Aboriginal Health in Australia: Some Historical Observations and Contemporary Issues

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1. Background: The National Aboriginal Health Strategy

The National Aboriginal Health Strategy was developed in 1989 and subsequently endorsed by Australian governments in 1990. The Strategy sets out a comprehensive program for the improvement of the status of health of Aboriginal peoples.

The Strategy's guiding principles are:

i) Aboriginal health is a holistic concept which involves physical, emotional, spiritual, social, economic and cultural dimensions; it involves the notion that individual and community health cannot be separated from one another; it incorporates a central tenet of Aboriginal religion i.e. the cycle of life-death-life.

ii) Self-determination is given expression in the area of Aboriginal health by the concept of Aboriginal community control of Aboriginal health. At the level of primary care, Aboriginal Community Controlled Health Services (ACCHS's) are the only legitimate structures for the delivery of Aboriginal culturally appropriate health services.

iii) The extreme health disadvantage of Aboriginal communities is a direct consequence of the effects of the economic, social, cultural and religious oppression which have occurred since the installation of non-Aboriginal governments in the Aboriginal land of Australia.

iv) In order to address Aboriginal health needs effectively, intersectoral collaboration across all relevant areas of government and society is required. Since Aboriginal health disadvantage is not merely a medical problem, the biomedical model is an ineffective solution towards the goal of improving the health of Aboriginal people.

v) Government interactions with representative Aboriginal Community Controlled Health Organisations (ACCHO) have all but rarely been characterised by unequal power relationships which features a lack of respect for Aboriginal peoples, and our history, culture, society, intelligence, human rights and sovereignty. It has been recognised that all too often bureaucrats and their appointed advisers see themselves as the experts in Aboriginal health, while diminishing, devaluing, contradicting or ignoring the expertise of Aboriginal peoples. In other words, government relations with Aboriginal communities are too frequently infected with the most offensive attributes of colonial oppression.

In recognition of the need of governments to improve their record in terms of their relationships with Aboriginal communities, the National Aboriginal Health Strategy recommends an approach characterised by partnership directed towards a common goal.

2. Evaluation of the Strategy

Even though Australian governments endorsed these guiding principles and the recommendations of the National Aboriginal Health Strategy across a range of Aboriginal health issues, the official evaluation of Strategy in 1994 made the following principal findings:

i) The Strategy was never effectively implemented.

ii) The Strategy's initiatives had been grossly underfunded.

iii) The National Council of Aboriginal Health - which was established to oversee implementation of the strategy - lacked political support on the part of the governments and their agencies.

iv) The Commonwealth objective of obtaining equity in access for Aboriginal peoples to health services and facilities in the year 2001 is unattainable at both current and projected levels of funding.

v) Health statistics show that Aboriginal peoples are so far behind the rest of the Australian community that equity considerations demand national large scale affirmative action programs.

The introduction to the Evaluation of the National Aboriginal Health Strategy makes the following salient point:

> *The principal difficulty does not lie in assembling overwhelming evidence legal or numerical to quantify the problem (of Aboriginal Health). Rather the difficulty lies in the living environment and the lack of political will to make the financial investment necessary to achieve equity.*

The evaluation recommended a human rights based approach to funding and estimated that $2 billion was needed to meet the backlog in the provision of essential services.

Subsequently, Australian governments endorsed the findings and recommendations of the National Aboriginal Health Strategy Evaluation and have given solemn commitments to imple-

ment the National Aboriginal Health Strategy.

Australian governments have also given commitments to implementing a stream of other Aboriginal health reports and recommendations including the relevant recommendations of the Royal Commission of Inquiry into Aboriginal Deaths in Custody, the National Aboriginal Mental Health Report known as "Ways Forward", the Report of the Stolen Generation's Inquiry, numerous state government Aboriginal health policies, national multi-lateral agreements and various memoranda of understanding.

However, to again quote the Evaluation of the National Aboriginal Health Strategy, "simply tinkering and fiddling and writing reports and setting up committees will resolve nothing".

