that work and seek ways to facilitate that with real urgency. What we will do at this early stage with the discussions and exchange we will have today is build on that.

Clearly, there is a very definite problem in remote areas. There is the usual issues that relate to federal and state relationships. It all adds up to frustration in achieving progress. I have already indicated on previous occasions that we want to work in collaboration and cooperation with Aboriginal and Torres Strait Islander people. We hope that we can secure their trust and confidence and that we will, at long last, recommend something at the end of the day that will make concrete progress.

[11.07 a.m.]

LYPKA, Ms Barbara, Acting Director, Corporate Strategy Division, Department of Community and Health Services, GPO Box 125B, Hobart, Tasmania

REID, Ms Debra Ann, Policy Officer, Aboriginal Health, Health Advancement, Health and Wellbeing Outcomes Unit, Department of Community and Health Services, GPO Box 125B, Hobart, Tasmania

CHAIR—I welcome representatives from the Department of Community and Health Services in Tasmania here today. I will introduce our committee to you. Mr Harry Quick, the member for Franklin, is probably well known to you, being from Tasmania. Harry Jenkins is the member for Scullin in Victoria. He has chaired this standing committee before his lofty appointment to deputy Speaker in the last government. Annette Ellis is the member for Namadji in the ACT. Allan Morris is the member for Newcastle. He was the previous chairman of this standing committee under the previous government. We all have an active interest in different sorts of ways in health delivery. The committee was very active last year. A couple of major inquiries were held. We are now in a position to put a really good effort into this inquiry.

There are a few formalities that I need to work through, if you will just bear with me. Before we proceed, I wish to point out that whilst this committee does not swear its witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as proceedings of the House of Representatives itself. Any deliberate misleading of the committee may be regarded as a contempt of the parliament. Since the publication of volumes of submissions in connection with the inquiry, the committee has received a submission from the Tasmanian Department of Community and Health Services dated 5 December 1997. It is proposed to incorporate this submission in today's transcript of evidence. There being no objection, it is so ordered. Leave granted.

The document read as follows—

CHAIR—That then puts your submission on the public record. You might not feel the need to read through it. However, either or both of you might like an opportunity to make an opening statement before we proceed to some questions on the detail from committee members.

Ms Reid—In the introduction, we mention outcomes that we have identified and know very clearly that we need to be addressing. One thing we take very seriously is the very clear identification of the needs of Aboriginal people within Tasmania. On numerous occasions in the past, Tasmanian people have quite clearly stated that their issues are different from those of Aboriginal and Torres Strait Islander people on the mainland. It is important to ensure that we are listening to their needs.

It is important that we deal with it in a way that takes into consideration their culture and the issues that have occurred in Tasmania in the past. That comes about through ensuring that there is a consultation process they are agreeable to and that it is not just an imposed process that is developed from our point of view. We need to clearly negotiate it. We work in partnership with Tasmanian Aboriginal people in identifying their needs. Working in partnership with the Commonwealth is something that the state is quite clear about. It is something that we have been negotiating with the Commonwealth for a substantial time with regard to the framework agreements on Aboriginal health. Those agreements give us the opportunity of not only working with the Commonwealth but also with the community sector in this state.

CHAIR—We understand that that framework agreement is now signed by the Tasmanian government.

Ms Reid—Yes.

CHAIR—Is there any reason why there was a delay and it took longer to get signed?

Ms Reid—There was a period of delay after we had completed our negotiations. The document went through the relevant processes here within government. Some very minor comments on the document went from one of our officers here. Basically, the community sector here had sat back and waited for the official documentation to come back. We have only heard within the last couple of months, when things started to move again, that unfortunately the hold-up was due to discussions within ATSIC internally within this state and in their central office in Canberra. The department was very supportive, as was the government, that the document be signed.

Mr QUICK—How many people in the Commonwealth department have responsibility for liaising with the state department for Aboriginal health?

Ms Reid—At this time, two staff members are working with us. One director is

employed to do that direct negotiation on Aboriginal health. My understanding of recent times is that there are now two people doing that work.

Mr QUICK—In the state Community and Health Services department, how many people are responsible for Aboriginal health?

Ms Reid—In the department, I am employed as a policy officer. Periodically, other staff are employed within Aboriginal health to assist me in the project work. But there are a number of other Aboriginal staff employed within the department in other areas.

Mr QUICK—So there is you. You work full-time?

Ms Reid—Yes, I do.

Mr QUICK—You mentioned other part-timers.

Ms Reid—Project work may occur at this time within the unit. We have a staff member doing work around sexual health.

Mr QUICK—They are employed for a specific, one-off project?

Ms Reid—Yes, they are. For periods of time. That staff member is employed for an 18-month period. There was a contract agreement upon their employment.

Mr QUICK—How much money has been allocated for Aboriginal health as part of this framework agreement? There are two Commonwealth people. Are they both full-time?

Ms Reid—Yes. That is my understanding. With regard to the framework agreement and the allocation of funds, the framework agreement is a structure for us to be working together around Aboriginal health. The allocation of funds as negotiated within the document becomes the responsibility of the Commonwealth and the state, particularly in regard to what transpires within that area. But the state is in the process of negotiating other staff members within areas in the agency to work with Aboriginal people. Those negotiations are still occurring with those other divisions at this time.

