Human Rights for Rural and Remote Communities

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Thank you for the opportunity of providing a keynote address in this important forum. The theme of my talk this morning is human rights for rural and remote communities - health, access and equity.

Australia is predominantly an urban country. However, approximately 29 per cent, or nearly six million people, live outside major urban areas in rural and remote parts of the country. This figure alone underlines the importance of your work and the subject of this Conference. For Australia to meet its human rights obligations the needs and aspirations of these communities must be addressed.

But what are human rights in this context? When most of us think of human rights we think of civil and political rights -- the right to vote, freedom of speech and assembly, the right to equality before the law. In many ways Australia has a pretty good record in these areas. However, when we reflect on access and equity, we also need to consider the other half of the human rights equation, that of social and economic rights. It is in this area that the question of health care is central.

First let me give you a brief overview of Australia's international obligations.

The body of human rights instruments ratified by Australia sets out a very wide ranging code of behaviour for governments - not only freedoms that they must not restrict, but rights that governments must take positive measures to ensure.

These instruments have relevance to almost every aspect of social, economic and public life. They are especially relevant to the rights of those people living in rural and remote communities.

Our international obligations require us to take all appropriate measures to prohibit discrimination in all its forms. Australia has undertaken to prohibit discrimination and to provide effective remedies under a number of Conventions. Some of these Conventions relate directly to those who live in rural and remote communities. For example, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), enacted in Australia in the Act that I currently administer, the Sex Discrimination Act 1984, specifically addresses issues affecting rural women in Article 14.

Article 14 recognises the important role women play in a nation, and their rights to equality:

*States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic*
survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of this Convention to women in rural areas.

*States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women …*

Following this are eight specific areas of women’s rights. One of them, Section b, requires States Parties to ensure that rural women:

...have access to adequate health care facilities, including information, counselling and services in family planning;

But it is the International Convention on Economic, Social and Cultural Rights (ICESCR) that sets out what ratifying countries should do to ensure that economic, social and cultural rights are protected.

At the heart of social rights, set out in the ICESCR is **the right to an adequate standard of living.**

It has been argued that the right to an adequate standard of living is the most central right in the ICESCR. This is because, without some realisation of the right to an adequate standard of living, other economic and social rights, as well as civil and political rights, have little meaning. As one writer points out:

civil and political rights ... may seem rather empty without regard to the economic and social rights (such as the right to an adequate standard of living) which underpin them.

Of course, the right to an adequate standard of living is related to the economic viability of a State to provide it, because it is a claim upon the State. To implement the rights set out in the ICESCR:

• to an adequate standard of living (Article 11),
• to social security (Article 9), and
• to the highest attainable physical and mental health (Article 12),

requires the State to take action that is often very expensive.

But it is a responsibility of government that is very often forgotten in our State, Australia. We have been assiduous in the past about the importance of implementing civil and political rights, and critical of other States who have not been so assiduous. At the same time, we are guilty of overlooking the importance of economic and social rights.

Our ‘blindered’ perception with regard to economic, social and cultural rights is glaringly obvious when we examine some frightening facts about economic and social inequalities in Australia.
Around two million Australians live below the poverty line. 14.1 per cent of our children live in poverty. 20 per cent of indigenous children in the Northern Territory are malnourished, and Aboriginal infant mortality is three times that of the nation as a whole.

Many national studies confirm the growing inequality in Australia.

Analyses based on comprehensive Household Expenditure Surveys are conducted by the Australian Bureau of Statistics (ABS) confirm that the rich have become richer and the poor poorer from the middle of the 1970s onwards.2

A new concept of the ‘disappearing middle’, common to many OECD countries, is increasingly obvious here. This trend has been borne out by numerous studies.3

There is growing international evidence of the costs of increasing inequality. Numerous studies highlight the effects of inequality on a wide range of social and economic indicators. An international study has shown strong links between inequality and poor health. The author of the study concluded:

"National average death rates are so strongly influenced by the size of the gap between rich and poor in each society that differences in income distribution seem to be the most important explanation of why average life expectancy differs from one developed country to another."4

There is also evidence from many countries that economic inequality has especially disturbing consequences for children.

The British Medical Association reports that the baby of an unskilled worker is one and a half times more likely to die than the baby of a manager or professional employee. The BMA points out that this mortality gap is not inevitable. In Sweden, for example, infant mortality rates are very similar for all social classes.5

The issue of children's well-being is especially pertinent to inequality in Australia. The Bread for the World Report demonstrates the parlous position of Australia's children in world terms. This is of particular concern to HREOC because it reflects, in particular, the poverty of Australia's indigenous children. This poverty is reflected in the poverty of all indigenous people.

A 1992 ATSIC survey6 of national housing and community infrastructure found that poor nutrition, overcrowding, poor hygiene and lack of basic services such as clean water and sewerage, contribute to high rates of infectious disease, rheumatic heart disease, respiratory disease, genito-urinary diseases and cervical cancer in indigenous communities.