While it would be unfair to say that there have been no positive achievements by Australian governments in Aboriginal health in the five years since the Evaluation of the National Aboriginal Health Strategy was written, it would be far more deceptive to maintain that those achievements have made any significant contribution to counterbalancing the ugly tide of racism and prejudice which have re-emerged with new found force in Australian society. Uncomfortable as things were for Aboriginal people five years ago in 1994, the current time is much worse.

3. Recent Political Environment

While the Australian Hight Court's Mabo Decision and the Native Title Act gave us some measure of hope and optimism because we were finally given recognition under Australian law of our prior ownership of Australia, the events surrounding the rise to prominence of Pauline Hanson's One Nation Party in 1996 have had a catastrophic impact on our capacity to lead our lives with the dignity to which we are entitled as human beings.

Ms Hanson's political organisation promulgated many anti-Aboriginal prejudices and untruths including:

i) that Aboriginal peoples were cannibals;

ii) that Aboriginal peoples should not have a right to self-determination and culturally appropriate services;

iii) that Aboriginal peoples obtained government benefits in excess of those available to non-Aboriginal peoples;

iv) that Aboriginal peoples would use the Native title Act to evict non-Aboriginal peoples from properties over which they had free-hold title.

In addition to these extremist policy pronouncements about Aboriginal peoples, the One Nation Party promoted the general view in relation to equity that all people should be treated equally regardless of need. That is to say, the One Nation party promoted a policy on equity by virtue of which existing levels of socio-economic disadvantage would increase.

It is a matter of record, both domestically and internationally, that Australian governments failed to act with speedy and decisive conviction against the One Nation Party. While a number of Australian governments went so far as to argue that a counter attack on One Nation would only increase its popularity, some of those governments began to shift ideologically towards the very policy prescriptions to which they were allegedly opposed but would not openly criticise.

As political opinion polls began to register increasing support for extreme right wing political sentiment, some Australian governments became more disposed to advocate actively against the interests of those who ought to be major beneficiaries of government activity.

4. Impact of Recent Political Developments on Aboriginal Health

The impact on Aboriginal health has been profound at every level. Nowhere to be seen are the large-scale affirmative action plans, the additional $2 billion (1994 dollars), an analysis that Aboriginal health is a scandal and therefore should be a central concern of government, all those very recommendations identified in the National Aboriginal Health Strategy Evaluation. Instead, the gross under funding of Aboriginal health programs remains substantially unchanged.

As demonstrated in the Deeble Report on Aboriginal Health Expenditure in 1998, the per capita expenditure for all health services adjusted for socio-economic status is the same for Aboriginal and non-Aboriginal people. Given the appalling state of Aboriginal health it is estimated that overall per capita expenditure should be at least three times the relevant national average in order to lay the foundation for any improvement in Aboriginal health status.

When only national (as distinct from combined national and state government expenditure) government expenditure are considered, Aboriginal health per capita expenditure ratios are much worse. The Deeble Report demonstrates that expenditure on pharmaceuticals for Aboriginal people was one quarter of the per capita national average whereas the per capita expenditure ratio on primary and specialist medical services through Medicare and Aboriginal Community Controlled Health Services was 0.75:1.

In this context, it should be noted that since 1996 funding to Aboriginal Community Controlled Health Services has diminished in real terms through the operation of funding cuts known in euphemistic bureaucratese as "efficiency dividends" and the fact that the federal government has not funded salary increases for which ACCHS's are legally liable.

At the same time, while ACCHS's have witnessed a diminution in their available levels of funding resources, the federal government's Aboriginal health policy arm, OATSIH (the Office of Aboriginal and Torres Strait Islander Health) has developed into a sprawling bureaucracy of over 117 staff with an annual budget of over $10 million and expenditure on con-

sultancy fees of between $2 to 5 million.

When federal bureaucratic responsibility for Aboriginal health was vested with ATSIC (the Aboriginal and Torres Strait Islander Commission), its Aboriginal Health Policy Unit operated with a total staff complement of 15. The bloated size of OATSIH seems even more ironic when it is considered that one of the reasons for the transfer of Aboriginal health policy responsibilities from ATSIC to the Department of Health was that OATSIH was supposed to identify and secure additional sources of Aboriginal Health Service delivery funding from within mainstream health programs.