Mr QUICK—There are two Commonwealth people and one state person. You say to whoever is in the department, 'We need to do something on sexual health. We will put out tenders and we will employ someone for 18 months to come up with a report which we will take notice of'? Someone else says, 'We need to do something about the health of young Aboriginal people in the community. We will hire someone for six months to do a report'? There is then you plus whoever you 'second' to come up one relevant health issues?

Ms Reid—It may work in that way sometimes but not necessarily all the time. On numerous occasions in this state, Aboriginal people have raised the issue of our constructively dealing with access to services. It might not necessarily mean employing an individual but looking at what is actually occurring within that service area and then how the community has the opportunity to raise with that service area issues of service provision.

The national indigenous Australian sexual health strategy requires that each individual state has to develop its own strategic documents on how they look at sexual health issues within their state. Because the same person was employed at the time the community consultation process was occurring around the development of the national strategy, we are following on and utilising that person again. That person was involved in the information gathering that the state did around the national indigenous sexual health strategy. We are now following on and doing work on the strategic development of a sexual health plan for Tasmanian Aboriginal people.

Mr QUICK—I do not want to dwell on that. The submission says that one of the barriers is access to mainstream health services. It says that Tasmania, like other states, needs to improve the linkages between community and mainstream services, thereby increasing the choices available to Aboriginal people. I do not want to tell you how to suck eggs. However, if we are going to do it properly, how the heck can three bureaucrats within the system cover such a huge range of problems that are obviously facing the Aboriginal community?

Prior to this, we had the Meals on Wheels people talking about competitive tendering, which is another reason why we are here. How do the Aboriginal people access something as simple as Meals on Wheels? We are talking about the preventive side of health. It is not just about delivering a meal; it is also about social interaction and so on. Do Aboriginal people have problems accessing Meals on Wheels? Is there a linkage between the Tasmanian Aboriginal community here and the department with the Meals on Wheels system? I know of the problems with SETAC at Cygnet accessing services and wanting to set up their own within the framework. Is it enough to have one state bureaucrat and two Commonwealth bureaucrats and a limited amount of money?

Ms Lypka—We have to make a distinction between the development of policy and planning frameworks and service delivery. The department has recently, for example, undergone a review. It has adopted a resource allocation model based on improved outcomes. It is looking at ways of investing resources that follow high needs and working that model up. We would like to see people such as Debbie work out frameworks and then the various planning processes, injecting resources in high priority areas and developing service delivery models that are responsive and appropriate. It is not just Debbie and the two Commonwealth bureaucrats who are providing services. They are developing the strategic context within which services are developed.

The department has a history of investing in stand-alone, discrete Aboriginal services where they are required. For example, we have just invested resources in a project in the welfare area, the children services area. There are stand-alone resources to help Aboriginal people access identifying information. A useful thing to recognise about our department is that it has a broad spectrum of services, including housing, welfare and health. We try to integrate our delivery of services to Aboriginal populations. Where we have identified through our planning processes high need, we will tend to dedicate resources to that effort. That is what Debbie is trying to say.

Mr QUICK—I am raising these questions because Denise Swan is the Minister for Aboriginal affairs and Peter Mackay is the Minister for Community and Health Services. We also have the Minister for Education. The whole health issue is a holistic thing. Some health issues might surface at school. Some are to do with inadequate housing and so on. How do we draw in the linkages? We are trying to do this nationally to come up with a template.

If the Aboriginal community and the non-indigenous community of Australia has these services and proper inputs, the health system that we have now should be able to cater for everybody irrespective of individual ethnic differences, be they material, language based or whatever. We do not set up a service for indigenous people and say to others, 'You are aged people but not aged indigenous people, so you cannot access the service.'

Ms Lypka—The issue is efficient differentiation and responsiveness in our service system to deal with the differing needs. That is an issue that we are trying to grapple with in the development of appropriate service models and the better targeting our resources so that we get a more responsive service system.

Mr QUICK—In order to make a value judgment, you need some statistical data. If we asked state departments—this one is not excluded—what have you got, they would have to hunt around for light years trying to find that information. We heard previously about developing a common assessment form across Australia for HACC. It is not compulsory. It depends on who you manage to get whether that common assessment form is used. Are you going to develop strategies to say that someone has a heart attack and they are of Aboriginal persuasion? When they go into cardiac care at the Royal Hobart Hospital, will someone tick a box to say that a 35-year-old has had a heart attack and he is Aboriginal and so, therefore, thus comes another statistic to say that Aboriginal health needs are different from non-indigenous needs? How are we going to draw all that together?

Ms Reid—That is one thing that we are quite conscious of from the point of view of how we go about it and how we plan. It is about giving us the information for just what you have described. At this time in the early stages of our development, we need to be looking right across the board within this agency at our data requirements, such as how we are gathering data and how we can utilise it in service delivery. We are developing our

strategic planning process at this time. The national Aboriginal health strategy was quite a substantial document. It identified a lot of different areas. From our point of view, it is about how we look at strategic planning and service delivery, access to information and utilising it in meeting people's needs and allocating resources. We need to ask whether we are meeting people's needs. Changing health outcomes is something that we are taking into consideration in developing that strategic planning framework. So it is not just a simple thing.