The data on variations in mortality within remote settlements show that remote indigenous settlements have much higher mortality ratios for a range of causes of death. For example:

- indigenous women are eleven times more likely to die of cancer of the cervix than other Australian women;
• indigenous people are fifteen times more likely to die of rheumatic diseases than other Australians; and

• indigenous people are eleven times more likely to die of diabetes than other Australians.7

These are just a few examples of the very different mortality experiences of indigenous people living in remote settlements. Their extremely high levels of infections and parasitic diseases, for example, indicate the lack of basic and appropriate sanitation in many areas.

Key results of the 1992 ATSIC survey of national housing and community infrastructure help explain some of the reasons why this occurs.

Large numbers of indigenous people do not have a water supply that is maintained to an acceptable standard, many communities do not have a sewerage system and others do not have a sewerage system that is working.8 These results are also graphically illustrated in HREOC’s “Water Report”.

However, all those who live in rural and remote communities suffer particular disadvantages, especially with regard to health care. More rural people experience injuries from accidents, allergic reactions to dusts, herbicides and pesticides and have higher incidences of some cancers.

The 1993 National Inquiry into the Human Rights of People with Mental Illness conducted by HREOC highlighted the lack of adequate mental health services for people in remote and rural areas. In many rural communities these services are non-existent. Services for people with physical disabilities are similarly lacking and the costs of obtaining access consequently very much higher.

The link between social and economic rights, and health care as crucial to both, is graphically illustrated by the disproportionate number of suicides reported in rural areas. This phenomenon is now widely reported, particularly with respect to young men, and has been directly related to the high incidence of long-term unemployment amongst this group. By way of example, in NSW where 27 per cent of per cent of people live outside urban areas, 52 per cent of long-term youth unemployment occurs. HREOC’s report demonstrated how economic conditions and remoteness combined to deny many young people their basic rights including the right to life itself.

The evidence is overwhelming that the social and economic rights of those who live in rural and remote Australia are being breached. This is not a new conclusion. It is one that all of you live with day to day.
During my time as Sex Discrimination Commissioner I have been particularly interested in the rights of women in remote communities. Health care is central to these women's lives and a brief look at history is valuable to enunciate the issues, particularly the role of nurses.

When trained nurses did start arriving in Australia they were faced with diseases in epidemic proportions extending from the late 1830s to the twentieth century. The work was long and arduous and the women evidently carried out their tasks with selfless devotion.

During the goldrush in Western Australia every woman on the goldfields became a nurse in emergencies until typhoid broke out in the settlements. In response to calls for assistance the Methodist People’s Mission opened a hospital at Woolgangie and a government hospital was established in Coolgardie in the 1890s and gradually nurses arrived to treat their patients, often under horrendous conditions. The government hospital was described as:

The most sadly busy place ... a scattered collection of odd buildings with no surrounding fence ... The dispensary, theatre and morgue were stone, the wards corrugated iron set on piles, and a few others of canvas.

... Surgical instruments were in short supply and carpenter's tools were sometimes called on. Sterilizing before an operation usually meant the nurses dipping hands and arms up to the elbows in strong Condy's fluid till they were nearly black, then scrubbing in very strong, hot brine.

... Uniforms and aprons were three inches off the ground, but the conventional cap was not worn. For some protection from sun and sand, nurses wore "any old hats and the bigger the better". Under the hats was "long hair coiled on top of our heads ... like a wet cushion - it was never dry".

In 1909 the Bush Nursing Association was established in Victoria to provide accessible nursing services.

Although nursing services were making their way to the remoter areas of the country, there was still a heavy reliance on untrained women to care in their communities. Midwifery was a common duty undertaken by women in remote and rural areas.

In 1920 legislation was enacted in South Australia prohibiting untrained women from performing nursing and midwifery services. Women in country areas were particularly affected by this requirement.

As described by Daniels and Murnane (1980) insistence on professional qualifications sometimes created problems amongst women in rural areas who were dependent on payment from attending these cases. They quote a letter from a woman living in Wallaroo, South Australia, to the Inspector-General of Hospitals.

Dear Sir,
Having received notice from the Secretary of Children's Welfare ... warning me against taking in maternity cases as I am not a registered nurse I am writing you to explain the state of affairs in Wallaroo at the present time. There is only one registered nurse here, a woman 66 years of age and too old to attend cases, she has a small house and only takes in one or 2 cases per month, there is no-one here that goes out nursing, so what are these women to do ...I have gone to a good deal of expense to make everything as it would be and I am relying on this to keep myself and little boy 12 yrs of age. All day today I have had women calling and asking me, whatever are we going to do, whatever is wrong. I can assure you it is putting them to a lot of worry and it is unreasonable to think of them going to Moonta or Kadina as the Lady Inspector suggested they could do, it is 8 & 12 miles and would cost 10 & 14/- each way and double at night and mean risking their lives besides, if I were not capable of nursing maternity cases I would not undertake the work.

Will you please grant me a License and let me have a reply as soon as possible.