Apart from funding to address the critical issue of funding inadequacy in Aboriginal health, many Australian governments have actively attempted the thwart Aboriginal Community Controlled Health Organisations in their right to pursue the practical implementation of Aboriginal self-determination in Aboriginal health. All too often, the only intersectoral and inter-governmental co-operation in Aboriginal health is manifest in collusive machinations between bureaucrats and their chosen external experts who together conspire to promote policies and activities whose intention or effect will militate against the economic, social, legal, spiritual, cultural or religious rights of Aboriginal peoples.

While this particular aspect of bureaucratic neo-colonialism is by no means a recent feature of government approaches to Aboriginal health policy, its practitioners are now more brazenly adventurous since their political masters have become willing acolytes of the prejudices of a former time when the White Australia Policy prevailed.

5. Recurrent Themes in Aboriginal Health and Aboriginal Affairs

Indeed, the present and the past share many common themes. There may be changes in the details and actuality of the oppressive behaviour to which we are subject. It could be argued that racial prejudice is now practised with more subtlety although it would also be argued with equal cogency that subtlety is not a term which can be applied readily to racial prejudice.

In the past we were shot poisoned, hung, tortured and raped, physical genocide was perpetrated against us. We were forcibly expelled from our lands, we were told to forget our culture and religion, we were told to become Anglicans and to speak English. Our children were taken from us, we had no legal rights and we were owned by white people. We were governed under legislation that related not to human beings but to plants and animals, that is under the Flora and Fauna Act. We are told to forget all this as though it did not happen, but it did happen and it continues to happen.

That the tragedy of our past remains with us is manifest in the fact that our men rarely live past 48 years and the life expectancy of our women is about 52 years. We have unacceptably high rates of maternal, infant and child death. The effects of diabetes, premature heart disease, infection, substance misuse and psychological illness ravage our communities.

The root causes of ill health in Aboriginal communities result from the economic, social, cultural, religious and spiritual dispossession of our peoples. All this is well known and documented in numerous government reports. Yet too often when we negotiate with government over the implementation of these reports, we are patronised, talked down to and devalued, even shouted at. It is as though we should bow down before our superiors. We are treated with contempt and not respect. Nothing has changed.

Indeed, today's government officials are like the 'mission managers' of old and we are their blacks to be controlled. Their attempts to control us are manifest in many ways. It is their agenda and their priorities to which we must submit.

Furthermore, we are told to emphasise positive achievements. Yet if we dare to say that the positive achievements are all but inconsequential when viewed in the context of the overwhelming burden of ill health, the message comes down that our funding might be threatened. We are fed the line that evidence-based medicine, computerisation and recall systems are tremendous advances in Aboriginal primary health care.

Actually, much of the thinking behind this technical approach came from the Aboriginal health sector but it was only conceived as a small part of an overall strategy. It was never intended that it should become the strategy - the medical model has never had any legitimate currency in Aboriginal health - and it was certainly never intended that these so-called positive achievements should be used as a smokescreen to camouflage the fact that the structural determinants of our ill-health have been influenced adversely as a consequence of the increased ascendancy of extreme right-wing policy in Australia.

6. Conclusion

The bare truth of our history is that non-Aboriginal governments and their agencies have always oppressed us. Attempts from within Australia to right these wrongs against us have failed. The breadth of vision and determined political will are not to be found within this country. We cannot afford more time, we do not need more committees, more reviews or more reports. We cannot again go through the cycle of having our hopes raised and then to watch them disintegrate as the reality dawns that Australian society has an ingrained and fundamental incapacity to recognise our dignity as human beings.

The scandal of our health and our socio-economic disadvantage are massive human rights concerns about which international community must now exercise its influence. Perhaps a vehicle for such international action may be through the establishment of an international monitoring agency charged with the responsibility of calling governments to account over their treatment of Indigenous peoples.