One thing I have realised since working outside government and now in government is that there are documents about what a strategic plan is. There have been comprehensive documents put out before on Aboriginal health. It is using them as a baseline for addressing the issue and as a part of the resource allocation process.

Mr QUICK—But it should be so much easier in Tasmania. We are an island. ABS could tell you how many Aboriginals there are. They could give you their age breakdown. It is probably 6,000.

Ms Reid—There are over 13,000 Aboriginal people.

Mr QUICK—There are 13,000 people who claim Aboriginality. Your department should be able to tell me how many of them are over the age of 65 plus, where they are situated and what their nearest health units are. How many are there in the Huon, how many are there in the channel and how many are in the Glenorchy council area? All that information should be there. Tasmania should have the easiest job of setting up a really cohesive, effective Aboriginal health strategy to deal with the multiplicity of problems.

Ms Reid—In some ways, we have. We are in the process of doing that planning at this time and taking into consideration the gathering of that information and having the linkages with the ABS. But it is about being very conscious of the data systems we have within the agency at this time and across government really.

Mr QUICK—But how sensitive are they to your gathering that information?

Ms Reid—That is one thing that we have been in the process of changing slowly over the last couple of years. When we have asked people whether they are of Aboriginal origin, the responses received in the past have been quite different from each other. When a person is asked whether they are of Aboriginal descent, you will get quite a different answer from when you ask them whether they are Aboriginal. That is one thing that we have been slowly looking at and dealing with constructively in the agency. It needs to be dealt with so that we have information that can be utilised for resource allocation and health outcome change. We are in the process of doing that at this time.

Mr QUICK—Should the Minister for Aboriginal Affairs, Denise Swan, or Peter Mackay or the TAC say of the Aboriginal community, 'In order for our constituents'

health to improve, we need some money'? The Commonwealth and the states are busy chopping the money for health budgets left, right and centre. If you can say that there are 187 people between the ages of 65 and 75 who have diabetics or a heart problem—you have some statistical evidence—you can go the minister and ask for more funding. Whose responsibility is it?

This is the 15th national inquiry into Aboriginal health. The Aboriginal community are getting sick and tired of us coming around asking questions. As the chairman said, we are trying to come up with the solution. There cannot be a solution until we know how many people have a problem and what resources are needed to solve the problem. It does not matter whether it is Tasmania, Victoria, New South Wales or wherever; there is someone saying that we do not have the information. That is why I am asking these questions.

I do not know how many people from Denise Swan's Aboriginal affairs committee are liaising with you or how many people in the housing or education departments are liaising with you. Are the two people in Battery Point in the Commonwealth department liaising with you? They should know that there are, for instance, 2,000 Aboriginal people on Cape Barren Island. Barbara is responsible for making some financial decisions. How could she make them, with all due credit to the efficiency of Barbara, if she does not have some of that information upon which to base a sound judgment?

Ms Reid—Achieving a sound judgment is about identifying the required process. It is required as it happens in a constructive way. As you say, this is the 15th inquiry. One would hope that we do not have another one. It is about having sound processes and how you are gathering that information. There are partnerships between our minister and the other ministers for Aboriginal affairs. There needs to be clear communication about what is transpiring between not only our agency but other agencies across government.

It is also about how we work with the Commonwealth. We want to work very effectively with the Commonwealth and have a clear partnership with them. Within that partnership, we all have identified responsibilities. We need to be very clear about the processes of change. If we say, 'This agency needs to do this and we will do that', that will not achieve change in any way. It has to be planned. We have to ensure that the voices of the Aboriginal people of this state are heard within that process and that we are taking on board in an effective way the health issues of Aboriginal people in this state. We are identifying what their health issues are and utilising that information in allocating resources. If we do that well, we will ensure that effective change occurs.

We do not want another inquiry. I am an Aboriginal person who is not from this state. I am very conscious of the number of inquiries that have occurred on Aboriginal health. The change that occurs needs to be sustainable; that has been very clear since the restructure of our department. What needs to occur within this state is sustainable change. It should not be a short-term fix. That is one of the very clear messages. We need to at

times have workers come on board to deal with issues and to start processes. What is occurring within the department at this time is about sustainable change and dealing with health issues of Aboriginal people in this state in a more constructive way. All the individuals and government agencies, including Denise Swan's portfolio or the education department, have to be a part of that process of strategic planning and bringing those processes into play.

CHAIR—I disturbed your introductory statement with a question, which gave Mr Quick an opportunity to gnaw on the bone. It is good, as it is his state. I would not like you to think you had no opportunity to complete that statement. Are you happy with that? You probably have a lot of things you want to say that might answer questions we already have in our minds. Perhaps we will go back to that process. We will then ask questions.

