Issues in Indigenous health

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I’ll just go straight into my paper because I know that you are all probably getting a bit restless. So it hardly needs to be said again that the health of Aboriginal people is poor when compared to the wider community. It has been discussed in a stream of both national and regional reports, most of which made similar recommendations of greater Aboriginal community ownership and self-determination in the provision of health services. Many of these recommendations have never been effectively implemented.

In health terms, Aboriginal people are disadvantaged by poor living conditions, limited access to health services and a health workforce that is insufficient to their health needs. Over the last 20 years, the causes of excess mortality in the Aboriginal population have shifted from acute infections to chronic non-communicable diseases and deaths resulting from accident and injury. Aboriginal people are more likely to be affected by lifestyle-related conditions, including diabetes, the use of alcohol, tobacco or other drugs and injuries or medical conditions relating to hypertension and mental illness than the non-Indigenous population.

Mental health, particularly social and emotional well-being, is a major problem for Aboriginal people. The House of Representatives Standing Committee on Family and Community Affairs, in 1991, noted the following:

The loss of loved ones, childhood trauma, alcohol and drug-related misery, violence, ongoing racism, stereotyping and discrimination and the accumulated loss of 211 years of cultural destruction and dispossession.

Current health problems are thus multi-factorial and related to past experiences as well as to present conditions. The Commonwealth inquiry also recognised that the health of Aboriginal and Torres Strait Islander people is affected by an interplay of socioeconomic status, social and cultural factors, including past dispossession and dislocation, environmental factors and specific risk factors such as poor nutrition, alcohol misuse and high levels of tobacco consumption.

Health is also linked to the provision of good health care, with lack of cultural awareness, location, workforce limitations and financial circumstances acting as barriers to access by Aboriginal and Torres Strait Islander people. Another significant issue, as far as services like Winnunga Nimmityjah Aboriginal Health Service is concerned, is that the Commonwealth inquiry noted that the health of Aboriginal and Torres Strait Islander people is as poor in urban areas as in rural and remote areas.

Health is a fundamental human right. The United Nations Charter, the Universal Declaration on Human Rights, the Royal Commission into Aboriginal Deaths in Custody and the International Covenant on Human Rights expressed the right of Aboriginal and Torres Strait Islander people to self-determination, to have community control over their health needs, over their health decisions and resource allocation. Self-determination is a very basic proposition. It means agencies no longer tell Aboriginal and Torres Strait Islander communities what they need. Instead, Aboriginal
communities should inform governments and mainstream agencies about their needs and priorities and how these can be best addressed.

It is time for policy, program and service delivery responses to be built up by the community, time for these responses to be driven by and to be accountable to Aboriginal people. If we are really to move forward from the stop-start bandaid approach of the past, self-determination and Aboriginal community control must be put into practice. They are essential to achieving equitable health outcomes for Aboriginal people. It is also timely that we take a brief look at policy development in Aboriginal affairs. Australia’s history in Indigenous health shows fragmentation, lack of common goals and purpose, administrative confusion and subsequent lack of accountability.

It has only been in the last decade that Aboriginal health has developed any clear agenda at the national level. Constitutional responsibility for Aboriginal health, as with health generally, was always considered to be a responsibility of the State and Territory Governments. This changed as a result of the 1967 referendum when the Commonwealth powers came to include Aboriginal people. The Commonwealth established an Office of Aboriginal Affairs and made specific purpose payments to the States and Territories for Aboriginal advancement, which included health.

This constitutional change resulted in a concurrent responsibility, with neither level of government accepting full responsibility. The emergence of Aboriginal community controlled health services is 1971, which started with Redfern Aboriginal Medical Service, was an important institutional manifestation of the politics of self-determination that surfaced at the time. The number of Aboriginal community controlled health services has continued to grow since Redfern’s inception in 1971.

Self-determination was adopted by the Commonwealth Government in 1972 but this seems no longer to be the case with an apparent shift from supporting Aboriginal community controlled health services to increasing support and resources to mainstream services under the guise of making them culturally appropriate. We believe this to be inappropriate, as mainstream services continue to be unresponsive, do not support self-determination, they continue to provide inappropriate service and, in many cases, our people still experience many obstacles in access to these services.

This places enormous pressure on our severely under-resourced and under-staffed Aboriginal community controlled health services. We can give you many examples of our people still being denied access to mainstream services. For example, only last week in Canberra, a young Aboriginal man who is a paraplegic was denied admission to hospital as he was seen as a security risk to staff. We received written advice from a resident medical officer that the man would be admitted only when he presented with septic shock. I’m sure, as health professionals, that you would recognise this is only one step away from death.