The public image of ‘bush nurses’ is one of selfless devotion, relentless dedication and exceptional competence. In tandem with this is the image of servility and subservience.

I would like to explore these latter images and their impact on remote area nurses.

Some of the ways nurses are popularly described include:13

- the angel of mercy
- handmaiden to the physician
- woman in white
- old maid
- battle axe
- sex symbol

For remote area nurses, stereotyped images and attitudes, and the lack of value placed on the work have paid their toll. Remote area nurses are still expected to carry out their work for love and commitment. Adequate resources, proper training and appropriate decision-making powers are needed to meet the task of providing quality, safe health care.

This has meant that some nurses are expected to undertake procedures which they are not strictly authorised to do. A national study held in 1991 found that there is tacit approval by medical, pharmacy and administrative personnel for remote area nurses to undertake medical and pharmaceutical responsibilities. It is reported that this occurs without the preparation and authorisation necessary to ensure the competence of the nurse, or Aboriginal health worker, and safe care for the client.14

Inadequate support and under-recognition of remote area nurses has also meant that staff turnover is very high.15 I would add that a contributing factor here is the high level of sexual harassment experienced by these women and the lack of any practical mechanism being put in place to deal with this.
For those of you working in rural and remote Australia the costs are high, for you are the very people required to place a bandaid on the wound created by the structural inequality of communities in which you live and work.

Over the past decade or so there has been a much greater emphasis placed on what economists call ‘utility-maximising’ behaviour. That is, there has been a much greater emphasis on the relative cost of the provision of goods and services, rather than on the social objectives of cohesion, social justice and a reasonable standard of living, including that of health care. For rural and remote communities this approach can lead to even further reduced access to services as a result of rationalisation and/or regionalisation programs. These are difficult issues to which there are many answers.

Two of the answers in my view are common to both the medical and human rights communities and it is to these that I now want to turn.

The first of these is special measures. As any healthcare worker knows, in some circumstances particular and special steps need to be taken in the care of some diseases. Thus there are special procedures for dealing with infectious diseases, particularly processes for the admission of minors or those with mental illness and the like. The fact that these special measures exist is not questioned, although there may be endless debate concerning their precise nature and content.

The concept of special measures in the human rights arena is not so undisputed even when it is based on scientific data. The recent debate concerning free Hep B inoculations for Aborigines is a classic example. This was characterised as discrimination against non-indigenous Australians. What was conveniently forgotten was that nurses also receive these free inoculations for the same scientific reason. They are at greater risk personally and it is in the public health interest to limit that risk. It is also a cost-effective way of protecting the public’s health generally. It is my view that there is a crucial role for the health community in explaining such initiatives. The task is not simply one for the human rights community and indeed, in the light of recent debate, much sensible health care could be challenged if left only to be defended by members of the so-called ‘special interest’ groups.

The second concept that is common to us is that of outcomes. Any health care worker knows that despite commonalities of anatomy, health history and the like, people seeking health care must be treated as both individuals and as members of a group (such as women) if good health outcomes are to be achieved. Pap smears are a classic example. They require treatment of women as a group and particular attention is needed should the woman concerned have a family history of cervical cancer or be in an older age group. The reason for this is that epidemiological studies have shown us that for a good health outcome it is necessary to do so.

Human rights, be they civil or political, social or economic, also require an emphasis on outcomes if they are to be achieved. Substantive equality recognises that simply treating all people in the same way may lead to serious inequality for groups that have been disadvantaged by a system that fails to take their situation and perspectives into account. Outcomes and special measures are thus inextricably linked. They are crucial concepts for those living and working in rural and remote Australia. They involve both rights and responsibilities for individuals and the necessity for
government intervention. The current emphasis on the cost of services needs to be examined against the short and long term costs to individuals and the community if equality is to be achieved.

In June 1995 the Human Rights Act was amended to place upon the Commission a duty to ensure that its functions are performed with regard for "the indivisibility and universality of human rights; and the principle that every person is free and equal in dignity and rights; and with the greatest possible benefit to the people of Australia".

I would suggest that the same task is before you over the next few days. The health of rural and remote Australians is inextricably bound up with their human rights to social and economic equality. Access and equity are key issues to a successful beginning, middle and end to that greatest of all adventures, life itself.

George Eliot in that great book [Middlemarch] which, apart from all else, describes health care in a rural community, said: "There is so much suffering in the world it is like a noise on the other side of silence." The job ahead is to break the wall of silence and turn the noise into coherent speech.


2  P Raskall and R Urquhart, 1994, Inequality, Living Standards and the Social Wage During the 1980s, SSEI Monograph No 3, Centre for Applied Economic Research, Social Policy Research Centre, UNSW.


8  ATSIC, 1993, ibid.


10  Pownall E, 1988, Australian Pioneer Women, Viking O'Neil, Victoria, p 244.
11 Pownall E, 1988, ibid, pp 245-246

12 Daniels K & Murnane M 1980, Uphill all the Way - A Documentary History of Women in Australia, UQP, Brisbane, p 252.


15 Cramer J, 1992, ibid, p 56.