Ms Reid—When we commenced negotiations with the Commonwealth about how we identify, plan and address in a constructive way the Aboriginal health issues within this state, we aimed to ensure that the Aboriginal community were at that table. We made very clear statements that it was a process that we wanted them to be involved in. We also acknowledged our responsibility for Aboriginal people and their health issues within this state and how we move them forward. We are very conscious that a substantial amount of the health data on indigenous people within this country has been the responsibility of the Commonwealth. Within 12 months of the commencement of our negotiations, a restructure of our department occurred. The restructure of the department has ensured that we address Aboriginal health within this state constructively. Our agency has been placed within health advancement, and health advancement is part of the health and wellbeing outcomes unit. Within that unit, Aboriginal health is one of those areas.

There is also the information and analysis people. Therefore, there are people in the agency who have the responsibility of advising and assisting in the development of data requirements for the agency. We also have a research component. That offers us the opportunity to identify health needs through a process that is acceptable to the community. When I was addressing some of Mr Quick's questions, I was trying to state that they are processes that we are taking on board at this time. Where we are located gives us the opportunity to deal with that. Even though the department is quite a large department, it offers us opportunity. Housing is included in it. In the last 12 months, in conjunction with Denise Swan's office of Aboriginal affairs, we have participated in the process of looking at Aboriginal people's housing needs within this state. We recognise that we have that responsibility and that we need partnerships to ensure that we are addressing those issues in an effective way.

Ms Lypka—I will endorse those comments. It is probably important to note the emphasis that we have placed on health gain in restructuring and reordering the department and its policy framework. The health and wellbeing unit is probably unique. It monitors the health status of the Tasmanian population. It has the capacity to evaluate alternative approaches to service delivery and service delivery models in order that we can

invest resources in the way that best promotes the health status of the Tasmanian population.

This may not be known to you, but Tasmania has, after the Northern Territory, the second lowest health status in the nation. It is predominantly of concern in rural areas. We have a very high aged population. We are concerned to do something very pro-active to improve the status of the population's health. We are looking at ways of linking our strategic planning processes and our resource allocation models directly to improving health outcomes. That is probably unique.

In other states, you will probably find that there is a separation between old notions of health goals and targets and what is the department's planning objectives. Here we are looking to link the two; that is, what particular activities promote the greatest health gains and where we should invest our resources. It is a really important approach. Within that, Aboriginal health, as Debbie says, is a major consideration.

Mr ALLAN MORRIS—Your submission does not go to a great deal of depth; that is not meant as a criticism. I want to probe it a bit further. In other submissions, we have had a couple of things come forward from the Aboriginal organisations, such as the importance of the linkages and the difficulty of getting funding of a non-health nature to educate people about health programs. They are saying that the cuts that have been felt are being felt in the areas of communicating health agendas and programs and making facilities available. That has been very bad. I am interested in whether that is the case in Tasmania.

Secondly, in your submission, you talk about medical students. The ATSIC submission quotes a study in 1989 from the University of Queensland, where 90 per cent of the medical students at the time felt that Aboriginal health problems were the fault of Aboriginals. In other words, the community perception was that Aboriginal health is the fault of Aboriginals; it was a blame-the-victim mentality. I am curious how those things play in Tasmania. Firstly, have there been cuts to linkage programs in education, not necessarily funded by health but by other areas? Is there a concern about that? Secondly, is that perception about Aboriginals creating their own health problems true? We do not blame anybody else for their health problems. However, if an Aboriginal is sick, we have this perception of blame. Is that true?

Ms Lypka—I do not know of any direct cuts to Aboriginal education programs as such or prevention programs.

Mr ALLAN MORRIS—These are mainstream programs being available but Aboriginals not knowing about them.

Ms Lypka—Not being able to access them.

Mr ALLAN MORRIS—Who funds that linkage? There is not a clear charter. One thing put to us was that there should be a requirement within each department or health budget so that that information is communicated to various people, particularly Aboriginals. There is then actually a pro-active approach.

Ms Lypka—A targeted approach.

Mr ALLAN MORRIS—Because it is not done, are you relying on the community to tell others what is in the system?

Ms Reid—One thing we have been quite pro-active about within the department over the last couple of years is in ensuring that when funding is advertised, we are in direct contact with the agencies. We ensure that any relevant papers are sent to all the Aboriginal organisations around the state. An example of that concerns the health promotion dollars that are available within this state. A general advertisement is placed in the press with regard to that and submissions are called for. We have had negotiations in that area and have asked for the information that is circulated. It is then circulated to the Aboriginal organisations within this state. That is what has been occurring. We have been slowly able to negotiate for that information. It has been one thing that we have taken on board. In the time I have been in the agency, any advertised information with regard to funds available for education or prevention programs is given to Aboriginal organisations within this state. An opportunity is then there for them to submit for those funds.

Mr ALLAN MORRIS—Culturally appropriately?

Ms Reid—We offer to assist them in the development of their submissions. That is one way that the unit has been working with the Aboriginal organisations if they have concerns about the structure. Because there is a standard format with regard to submissions, we assist the organisations in negotiating in those areas and dealing with slight delays in submissions coming in. It is a process that we have put in place over the last couple of years.