For your information, he was admitted after I personally called the hospital’s CEO. However, his management continues to cause us concern. He has been placed in a four-bed ward by himself with a security guard at the door who follows him in his wheelchair to the public areas of the hospital. Even if we were to accept the security guard as reasonable, his care by hospital staff continues to cause concern. For example, he was left in emergency section for over 12 hours before being admitted.
He was provided with adequate pain relief but little else, including adequate explanation of his condition and the proposed plan for management. He was not told he was fasting due to the possibility of surgery. He only found out because a visitor requested some food for him as he was very hungry. The same visitor, who also works for another Aboriginal service, was asked by a nurse if the patient could get out of bed without assistance. I’ve already told you that he is a paraplegic and he’s in hospital because he’s sick. If we had not intervened, he may not have been here at all.

A report in 1979 suggested that the standard of health of Aboriginal people was still lower than the general population, with little advancement in raising it. This report called for more attention to the physical environmental conditions and to the social and cultural factors relating to Aboriginal health. It argued for greater Aboriginal decision making and involvement in health care. This was not a blanket endorsement of Aboriginal community controlled health services; rather, it saw the fundamental issue as being Aboriginal people should have access to information concerning the full range of health care options from which they might choose.

We would argue, even with the development of the National Aboriginal Health Strategy and the establishment of framework agreements, that little has changed. We would like to see the same level of accountability that is imposed on Aboriginal community controlled health services imposed upon governments.

The next major milestone was the release of a report on Aboriginal health in 1989. This report is known as the National Aboriginal Health Strategy (NAHS). The National Aboriginal Health Strategy 1989 Report contains a comprehensive picture of Aboriginal health that describes State, Territory and Commonwealth roles and responsibilities, describes the workforce delivering services to Aboriginal people and then recommends a policy and planning infrastructure with goals and strategies in key action areas, such as the establishment of the tripartite forums, now known as the Framework Agreements. The National Aboriginal Health Strategy defines health as:

Health to Aboriginal people is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem and justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity. Prior to colonisation, Aboriginal people’s had control over all aspects of their life and were able to exercise self-determination in its purest form.

A key factor in relation to the National Aboriginal Health Strategy was that it was driven by the grassroots Aboriginal community in its development and, therefore, validated by the Aboriginal people. It was a real working partnership between the Commonwealth and Aboriginal people. This is the basic principle that is supported by Aboriginal community controlled health services. In recent times, there seems to have been a shift away from this approach. We would encourage and support the same level of community consultation in the development of any new strategies or policies.

Improvements in Aboriginal health status are clearly bound to community development strategies. Initiatives that enhance development and advocacy are at once prerequisites for health improvement and direct causes of health improvement. Aboriginal community control is a necessary element for improving Aboriginal health. Aboriginal community controlled health services and Aboriginal health workers are working examples of Aboriginal self-determination, that is Aboriginal community controlled
health services are established by the community and managed by members of the Aboriginal community through local elected representatives, therefore have the mandate from the community to speak on their behalf in relation to Aboriginal health.

Aboriginal Health Workers are recruited from the local community and have intimate knowledge of the local community. The benefits of properly resourced Aboriginal community controlled health services include better access due to local community ownership and control of the service, the full range of primary health care services is available in one place, service delivery is integrated and holistic and the care provided is culturally appropriate. For those of you who attended the NACCHO Showcase today, you would have heard some great examples of the excellent services we are providing to our people.

Let’s have a look at what Aboriginal people would expect from a consultation process. The broad meaning of community consultation creates confusion. We all experience health problems as individuals and families. However, Aboriginal community controlled health services are the experts in addressing the serious health needs of Aboriginal people. This expertise has been gained from many years’ experience as service providers as well as the knowledge of our local communities. The consultation process used in the development of the NAHS should be used as a model of best practice.

In closing, let me reiterate that social issues have a huge impact on the health of Aboriginal people through poverty, housing and homelessness, which I would like to say is a major issue in Canberra. The lack of employment opportunities, ongoing racism and discrimination, the issues associated with incarceration also continue to be a major concern for us. A particular issue for Canberra around this is the fact that ACT uses New South Wales prisons for offenders.

The theme of this conference is “Good Health, Good Country — from conception to completion”. This is the principle on which Aboriginal community controlled health services are based. From identifying the issues to developing strategies, through to implementation and evaluation to provision of workers. Please recognise and respect our right to self-determination and help us achieve this. We welcome your assistance, especially your money. We want you to work with us but let us take the lead.