Ms Lypka—It is important to recognise the role of the Aboriginal health unit as a bridge in that regard. It can convert bureaucratic information to the community and back the other way. It is a good translation and advocacy service.

Ms Reid—We have been quite pro-active in the last couple of years in highlighting to people that those funds are available to them as a community organisation within this state.

With regard to the medical school and medical students, we have been negotiating with the medical school here in the last couple of years over what is happening. It has come about because the medical school is approaching us to be involved. They were asking how to go about it. We said at that time that we were quite happy to assist them

and talk about the people they needed to write to and involve. Over the last couple of months towards the end of last year, when the department here was successful in receiving one of the new funding grants that the federal health minister put forward for rural health, we made it very clear that we were quite happy to act as a resource in that area and to advise them about people they needed to talk to and relationships they needed to build up. There is now direct communication with the person coordinating that for the medical school in rural health. They now have direct negotiations with the community based health services in this state for their participation in that area.

Mr QUICK—That sounds fine. I do not want to be negative. However, the Dover community, which has a large Aboriginal population, has trouble getting a doctor. The last doctor it got came from Scotland. It is fine to liaise with the 36 students who are going through the medical school here in Tasmania and developing all these wonderful strategies. However, if none of them ever goes out and services the remote parts of Tasmania, how effective is that? All they are doing is practising medicine in Hobart, Burnie, Devonport and Launceston.

Tasmania is not unique. The chairman deals with remoter areas than we could ever dream of. We then have Western Australia and New South Wales. The Commonwealth department says, 'We will give you a grant. You can then do this, and that will be wonderful.' But the people who get the grants never go out and practise in the area. How do we say, through the Commonwealth and state governments, that if you are a recipient, you have to work with the people you are talking to?

Ms Lypka—You have to see the problem in the broader context. What Debbie said about the medical contact needs to be set in the memorandum of understanding that we have developed with the medical school about better targeting and skill development regarding the health needs of the Tasmanian population. That includes training in rural hospitals. It is about setting up divisions of rural medicine in places like Scottsdale, for example, where doctors can do some training and live in so that they can become familiar with issues around rural medicine. Perhaps given that skill development and understanding, they will be better attracted to working in those sorts of locations. We have to look pro-actively at packages that attract medical practitioners to those areas. That is some of the work that we are currently doing.

Mr QUICK—The Commonwealth government gave incentives to doctors to go there. But, for example, in my electorate of Dover, the only medical practitioners we can get are from overseas. Aboriginal health problems are as foreign to them as any you could ever dream of. How do we go about addressing those problems?

Ms Reid—In the course of discussions with the medical school and rural health, one issue that has been raised is how the teaching is structured at this time. It is very limited with regard to access to information about Aboriginal health issues. We have said to them that we are quite happy to work with them. We have encouraged them to have

contact with the health service and said that they need to be an important player. But that is not going to address the issues that you are talking about. It is a long process of changing how training occurs for doctors in this country, realistically.

CHAIR—It is a much broader issue.

Ms Reid—It is.

Mr QUICK—One of the key points in your submission under (c) mentions the identification of the specific health needs of Aboriginal people in Tasmania. Can someone give me an A4 sheet, double-sided listing the specific health needs of the Tasmanian Aboriginal people? Is it in dental care, aged care or the health problems of young people? Is it diabetes or heart disease? What are the specific health needs of Aboriginal people? We have to come up with recommendations to the minister. Further on in your submission you say:

There has not been any significant research into the health status of Aboriginal people in Tasmania in a general sense

You also state:

Tasmania supports the need for identified research studies on the health areas of particular concern to Tasmanian Aboriginal people

If we asked you how much you need, how many people you need to employ and how long it would take you to identify the specific health needs of Tasmanian Aboriginal people, what would you say?

CHAIR—You said earlier that Tasmania's situation was different from the mainland situation. I am interested in knowing how and why it is different. I am familiar with Victoria and the remote areas. What is different in Tasmania? Answer that in the context of Mr Quick's question.

Mr QUICK—I am asking this because we are an island. If we cannot do it in Tasmania, the rest of Australia has no hope in the world. What are the specific health needs of Aboriginal people in Tasmania?

Ms Reid—We do not have that definite information with regard to the identified needs of Aboriginal people within Tasmania. With regard to how we go about that and how we gather that information, one of the things that I would not like to participate in is a process where it becomes a situation of what occurs within that. It is important in identifying those health needs that the Aboriginal people within Tasmania have an opportunity to be the major players in that process. They have to be a major player in how they want those issues dealt with in a constructive way. It is one of the things, as I said to you earlier, that we are in the process of dealing with.

If there were a wish list of how to deal with it, and you were about to recommend what needs to happen in this state, it would be about having realistic financial support from the Commonwealth for identifying some of that information. We can do some of it with our processes and within our budget. However, if the Commonwealth were feeling very generous, it would be greatly appreciated.

Mr QUICK—But what about something as simple as SIDS? If we rang the Menzies Research Centre today and asked what percentage of the SIDS deaths in Tasmania are related to the indigenous community, I am sure that they could give us that information. I am not trying to be pedantic. We are trying to come up with a solution. I will ask the same questions in every state we go to. How can we address the problem if we do not know what the problem is and what number of people are involved? If dental care is a major health problem for the indigenous people in Tasmania, we ought to know that. When all people complain about the inadequacy or success of the dental clinic at Newtown, we will know whether that is a problem.

Ms Lypka—I have a copy of something called *Community profile*, which is a publication of the health and wellbeing unit. It goes to what we were talking about earlier. This begins to look at the health status of the Tasmanian population so that we can inform our planning and resource allocation processes with appropriate data about where our health needs are occurring in the Tasmanian population. You have to appreciate that this is an iterative process. There is no one point at which you can capture all the data that you need about the population's health. Aboriginals within that process will be targeted as a high priority need. We will build on the baseline data, begin to differentiate it according to need, including the needs of the Tasmanian population, and plan our services accordingly. That is probably the answer to your question. We are in the process of developing it.

Mr QUICK—How many people are in your information and analysis section in the department?

Ms Lypka—How many people are in your health and wellbeing unit?

Ms Reid—Within the health and wellbeing unit overall, there are about 20 to 22 staff members. In the information and analysis area, at the moment, there are four staff. I understand that a part of how they function involves bringing in contract staff.

Mr QUICK—If we took that information and related it to ABS census areas, could that be easily achieved?

Ms Lypka—Easily. It is the basis of our planning.

Mr ALLAN MORRIS—It is part of the framework?

Ms Lypka—It is part of the health and wellbeing framework.

Mr ALLAN MORRIS—You missed the Friday hearing on the Commonwealth state framework.

Ms Lypka—It is not part of the Commonwealth-state framework. It is part of our state program.

Mr ALLAN MORRIS—It is compatible. You do not want data from any one state. We have not been able to compare data from state to state or with the Commonwealth with the ABS.

Ms Lypka—I need to emphasise that this is a structured approach for dealing with investing resources.

Mr ALLAN MORRIS—We find that it is a question of identification. Some people do not identify. What is the state's response to that? How are you handling it?

Ms Reid—When people are presenting for services and filling in their first contact form, we ask whether they are Aboriginal. We try to get away from the format of the ABS, which is, 'Are you of Aboriginal origin or are you of Aboriginal descent?' You get very different answers because of that format, so you will get very different information. Aboriginal people have said continually, 'If we get asked about our descent or our origin, we will not answer.' They feel very comfortable when asked if they are an Aboriginal or Torres Strait Islander.

Mr ALLAN MORRIS—There are different ways to do it. One way is to give a person a form. They are more likely to fill in a form than answer face-to-face questions because that is challenging. Their cultural mores may be different in terms of identification and so on. We would all be aware that it is not just Aboriginal but also people from non-English speaking backgrounds who have this problem. Is identification made in the public service in Tasmania? Is it known?

Ms Reid—Within employment, for example?

Mr ALLAN MORRIS—Does the state government have a policy of identification of background or whatever?

Ms Lypka—It does in employment forms.

Ms Reid—In employment forms, yes. The forms you fill in when you are first employed contain that information.

Mr ALLAN MORRIS—Do you have any further thoughts on methods or modes of culturally appropriate ways to encourage identification? If we make it compulsory, it is intrusive in terms of privacy. On the other hand, if we do not ask the question, we do not

get good data. That is one area of difficulty across the country. It will vary from town to town and state to state.

Ms Reid—As a worker in the government sector—I know other workers are doing it as well—I tell Aboriginal and Torres Strait Islander people why it is important for them to fill in those forms. If they are asked the question, it is important for them to ensure that the information is given. It affects service delivery and resource allocation. It has been a process that we have continually been involved in.

Ms Lypka—The important point is that the Aboriginal health unit encourages people to register, if you like.

Mr ALLAN MORRIS—I was trying to get to that.

Ms Reid—We say to them, 'We know how questions are sometimes structured about descent or origin. We are trying to address that.' It is about being clear that we would like it that taken off. We are having discussions with the ABS about how they write the question.

Ms Lypka—Is that because in the Tasmania the issue of origins is contentious? Is that what are you saying?

Ms Reid—Yes. The issue of origins is contentious. With regard to Aboriginal people in Tasmania, whether a person is Aboriginal or not is quite contentious. That is why we have tried to ensure that we have listened to Aboriginal people over how they would like those questions asked. We are trying to deal with that in an effective way.

Ms ELLIS—I have one question. It is a little provocative, but I am a bit alarmed and I need you to explain something to me. I am a new member to parliament. I have not been involved in any of the previous 14 inquiries into Aboriginal health. We all know that it is a problem. That is why we are having this inquiry. It is something we need to deal with as a community. I am alarmed to hear you say that right now you cannot tell me what the health needs of Aboriginal or indigenous people are. I do not understand why we do not know. I know what you are attempting to do from the department's structural side. I applaud it; I am not criticising it. I am not looking for figures such as 13.25 per cent dental problems and 27.17 per cent diabetes problems. However, that answer was too simple. I cannot believe that we do not know to any extent what the Aboriginal health needs of the Tasmanian population are, and that was basically your earlier answer. In 1998, after all the history and inquiries, we do not know. The need exists for you to do this in the department. It is an acknowledgment, but it must be based on something. We must know more than that.

Ms Reid—There is some very limited information from studies that may have occurred within Tasmania previously. However, there have not been any substantial

studies of the health status of Aboriginal people in this state.

Ms ELLIS—I will interrupt you for a second. If that is the case, have we tried a non-academic approach? That is, has anybody bothered to go out and speak to what I imagine would be grassroots, shopfront indigenous community workers around Tasmania, who must have contact with these communities at some point in some way to give you an indicative answer, if you do not have the scientific information?

Ms Lypka—The question is what we know about Aboriginal health.

Ms ELLIS—At the moment, you are telling me nothing, and I do not believe that. Is there any evidence, be it anecdotal, scientific, academic or non-academic? You must know, but you have told us nothing.

Ms Reid—From the point of Aboriginal people's health status here in Tasmania and from hearing and listening to Aboriginal people, it seems that some of the issues that have occurred on the mainland have occurred here. So there are Aboriginal people who may have heart conditions and there are Aboriginal people who have diabetes. I know a few of them. One difference here in Tasmania with regard to the health status of Aboriginal people is that there are more Aboriginal people living longer here. From what you hear about the written documentation and other studies that have occurred on the mainland, it is a bit of a difference. The life expectancy of an Aboriginal person on the mainland is quite short. As an Aboriginal person from the mainland, I do not have a long life expectancy. Here in Tasmania I know a substantial number of Aboriginal people who are older members of the community. These are people in their 80s and 70s and older. They say that they have lived longer because of the mutton bird oil they had when they grew up.

Ms ELLIS—It very well may be. But we have not done anything about finding that out. It is pretty pathetic as a community.

Ms Reid—The Aboriginal community here in Tasmania has been fighting for their basic rights and the acknowledgment that they are Aboriginal people in Tasmania. The government has made huge steps over the last couple of years. The land bill went through in the last year and a half. It was a huge indication of how the government wants to deal with issues here in Tasmania and recognise what has transpired in the past.

Ms ELLIS—The land bill could be an example of what can enhance the wellbeing and, therefore, the longevity of indigenous people. But we have evidence in Tasmania, from what you have just said, that their health and wellbeing was well advanced before the land bill. A lot of other things may have been proven useful in other parts of this country, if they have been documented. Is it because of the climate or what?

CHAIR—Decent water.

Ms ELLIS—This is the very point I am making. I am not criticising either of our witnesses or the department so much as making a really strong community comment here. As a community, we have seemingly done little or nothing in relation to really understanding the health, be it good, bad or otherwise, of the indigenous population of Tasmania. After all the controversy and reports that have been done, I am incredulous.

CHAIR—It is a question that I was going to ask. We have been spending 20 years on this. The more we exchange with people, the more I can understand the frustration and lack of progress. Last week we were presented with some statistical information of other nations, such as Canada, New Zealand and the United States, on indigenous people's health. Our figures are appalling. Their records start 20 years earlier than our records start. Even after 20 years, we still cannot conclude that when we did X we improved health outcomes by X percentage. I am starting to understand some of the frustrations.

Ms ELLIS—For all we know, the mutton bird oil might have been the greatest thing. Do we need to disbelieve that?

Ms Reid—I want to comment on that a bit further. I do not think it is just the mutton bird oil.

Ms ELLIS—Neither do I. How do we know?

Ms Reid—It is about how they lived within their culture and the limited impact from non-Aboriginal society on their lives. That is how they continue to survive. It is also that they see their health in a very different way from how non-Aboriginal people see their health. It is about the health issues that they have to deal with and not the health problems. They see them as issues within their life.

Mr JENKINS—That comment was very important. I want to slowly but surely get back to it. I am going to sound very pedantic, but I want to get it straight. We are saying that it is not only health needs but health status?

Ms Lypka—Yes. Health and wellbeing is what we are terming it.

Mr JENKINS—On Friday, we received figures about indigenous health at a national level. I took it that these figures were not plucked from the ether; they are either part of ABS studies or other studies. They are not, as part of those studies, subsets that give an indication of the health and wellbeing of Aboriginal people in Tasmania. Yet you are working in a total void. You cannot even pluck anything out beside the anecdotal evidence. I am trying to be very pedantic about this to get it clear.

Ms Reid—With regard to what has happened within Tasmania, the department—

Ms Lypka—We do not differentiate our statistics by either ethnic origin or

nationality.

CHAIR—The figures given on Friday were for Western Australia and the Northern Territory. They dominated.

Ms ELLIS—Dominated or solely?

Mr ALLAN MORRIS—There were three different investigations. The AMA submission pointed out that the figures they were using were only for the Northern Territory and Western Australia. The Commonwealth department figures were patchy and had different figures for different areas and different diseases. They were highly qualified figures on the submission.

Mr JENKINS—I had better look at the ABS study that was released last year and make sure that I know what I am talking about. We have had a short discussion—again, this is not a criticism—based on conjecture or anecdotes, feelings or talking to people. I want to put a scenario that you might like to comment on. The health of indigenous Tasmanians might be better than the health of a subset of indigenous Australians but the health status or health and wellbeing of indigenous Aboriginal Tasmanians is less than the health and wellbeing of the wider community of Tasmania.

Ms Reid—We would not know that.

Mr JENKINS—But you would hazard a guess that it is probably so? I accept that you do not know or that you do not have access to it. You have highlighted something that we really have not talked about. Sometimes we tend to talk about the health and wellbeing of individuals when definitely the literature and evidence we heard on Friday emphasises that we should not only do that in the case of Aboriginal people but talk about the health and wellbeing of the communities. In a way, you have indicated that, to some extent, the ability of the communities to keep together and to do things in a more traditional way has had some effect on health. Likewise, it would probably be the case that, where there has been a greater disruption which has led to other sources of these communities falling apart, there have been greater health consequences. Having said that, I am interested in the linkages between the department and Aboriginal communities. How do you use those communities within Tasmania as a resource in the work that you are doing?

Ms Reid—We have tried to maintain extremely informal links. A lot of the time, Aboriginal people like to work not through structures and processes but informally. I will explain that by talking to you briefly about HACC services. Fairly recently, HACC was doing a short assessment of their services as a part of how they did their community consultations. They were doing it through the focus group processes. There were major concerns about not involving Aboriginal people. I said that a community organisation here is offering substantial HACC services and that I would give them a ring to see whether

they would talk about it. Despite the lateness of it, they were willing to participate. It required a simple phone call.

You do the usual hello, catch up and then tell them why you are ringing. You ask them whether it is possible for them to be involved. We are very conscious of the process that goes on. I have been very clear in explaining that it is something we feel uncomfortable about. In the department, in the majority of times, I work with Aboriginal organisations by talking to people. A lot of the time fairly recently, most of it has been over the phone and the opportunity to do in-person stuff has unfortunately not occurred.

The department has recently started informal negotiations with the health service on issues of mental health. That has come about through phone calls and written letters, using the processes we need to. We are then able to meet informally and deal with it.

Mr JENKINS—We have talked about giving indigenous people a sense of ownership about what is happening. We have learnt that the concept of ownership in other spheres to do with indigenous people is a very contentious one. Would indigenous people have through that informal process a feeling of some ownership over what was happening on their behalf and for them?

Ms Reid—Yes. They know that they can say no to me. I feel very clear in going back to the people in the department with that answer. I say, 'They have they have said no and this is why. When we think in future about this, this is what they would like to see happen.' Those issues have been taken on board. Being used as a resource within the agency in that kind of a capacity has been quite useful. There are always ups and downs within those environments; you accept that. However, you keep persisting and going back. One of the most important things is that you keep talking to people. For Aboriginal people, that is the most important thing.

CHAIR—You have said that a few times. How do you do that? Do you have a consultative process? You have 13,000 Aboriginal people. I have 80,000 constituents, and it is difficult talking to each of them. How do you do it?

Ms Reid—One of the most important things with regard to access to the Aboriginal community here is, because the organisations have come out of identified need, respecting that they are there and that they are working, supporting and offering services to Aboriginal people within their state. It is approaching them within the first instance and saying, 'This is what we are in the process of doing. This is what it is about for you.' It is about talking through it but then undergoing the processes in the department, such as writing to people.

First and foremost, it is doing it by talking. They will say, 'This is how we want to do it.' Some workers in the organisations may come along to talk to us. Other organisations may organise a community meeting where none of their staff are there, only

community people. There are Aboriginal people I know here and socialise with. If go to community events, people will talk to you. They sometimes ask whether you have fallen off the face of the earth. There are lots of different ways of going about it. It is about using all of them. The first and foremost is remembering that Aboriginal people prefer to do it by talking.

CHAIR—Not writing.

Ms Reid—You make your first contact through talking.

CHAIR—I thank Ms Reid and Ms Lypka for talking to us. I have a feeling that we will come back to you. When I read your submission, I thought that it was a bit bony. I thought that there must be a lot of information to back it up. You have referred to some of it this morning. I think we will have you back as we get a better handle on where we are going. Can you able to give Australia us a of the report you referred to. Thank you very much.

Mr ALLAN MORRIS—I noticed in the weekend newspapers of an inquiry into competitive tendering in western Victoria. There is a report on the tendering of some local government community services and an inquiry is being launched.

CHAIR—At what level?

Mr ALLAN MORRIS—State government level. The government will not talk to us.

CHAIR—Darren will follow it up.

Mr ALLAN MORRIS—There was a report in the newspaper that the state government has initiated a formal inquiry into the tendering processes in some western Victorian area. I did not recognise the names of the places or the councils.

CHAIR—Perhaps we will put some pressure on.

Mr ALLAN MORRIS—If we could put some pressure on, it may be helpful to us.

CHAIR—The committee stands adjourned until a date to be advised.

Resolved (on motion by **Mr Quick**, seconded by **Ms Ellis**):

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

Committee adjourned at 12.20 p.m.